



The Signs of Safety

Comprehensive Briefing Paper

Dr Andrew Turnell

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CONSULTANCY

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The Signs of Safety: Comprehensive Briefing Paper

Dr Andrew Turnell

Version 2.1

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/briefing-paper.

Updated in version 2:

- Chapter Eight on Safety Planning
- New outcome and data information in Chapter Five
- New section in Chapter Nine on executive leadership

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1. Introduction: A Constantly Evolving Approach

It is with great pride that we at Resolutions Consultancy have prepared and offer this second version of the Signs of Safety Briefing Paper. I believe I can confidently say that the Signs of Safety approach to child protection casework is now recognised internationally as the leading progressive approach to child protection casework currently available.

Although the approach has been growing since Steve Edwards and I began to collaborate in the late 1980's, the last few 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 completely grounded in and continues to evolve focused on what works for the frontline practitioner. There are currently nearly 100 jurisdictions in 12 countries undertaking some type of substantive implementation of the Signs of Safety. I am very proud to be able to report that the most substantial and comprehensive system-wide implementation is underway in my own state of Western Australia where the Signs of Safety is the assessment and practice framework for all child protection practice. That implementation is ongoing and began in mid 2008. Beyond Western Australia the most substantial system-wide implementations are occurring (or have occurred) in: Olmsted, and Carver, Yellow Medicine, Shurburne, Scott and numerous other Minnesota counties; Gateshead Children's Services Authority, England; Bureau Jeugdzorg in Drenthe, The Netherlands; Open Home Foundation, New Zealand; all Copenhagen boroughs in Denmark; Ktunaxa Kinbasket Child and Family Services, British Columbia, Metis Child Family and Community Services, Manitoba Canada, Saitama City, Japan.

Child protection services need to be structured and systematic in their organisational and casework responses to child maltreatment. Anyone who was influenced by the open, almost-anything-goes field that was social work in the 1970's, knows that while there was extraordinarily good child protection work happening at that time, there was also correspondingly appalling work happening at the other end of the practice continuum. Since the 1970's, when the poorest organisational and casework practices began to be exposed through critical case reviews and death inquiries, proceduralisation has become the dominating paradigm for reforming child protection practice in all developed countries around the world (Ferguson 2004; Munro 2004; 2010; 2011). Unfortunately, proceduralisation has not created the transformation that was hoped for. The following words of the US government's 1991 National Commission on Children are probably truer today than they were when they were 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 and conceptual challenge has lead almost universally to systems across the developed world becoming increasingly ex-



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pensive and defensive. Child protection systems worldwide are facing increasing numbers of children in care for longer periods, increasing numbers of parents being taken to court and increasing staff turnover, alongside decreasing staff morale. (It is worth stating that this does not mean that rates of actual child abuse have increased in these countries —determining that is a much harder analysis.) In 2009 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 sounds pessimistic it is actually very easy to mount an argument that the title is polly-anterish, since the reality is that almost all child protection jurisdictions everywhere in the developed world have indeed changed—they have all become worse!

Seeking to reform child protection practice, the burgeoning international community of agencies and professionals involved in the Signs of Safety work and I have taken a different route. The strategy for change 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.

The recent explosion of agencies and practitioners using and reporting their work around the world means that the Signs of Safety, which has always been a moving target, is evolving daily. This is exciting but the change is now so rapid I am certainly not able to keep up with all of the developments. The following are six of the most notable changes that have occurred within the Signs of Safety practice approach since the release of Turnell and Edwards 1999:

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

This briefing paper, which will be constantly updated through our website at www.signsofsafety.net, is designed to give an overview of the current state of play of the ongoing development of the Signs of Safety approach to child protection casework.

The paper begins by locating the Signs of Safety within its values base by exploring three foundational principles. All models and approaches have their genesis in the journey of particular professionals, wrestling with particular issues in particular contexts. These are important stories to tell in understanding any approach, thus the next section offers a brief history of the development of the Signs of Safety. Chapter 5 details the extent and locations of international use and the sorts of changes in data sets and outcomes that these jurisdictions have found in using the Signs of Safety. Chapter 6 goes to the heart of the Signs of Safety practice framework describing how this approach frames and undertakes the core child protection task of risk assessment and planning. Chapter 7 looks at the tools the approach draws upon to locate children in the middle of the practice. The final two chapters focus on system implementation. This briefing paper has evolved and is largely derived from the Background Paper (DCP, 2008) I prepared for the Western Australian Department for Child Protection when we began the state wide implementation in 2008. My thanks go to this department and to its Director General Terry Murphy for permission to rework the original Background Paper into this Briefing Paper.

2. 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 everyone is speaking a different language (Munro, 2002, Reder, Duncan and Gray 1993). The Signs of Safety framework is designed to create a shared focus 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 (often someone like a director general, a judge or child psychiatrist) to the 'smallest' person (the child).

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

Completing the Signs of Safety assessment framework is, in the end, 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 places in which the child lives.



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3. Three Core Principles of the Signs of Safety Framework and Approach

Child protection practice and culture tends toward paternalism. This occurs whenever the professional adopts the position that 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 further disenfranchises the families that child protection organisations work with and exhausts the front-line 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.

3.1 Working relationships

Constructive working relationships between professionals and family members, and between professionals themselves, are the heart and soul of effective practice in situations where children suffer abuse. A significant body of thinking and research suggests that best outcomes for vulnerable children arise when constructive relationships exist in both these arenas (Cashmore 2002; Department of Health 1995; MacKinnon 1998; Reder et al. 1993; Trotter 2002 and 2006; Walsh 1998). Research with parents and children who have been through the child protection system assert the same finding (Butler & Williamson 1994; Cashmore 2002; Gilligan 2000; Farmer & Owen 1995; Farmer and Pollock 1998; McCullum 1995; MacKinnon 1998; Teoh et al. 2004; Thoburn, Lewis & Shemmings 1995; Westcott 1995; Westcott & Davies 1996).

It only takes a few moments reflection to grasp the truth of the assertion 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 professional 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 Department of Health (2002); Munro (1996 and 1998); Hill (1990); Reder, Duncan & Grey (1993) would suggest that poorly functioning professional relationships of this sort 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. 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.

3.2 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. More than this the professional ceases to think critically and tends to exclude or reinterpret any additional information that doesn't conform to their original position (English 1996).

Eileen Munro, who is internationally recognized 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: 125)¹

Restraining an individual's natural urge to be definitive and to colonise one particular view of the truth is the constant challenge of the practice leader in the child protection field. Enacting Munro's maxim requires that all 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.

¹ *Bold text added for contextual clarity.*



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3.3 Landing grand aspirations in everyday practice

Just about everybody, from taxi drivers to parliamentarians want to tell the child protection worker how to do their job. The problem is 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 off like ‘voices from twenty seven thousand feet’².

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 and impose their views on the front-line practice practitioner. At all levels this is ‘command and control social work’³ and it rarely delivers a constructive outcome. This command and control approach alienates those at the front-line 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 USA, Canada, United Kingdom, Sweden, Denmark, Holland, New Zealand, Finland 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.

4. History

How the Signs of Safety Approach Evolved

The Signs of Safety approach to child protection casework was developed through the 1990’s in Western Australia. The approach was created by Steve Edwards and myself in collaboration with over 150 West Australian child protection workers and is now being utilized in jurisdictions in the USA., Canada, United Kingdom, Sweden, Finland, Denmark, The Netherlands, New Zealand and Japan.

The impetus to create the Signs of Safety approach arose from Steve Edwards’ experience of 16 years as a frontline child protection practitioner, eight of these working primarily with Aboriginal communities, within the Western Australian statutory child protection agency. Steve was very dissatisfied with most of the models and theory regarding child protection practice that he had encountered. Despite 16 years of frontline practice, Steve 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.).

² This is an expression used by Russell Martin, Director of Open Homes Foundation New Zealand.

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

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



Above: This graphic record was created by artist Mary Brake at a Signs of Safety workshop in Auckland, March 2004. For more info: www.reflectiongraphics.com

Steve and my collaboration and Steve' 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, Steve and I began the process of working with other child protection practitioners, training them in what they had learnt from the previous three years of collaboration. This opportunity was first opened up when then assistant District Director John Hancock invited us to train all practitioners in a rural district then called Eastern Region and work with them for six months to implement the approach in all their casework. Between 1994 and 2000, we undertook 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 train-



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ing and action-learning project, Steve and I would provide 5 days training in the Signs of Safety approach, as it had evolved and was able to be articulated at that point in time. The project groups usually comprised between 15 to 20 workers, but sometimes, for example in the first three projects in Eastern and Peel Regions they involved considerably more practitioners. The initial five-day training was always 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. Steve and I would spend at least one day a month looking closely with the workers at where they had been using the approach and it had made a difference as well as exploring and helping with cases in which they were stuck. By focusing on where workers were using the approach and making progress, we learnt directly from the practitioners themselves about where, when and how they were actually able to use the Signs of Safety approach. Steve had always insisted that only ideas, skills and practices that workers actually used would be included as part of the Signs of Safety model. This collaborative, action learning process used in all follow-up sessions was the basis of what I have come to describe as 'building a culture of appreciative inquiry around frontline practice' (Turnell 2006; 2007a; 2007b and In Press). This is the core practice and organisational change strategy underpinning the Signs of Safety approach. Steve and I brought two publications to press, which directly describe the West Australian 1990's period of the evolution of the Signs of Safety approach (Turnell and Edwards 1997; 1999).

5. International Use and Data

5.1 International Use

Since the 1999 publication of the book Steve Edwards and I wrote on the Signs of Safety there has been escalating international interest in the approach. I have been working overseas for at least three months each year providing training and consultancy since 2000 and there are now trainers and consultants well equipped to lead and train the Signs of Safety approach in Europe, North America, Japan, Australia and New Zealand. By this process tens of thousands of child protection practitioners have been trained in Finland, Sweden, Denmark, Netherlands, France, United Kingdom, Canada, USA, Japan and New Zealand and there are sustained implementations of the Signs of Safety being undertaken in nearly 100 jurisdictions and agencies in these countries.

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 used consistently in increasingly higher risk cases. Later publications describe the further development of the approach in North America, Europe, Japan and New Zealand (Brennan and Robson, 2010; 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; Koziolk 2007; Myers 2005; Parker 2009; Roessler, and Gaiswinkler, 2012; Shennan 2006; Simmons, Lehman and Duguay 2008; Turnell 2004, 2006a, 2006b 2007a, 2007b and In Press a, b and c; Turnell, and Essex 2006; Turnell, Elliott and Hogg 2007; Turnell, Lohrbach and Curran 2008; Weld 2008; Westbrook 2006; Wheeler, Hogg, and Fegan 2006; Wiggerink, and Rozenboom, 2012). The Signs of Safety approach has also been used as the organizing framework within collaborative conferencing procedures as an ongoing sustained practice in Western Australia (DCP, 2009) West Berkshire, England, Trollhatten, Sweden and Olmsted County, Minnesota USA (Christianson and Maloney 2006; Lohrbach and Sawyer 2003, 2004; Lohrbach, et. al. 2005; West Berkshire Council 2008). More information is also available at www.signsofsafety.net.

5.2 Evidence Base and Supporting Data

5.2.1 Professional Identity and Job Satisfaction

In the 1990's Steve Edwards and I undertook two follow-up studies with participants in the 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



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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/carveraiinterview-march2008>. Systems that implement the Signs of Safety consistently find increased worker morale and job satisfaction. This is reflected in many of the evaluations and studies presented below.

5.2.2 Case and System Change Data

The longest running and most complete implementation of the Signs of Safety within a statutory child protection system has occurred in Olmsted County Child and Family Services, Minnesota USA. OCCFS have utilised their 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. Before presenting the Olmsted data it is important to emphasise that the reform agenda within OCCFS goes beyond Signs of Safety.

In 1996 OCCFS were one of the first counties in the USA to implement the use of family group conferencing. OCCFS have maintained this effort and have significantly evolved their use of participatory conferencing processes such that all of their high-risk caseload is managed through the regular (as often as weekly or fortnightly) family and professional conferencing. Almost all child protection cases before Olmsted county courts are diverted into a conferencing process involving all stakeholders, family and professional, and high-risk infant cases are conferenced within 24 hours of presentation at hospital.

OCCFS also maintain a rigorous front-end actuarial safety assessment process that clearly distinguishes cases by risk type and thus the county has been able to pioneer one of the USA's most successful differential response programmes. This reform agenda began in 1994 and has been sustained through the leadership of agency Director, Rob Sawyer. In the 12 years to 2007 during a period in which OCCFS has tripled the number of children the agency works with, the agency has 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 be the result of a system that is focused on cost cutting or is lax on child abuse except that in 2006, 2007, 2008 and 2009 the county recorded a recidivism rate of less than 2% as measured through state and federal audit. The expected federal standard in the US is 6.7% and very few state or county jurisdictions meet that standard. The Olmsted data set are extraordinary figures as most jurisdictions in most countries have significantly 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); Lohrbach and Sawyer (2003, 2004); Lohrbach et. al. (2005); Turnell, Lohrbach and Curran (2008) and go to www.co.olmsted.mn.us.

Following the lead of Olmsted County, a second Minnesota county, Carver County Community Social Services (CCCCSS) 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 CCCCCSS practitioners to improve their skills, particularly in providing choice and in involving parents in safety planning. Significant changes in case data are usually not seen in any form of child protection reform agenda until at least the third year of a meaningful implementation but by the end 2007, some trends were emerging in the Carver data set. In 2004 and 2005 the Carver system terminated parental rights in 21 families, through 2006/7/8 only six families experienced the ultimate sanction⁴.

Carver's out of home placements and children in long-term care have been trending downwards over the past three years with new placements in 2008 less than half the 2005 rate. Throughout this time recidivism rates have been trending downwards. These figures are very encouraging but drawn from the first four years of full implementation and it is too early to say whether these trends will be maintained. The next two to three years will be critical in ascertaining whether the Signs of Safety implementation at CCCCCSS is having a significant long-term impact in casework data. More information about the Carver implementation can be found at: <http://www.signsofsafety.net/pages/implementations.html> that includes video-recorded interviews with 15 staff and a long-term alcoholic mother describing her experience of the Signs of Safety approach and Koziolk (2007).

With the ongoing and sustained system wide implementations in Olmsted and Carver counties the Minnesota State Department for Human Services together with Casey Foundation have funded a process for training and implementing Signs of Safety through 19 other counties in Minnesota. Shurburne County have been one of the early adopters in this undertaking and in the years 2007 to 2009 they have halved the use of court in child protection cases. In 2009 they reduced the county's placement of children by 19 percent. A substantial independent evaluation has been undertaken by the Wilder Research Group (Skrypek, Otteson and Owen, 2010) which describes the successes and struggles experienced by the 19 Minnesota counties involved in the statewide project. In 2011, Wilder Research undertook a follow-up study interviewing parents who had been on the receiving end of Signs of Safety child protection practice (N=24). The sample included 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% of parents interviewed felt that their caseworker had been honest and "straight up" with them about their case.

⁴ For me as an Australian sensitised by the trauma of the stolen generations this five-fold reduction is particularly satisfying.



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- Two-thirds of respondents reported that their worker had taken the time to get to know them and their situation.
- 71% reported that during the process of safety planning, their worker 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 very rich and nuanced manner. Two parental quotes that reflect this are listed below:

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).

5.2.3 Western Australia

The largest system-wide implementation of the Signs of Safety is being undertaken by the Department for Child Protection (DCP) in Western Australia. DCP serves a state that covers one third of Australia's landmass, stretching almost 4000 kilometres from north to south. Its population is 2.3 million and the agency employs over 2300 staff. While the Signs of Safety approach was created in Western Australia in the 1990's, the approach was not adopted as DCP's child protection assessment and practice framework until 2008 when it began a full system-wide implementation. 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% each year (Lamont, 2011). The rate of increase in the Western Australian system was above the average in 2006 and 2007 running at 13.5%. With the implementation of the Signs of Safety that rate has been cut to an average of 5% in 2009 to 2011. Alongside this, the percentage of child protection assessments that have been referred to intensive family support has increased from 2.5% to 13% and the percentage of protection and care applications has been reduced by 24%. Since recidivism rates have not changed, staying stable at 6.9% since 2008 this suggests the more collaborative approach to families has not increased the risk to vulnerable children. The recidivism rate is particularly meaningful because Western Australian has implemented mandatory reporting during the past three years which has increased notifications.

At the end of the second year of implementation in 2010, DCP conducted a survey of staff. The survey found the Signs of Safety approach had provided 64% 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
- Open, transparent, honest

DCP is currently designing a second more detailed staff survey that will be completed during 2012.

As part of its system-wide implementation of the Signs of Safety, DCP uses Signs of Safety meetings as a key mechanism for building and focusing professional and family collaboration on child safety. These meetings particular focus on pre-birth and pre-hearing court planning. The promotional brochures used to explain to professionals and family how these meetings work and what they will achieve are available at <http://www.dcp.wa.gov.au/Resources/Documents/SOSMeetings.pdf> and <http://www.dcp.wa.gov.au/Resources/Documents/SOSPre-hearingConferences.pdf>.

DCP evaluated the first year of using Signs of Safety meetings in pre-birth planning with pregnant mothers facing high-risk situations. The outcomes were impressive, including a 30% reduction in child removals for this cohort and a significantly improved working relationship between DCP and Western Australia's primary maternity hospital.

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, DCP and other professionals. Matters referred to a Conference resulted in 300% less 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 the Pilot matters led to more consent orders and negotiated outcomes compared to non-Pilot matters.

Both evaluations are available at <http://www.signsofsafety.net/westernaustralia>.

5.2.4 Gateshead England

Gateshead Children's Services Authority referral and assessment (investigation) teams have been using the Signs of Safety approach in all their work since 2001. This has had a significant influence on practice and the culture of practice in this local authority— including the fact that Gateshead referral and assessment teams have a very stable workforce with far lower staff



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turnover than investigative teams in other equivalent authorities. Gateshead local authority consistently scores very highly on the UK's national government Ofsted audit ratings including being assessed at Grade 4 in both 2007 and 2008. In 2007 Gateshead was one of the 14 top Local Authorities; in 2008 it was in the top three. Gateshead's standings in the national government's audit processes cannot be directly correlated to their practitioners' use of Signs of Safety but professionals in the agency say that this approach has made a significant contribution to the practice culture of the organisation.

5.2.5 English Research

Two recent 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 approach 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 and states the following:

In England, some children's departments are adopting this [Signs of Safety] approach to improve decision making in child protection. Police, Social Care with adults and children and Children's Guardians 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 continually be revisited
- The group could acknowledge that strengths and meetings could focus on how to achieve safety. (Gardner, 2008, p 78).

John Wheeler and Viv Hogg recently published a book chapter reviewing and summarising the evidence base supporting the Signs of Safety approach. This can be found in Wheeler, and Hogg; 2011.

The Signs of Safety approach draws upon and utilises the pioneering safety planning work of Susie Essex, John Gumbleton and Colin Luger from Bristol within their Resolutions approach to responding to 'denied' child abuse. The Resolutions work is described in Essex, et al., 1996; 1999; Essex, Gumbleton, Luger, and Luske 1997; Turnell and Essex, 2006.

Gumbleton (1997) studied outcomes for 38 children from the first 17 families that had undertaken the resolutions program 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 program between eight and 45 months prior to participating in the study, with an average time since completion of 27 months. The study found that the resolutions program 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 (see Fluke and Hollinshead 2003 for discussion on this matter), however a wide range of studies suggest re-abuse rates for families involved in the child protection system generally fall in a range between 20 and 40%.

Constructive relationships between professionals and family members, and between professionals themselves, are the heart and soul of effective child protection practice. A significant body of thinking and research tells us that best outcomes for vulnerable children arise when constructive relationships exist in both these arenas (see, Cameron, and Coady 2007; Cashmore, 2002; de Boer and Coady, 2007; Department of Health, 1995; MacKinnon, 1998; Maiter, Palmer and Manji, 2006; Reder, Duncan & Grey, 1993; Trotter, 2002; Walsh, 1998; Yatchmenoff, 2005). By contrast, research has also demonstrated that working relationships, professional relationships and attitudes toward service recipients are very often negative, judgmental, confrontational and aggressive (Cameron and Coady, 2007; Dale, 2004; Forrester et. al., 2008 a and b). A significant difficulty is that little attention is given within the literature of social work and the broader helping professions about how to build constructive helping relationships when the professional also has a strong coercive role (Healy 2000; Trotter 2006). The Signs of Safety approach to child protection casework seeks to fill this vacuum and there is every likelihood that the success of the approach as described above arises because the model provides specific guidance and structure to assist practitioners to both undertake their statutory role and to do this collaboratively.

5.2.6 New Zealand

Emily Keddell, a social work lecturer and researcher at Otago University, New Zealand undertook an in-depth qualitative study with ten families involving 19 children placed in foster-care. The study looked at the work of Open Home Foundation practitioners using the Signs of Safety approach in building safety to reunify children to their families of origin. 16 of the 19 children were reunified in 9 families. Keddell's study (Keddell 2011a and b) found that the key elements in enabling the successful reunification work were:

- Strong working relationship between worker and parents that considered risk and safety
- Strong focus on parental and family strengths



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- Sustained and detailed exploration of what exactly safe parenting looked like and how it could be achieved
- Time to build the working relationship and do the casework

5.2.7 Drenthe, Netherlands

Bureau Jeugdzorg, Drenthe in The Netherlands have been implementing the Signs of Safety since 2006. The agency has surveyed its staff regarding the benefits of using the approach. Workers report:

- They now don't feel alone in the responsibility for the child's safety, but share it with the family and their support network as well as the professional network
- They have become more open with each other about their practice and provide each other with more support through the dilemmas of doing their work
- Their practice is more transparent, because the professional anxieties are talked about openly
- Families understand better the decisions workers make.
- Using the Signs of Safety framework makes their work faster and leads them to focus on plans clients make with their own support network. This in turn reduces the pressure on practitioners to come up with solutions
- The focus on good practice brings energy and connection and enables practitioners to learn from each other
- They experience more joy in their work
- They feel greater pride in the work that they do with families.

In the period Bureau Jeugdzorg Drenthe 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 44%. In the Netherlands, the average length of agency involvement in long-term statutory cases is 2.9 years and between 2006 and 2008, Bureau Jeugdzorg Drenthe operated at that average. In the 3 years following 2008 average involvement reduced by 17.5% to 2.4 years. In 2007 the investigative arm of Bureau Jeugdzorg Drenthe, the AMK, directed 18.5% of its cases to the court. By 2011 this percentage had reduced to 11.3%.

5.2.8 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 found the following data:

- The project provided practitioners with more useful tools and skill set than previously available to them (75%)
- Increased practitioner focus on the family's resources (72%)
- Increased practitioner's inclusion of family's strategies and solutions (55%)
- Practitioners gave families more responsibility (49%)
- Regular use of Signs of Safety at team meetings (79%)
- Used Signs Of Safety framework together with families (69%)
- Used Signs Of Safety framework at network meetings with other professionals (66%)

As part of the study, a cohort of 139 families who received intensive services and were assessed as having a high likelihood that the children may need to be placed in care, were compared to a control group. The Families in the Centre cohort had a lower proportion of children taken into care – 15% removals compared to 42% in the control group – and the cost/per family serviced was significantly reduced.

5.2.9 British Columbia, Canada

Ktunaxa Kinbasket Child and Family Services (KKFCS) delivers statutory child protection services to Aboriginal children and their families in 4 geographic areas of the Ktunaxa Nation within the Kootenay Region of British Columbia. KKCFSS is what is described in Canada as a 'delegated child protection agency', which means that KKCFSS has full statutory child protection responsibility for the people it serves. 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 doing child protection work with rigour while also practicing collaboratively with the communities and families they serve. Collaboration is critical in aboriginal communities that have been devastated by the colonisation of earlier child protection practices.

The rapid growth of KKFCS's work over recent years raises difficulties in precisely analyzing the 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 substantive decrease in the number of children entering care; and when children do enter care there is a substantive decrease in the number of contested court matters. There are less child protection re-notifications and when families do re-engage it is often due to the family requesting support rather than a report of child protection.

Additionally, KKFCS has undergone two external practice reviews, one in 2007 and one in 2010, that measure compliance to Provincial Government Aboriginal Practice Standards. Findings from these reviews show compliance increased as follows:

- Overall compliance to child protective investigations standards increased from 73% to 92%,



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- Overall compliance to family services standards increased from 81% to 94%,
- Determining if a child needs protection increased from 67% to 93%,
- Recording and reporting the results on an investigation increased from 50% to 90%,
- Meeting timelines for investigation increased from 33% to 75%,
- Completed Support Service Agreement with families increased from 45% to 95%, and
- File documentation increased from 48% to 82%.

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

- The implementation of Signs of Safety as the practice model, and
- The development of an Information Management System (Client Database) that supports the practice model.

The following is an excerpt from the Provincial Director responsible for oversight of 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.”

5.2.10 Manitoba, Canada

The Metis Child and Family Service (MCFS) of Manitoba, Canada provides statutory child protection services to all Metis people in the state (17% of the population). In 2010 MCFS undertook a pilot project using the Signs of Safety in two sites and then conducted an evaluation (Caslor, 2011) of the approach particularly comparing the impact and utility of Signs of Safety with approaches the agency was already using. The evaluation found the following:

- Workers found the tools, particularly Signs of Safety mapping and the Three Houses tool, very useful and more useful than existing actuarial risk assessment (SDM)
- Workers felt more confident in their decision-making compared to the confidence they drew from using the SDM
- 85% of collateral service providers who had previous experience collaborating with MCFS workers identified a noticeably better experience working with staff from the pilot units. These service providers noticed more involvement of family, a more strength-based approach, a desire to keep trying until things work, and better knowledge of the families’ needs and circumstances

- Parental satisfaction with the services provided was very high, and the vast majority of families contacted would trust their worker enough to recommend them to a family member who needed help.

Since the completion of the evaluation and partly due to its findings and recommendations, the Signs of Safety approach has become the primary practice approach for the MCFS system.

5.2.11 Towards practice-based evidence

There is an increasing emphasis being placed on the importance of evidence-based practice in the helping professions and child protection. Quite apart from philosophical debates about the significance and meaning of evidence-based practice, there are considerable problems in believing it is possible to apply a strict evidence base to child protection practice. Within the field of psychotherapy for example, it is at least sometimes possible to undertake the 'gold standard' of randomised trials focused on particular modalities of treatment. Such research is impossible within child protection services, since it is not ethical or 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 that are usually of most significant research interest) there is almost always so much going on (e.g., family involvement with multiple services, court proceedings, police involvement etc., etc.) it is effectively impossible to stake a definitive claim for the causative impact of any particular change in policy, guidance or practice. Usually the best that can be achieved is to track a child protection system's outcome data and to endeavour to link this to the time periods during which a new initiative was implemented.

A significant problem with most child protection research is that large data sets and key performance indicators hold very limited import for the frontline practitioner and offers 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> and http://www.rtc.pdx.edu/pgProj_6practice.shtml.

The Signs of Safety approach has been created and evolved with an acute sensitivity to the lived-experience of those at the sharp end of the child protection business the service delivers and service recipients. Building on this sensitivity, Turnell has directed all of his research endeavour and writing toward documenting constructive practice as described by frontline practitioners, parents and children. The Signs of Safety model has and continues to evolve through the application of practice-based evidence and appreciative inquiry into practitioner and recipient-defined best practice. Building a culture of appreciative inquiry and research around frontline practice will be critical to the successful implementation of the Signs of Safety. This will be considered further in section ten of this document.



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6. Signs of Safety Assessment and Planning Framework

Reclaiming Risk Assessment as the Heart of Constructive Child Protection Practice

6.1 Risk as the defining motif of child protection practice

Child protection practice is probably the most demanding, contested and scrutinised of work within the helping professions, primarily because the endeavour focuses on our 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 constantly review whether there is enough safety for the child to return home.

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

6.2 Reclaiming and re-visioning 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 seriously engage 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 crucial issue in all this is that risk is almost always seen negatively, as something that must be avoided. Put simply, everyone is worried about being blamed and sued for something. Thus our 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's easier to see things differently (sport being such a core part of the Australian psyche). Usain Bolt doesn't hide from the world championships, Roger Federer doesn't run from Wimbledon, Dawn Fraser didn't run from Tokyo in 1964. These players champ at the bit to get themselves into these contexts because while they may fail spectacularly, on the biggest stage, in front of millions, it is also very possible they will succeed gloriously. The analogy isn't exact, particularly because no one dies at Augusta, Wim-

bledon or the Tokyo Olympics 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 maxim, known to child protection workers around the world, 'above everything, protect your own backside!'

The Signs of Safety approach to risk assessment 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. The Signs of Safety approach does not set problems in opposition to a strengths and solution-focus, nor does it frame forensic, rigorous professional inquiry as something that diminishes or erases the possibility of collaborative practice. Quite simply, the best child protection practice is always both forensic and collaborative and demands that professionals are sensitised to and draw upon every scintilla of strength, hope and human capacity they can find within the ugly circumstances where children are abused.

6.3 Comprehensive Risk Assessment and the Signs of Safety Framework

The Signs of Safety approach 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:

- Is simultaneously forensic in exploring harm and danger while at the same time eliciting and inquiring 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 (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) since it brings everyone, (both professional and family member) to the assessment table.

The Signs of Safety approach grounds these aspirations in a one-page assessment and planning protocol that maps the 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 underpins it) is designed to be the organising map for child protection intervention from case commencement to closure.



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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's 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)⁵.

In 2004/5 while working with Child Youth and Family New Zealand, the questions of the practitioners there prompted Turnell to more clearly identify the four domains operating in the Signs of Safety assessment and planning framework. This in turn led to the creation of a 'simpler' version of the framework.

This second, 'three columns' alternative should not be seen as a different framework to the earlier one – it is simply a different version of the same framework. The first provides a more formal structure and is more suited to court and more formal contexts. It is also more

⁵ Zero on this safety scale is often also described as meaning the situation is so dangerous the child must be permanently removed.

appropriate when making a careful assessment of high-risk cases since it immediately points workers and supervisors toward a careful exploration of danger and harm. The three columns variation is usually easier to use at initial investigation with parents and with whole families.

The three column version has the added advantage that it functions well as a strategic planning tool providing a very clear and focused map for reviewing case practice in case crises or child deaths. Alongside these two versions of the Signs of Safety framework, several additional versions of the same framework have been created that are specifically designed for use with children and young people (see section 6).

6.4 Case Example

The example on the next page is 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 plan for this example is an amalgamation of two fairly equivalent West Australian cases. In both cases the assessment was completed together with the mother while the infant was in hospital following an assault by the mother .

6.5 Disciplines for Using the Signs of Safety Framework

While the above assessment looks simple, it is a form of simplicity that synthesises considerable complexity . There are many disciplines that are involved in using the Signs of Safety assessment and planning framework to arrive at the sort of assessment and plan presented above. These disciplines include:

- **A clear and rigorous understanding of the distinction between, past harm (these are shaded yellow in the above example), 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; Meddin 1985; 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 is described in greater detail in Turnell and Essex (2006). In the example presented above, drawing upon this definition to interpret the constructive risk factors captured in this assessment, it can be seen that there is only one known instance of existing safety (shaded blue), related to the danger statements.



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DANGER/HARM	Signs of Safety Assessment and Planning Form	SAFETY
<p>Safety and Context Scale</p> <div style="display: flex; align-items: flex-start;"> <div style="border: 1px solid black; width: 50px; height: 50px; margin-right: 10px; display: flex; align-items: center; justify-content: center;"> <div style="width: 20px; height: 20px; background-color: gray;"></div> </div> <div style="border: 1px solid gray; padding: 5px; font-size: 0.8em;"> <p>Safety Scale: Given the danger and safety information, rate the situation on a scale of 0-10, where 0 means recurrence of similar or worse abuse/neglect is certain and 10 means that there is sufficient safety for the child to close the case.</p> <p>Context Scale: Rate this case on a scale of 0-10, where 10 means this is not a situation where any action would be taken and 0 means this is the worst case of child abuse/neglect that the agency has seen.</p> </div> </div> <p>Agency Goals What will the agency need to see occur to be willing to close this case?</p> <p>Family Goals What does the family want generally and regarding safety?</p> <p>Immediate Progress What would indicate to the agency that some small progress had been made?</p>		
© 1999 Andrew Turnell and Steve Edwards		

When we think about the situation facing this family:		
What are we Worried About?	What's Working Well?	What Needs to Happen?
<p>On a scale of 0 to 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 they can't live at home, where do we rate this situation? (If different judgements place different people's number on the continuum).</p>		
<p>0 ←————→ 10</p>		

Signs of Safety Assessment and Planning Form

DANGER/HARM

- We know of 5 times where Mary (19) has hit and hurt John (18 months) in the past 8 weeks.
- 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.
- DCP are worried because the doctor says it is possible John could be badly hurt in the future suffering brain damage, or death from a future incident of this type.
- CPS are worried because the doctor says the 19 year old Mary is not recognising this danger.
- Mary doesn't want contact with her family or Gary's and she can think of no friends to help her.
- Mary has a history of 'depression' which she calls being sad.
- Mary is not taking prescribed medications or attending appointments with psychiatrist.
- To make John safe 1 x Mary had to leave him unsupervised.
- Mary describes a history of violence in her family.

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Safety Scale: Given the danger and safety information, rate the situation on a scale of 0-10, where 0 means recurrence of similar or worse abuse/neglect is certain and 10 means that there is sufficient safety for the child to close the case.

Context Scale: Rate this case on a scale of 0-10, where 10 means this is not a situation where any action would be taken and 0 means this is the worst case of child abuse/neglect that the agency has seen.

Safety and Context Scale

Agency Goals What will the agency need to see occur to be willing to close this case?

- DCP wants to return John to Mary based on seeing that Mary has alternative strategies she uses when could 'lose it' with John and does this every time over 6 months.

Family Goals What does the family want generally and regarding safety?

- Mary wants to meet with someone she can talk to about her problems.
- Mary wants this for herself and because she says that talking/counselling will make it less likely she will hit John.

Immediate Progress What would indicate to the agency that some small progress had been made?

- Establish John in foster placement
- Contact visits established for Mary and John and focused on Mary doing something different under stress.
- Mary starts seeing someone she can talk to.

SAFETY

- Mary open in talking to DCP social worker.
- Mary clearly loves John, SWkr has seen that he goes to her, they cuddle, she responds to him being upset.
- Mary admits hitting John at least 4-5 times in 8 weeks and that she caused the current injuries.
- Mary is most concerned about her anger and violence making her John afraid of her.
- Mary describes one incident where she did not hit John when easily could have 'lost it'.
- John meets 'developmental milestones' for size, weight, he's talking and active.
- John's immediate safety is assured through hospitalisation and imminent alternative placement.
- Mary wants someone to talk to re sadness/anger sees this as a cause of the problem.
- Mary has separated from violent ex-partner Gary



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- **Rendering all statements in straight-forward rather than professionalised language that can be readily understood by service recipients.** 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.
- **As much as possible all statements 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 process of judgment is held over, to be brought forward in a straight-forward fashion within the safety scale.
- **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 the assessment example draws from, each worker offered the mother a choice between working with them on the assessment against the alternative of the worker doing it with her supervisor back at the office. This is a concrete demonstration of the sort of skilful use of authority that is necessary in using the Signs of Safety approach.
- **An underlying assumption that the assessment is a work in progress rather than a definitive set piece.** The Signs of Safety approach always seeks to create assessments drawing from a professional stance of inquiry and humility about what the professionals think they know rather than a paternalistic professional stance that asserts, ‘this is the way it is’. (The principles underlying the use of the Signs of Safety framework are more fully described in Turnell and Edwards 1999, and Turnell and Essex 2006).

7. Involving Children

A considerable body of research indicates that many 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 looked-after children tell researchers that they do not understand why they are in care. Visiting CREATE’s⁶ website (www.create.org.au) or listening to any of the young people who speak publicly through this organisation about their living in care experience tells the same message.

There is considerable talk 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 straight forward tools and

⁶ CREATE is a uniquely Australian organization, which provides support and a direct voice for young people in the Australian care system so they can influence governments and professionals.

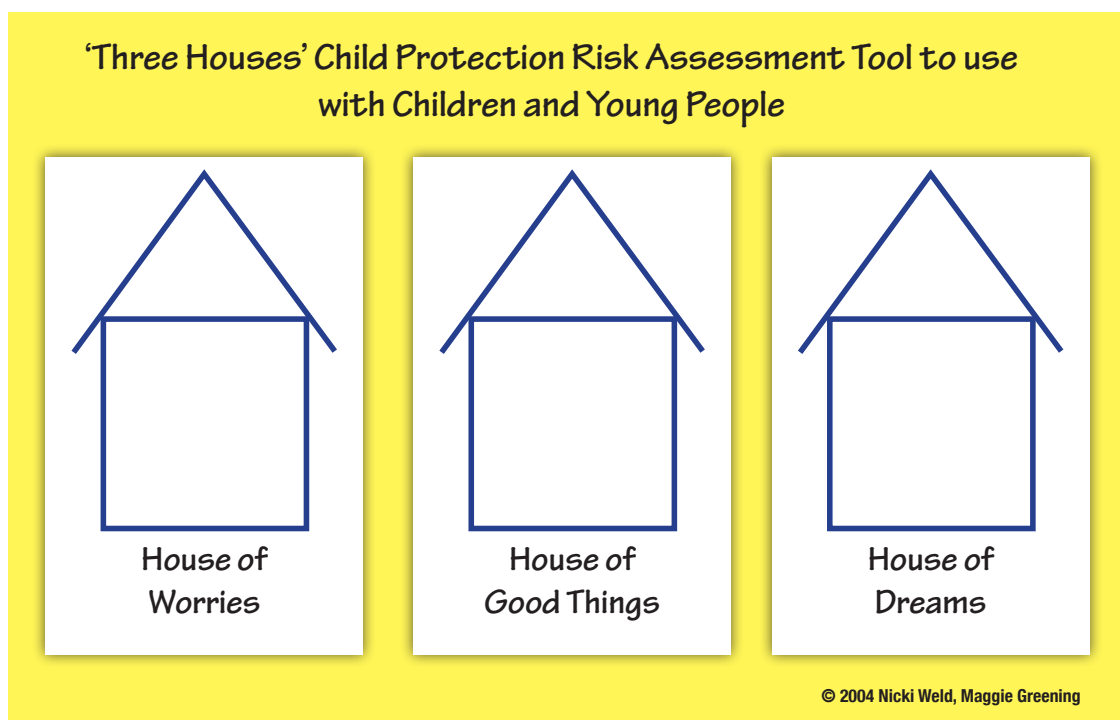
practical guidance that equips them to involve children in a context where they fear that involving children can create more problems than it solves.

Since 2004, one of the key growing edges of the Signs of Safety approach has been the development with practitioners of tools and processes designed to more actively involve children in child protection assessment, in understanding why professional intervention has happened, and in safety planning. These include:

- Three Houses Tool
- Fairy/Wizard Tool
- Safety House Tool
- Words and Pictures Explanations
- Child Relevant Safety Plans

7.1 Three Houses Tool

The Three Houses tool was first created by Nicki Weld and Maggie Greening from Child Youth and Family, New Zealand and is a practical method of undertaking child protection assessments with children and young people (Weld, 2008). The Three Houses method takes the three key assessment questions of the Signs of Safety framework: What are we worried about, what's working well and what needs to happen, and locates them in three houses to make the issues more accessible for children. Steps for using the Three Houses Tool include:





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1. Wherever possible, inform the parents or carers of the need to interview the children, explain the three houses process to them and obtain permission to interview the children.
2. Make a decision whether to work with the child with/without parents or carers present.
3. Explain the three houses to the child using one sheet of paper per house.
4. Use words and drawings as appropriate and anything else useful to engage child in the process.
5. Often start with 'house of good things' particularly where child is anxious or uncertain.
6. Once finished, obtain permission of the child to show to others—parents, extended family and professionals. Address safety issues for child in presenting to others.
7. Present the finished three houses assessment to the parents/caregivers, usually beginning with 'house of good things'.

The following is an anonymous example of the Three Houses tool used by Sue Robson Gateshead Referral and Access social worker (Brennan and Robson, 2010) in a case of emotional abuse, with boys 'Craig' and 'Martin' and their mother 'Carol'.

This case came into the Gateshead service because a health worker 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 wouldn't work with the professionals anymore.

Professionals reported that Carol's children Martin (5), Craig (7) and Timmy (2) all appeared frightened of Carol and when the health visitor and family support workers visited the home, Timmy was always in the playpen and there were no toys in the home. Sue decided to use the Three Houses with Craig and Martin and completed two sets of drawings with the boys. 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.



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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

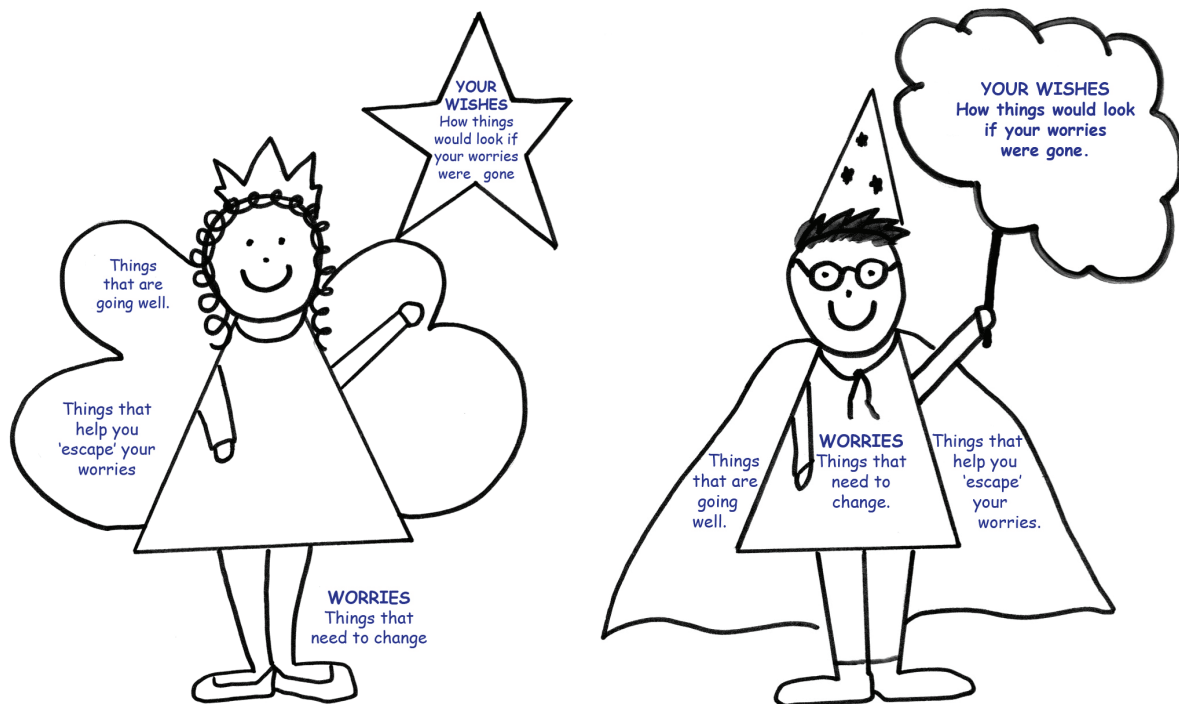
We would have a big family holiday-mam, dad, Timmy and me and Craig would all go to the beach and love each other.

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 The Fairy/Wizard Tool

Child protection professionals around the world have found that the Three Houses tool, because it focuses directly on the child's experience and voice, time and again creates this sort of breakthrough opportunity with parents who are 'resisting' professional perspectives and interventions. More information and guidance on the Three Houses tool and its use is available in Brennan and Robson 2010 and Turnell In Press a).

Vania Da Paz, a child protection practitioner working for the Department for Child Protection in Rockingham, Western Australia was involved in the 1996 Signs of Safety six-month development project. (Refer to a practice example in the Signs of Safety book, Turnell and Edwards 1999, p.81). Vania 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 with different graphic representation. Rather than Three Houses, Vania explores the same three questions using a drawing of a fairy with a magic wand (for girls) or a Wizard figure (for boys) as follows:



Above: Fairy and Wizard Outlines, drawn by Vania Da Paz

Vania uses the Fairy's/Wizard's clothes (which represent what can/should be changed—just as we change our clothes) to explore and write down, together with the child, the problems/worries from the child's perspective—or 'what needs 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; and the cape 'protects' the young Wizard and 'makes his



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problems invisible for a little while'. 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 record 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 explores hope for the future.

A comprehensive exploration of the Three Houses and Wizard and Fairy tools is available in Brennan and Robson, 2010 and 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 the next section at 8.9.

8. Safety Planning

8.1 Description

Safety planning within the Signs of Safety approach is designed to create a proactive, structured and monitored process that provides parents involved in child protection matters with a genuine opportunity, to demonstrate that they can provide care for their children in ways that satisfies the statutory agency. Child protection professionals will often claim they have a safety plan in place when what they actually have is a list of services family members must attend. It is a mantra of the Signs of Safety approach that a service plan is NOT a safety plan. A safety plan is a specific set of rules and arrangements that describe how the family will go about and live its everyday life that shows everyone, the professionals and the family's own support people that the children will be safe in the future.

Answering the question 'what needs to happen to be satisfied the child will be safe in their 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 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 number of professionals that tend to be involved in that case. 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 what their role will be in the process.

8.1.2 Establishing a Working Relationship with the Family

Building safety plans that are meaningful and 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 don't 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 parents want to know what they need to do to satisfy child protection authorities and so 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 is required of them.

8.1.5 Bottom Lines

The easiest way to distinguish between safety goals and bottom lines is think of the difference between what and how. The goal should articulate '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 should keep their bottom line requirements to a minimum. This creates maximum opportunity for the family to develop as much of the specific detail of the safety plan as possible.

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 that is connected to many people that care for them will almost always have a better life experience and be safer than an isolated child, so the next step involves asking the parents to 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 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 that is involved (both lay 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



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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 well looked after.

This is an evolving conversation as the professionals constantly deepen the parents and networks' thinking about all the issues the professionals see, at the same time exploring the challenges the parents and network foresee. The trick here is for the professional 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.

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 be testing, refining and demonstrating 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 by 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 make progress in 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. This sort of safety planning journey usually takes between three to 12 months.

8.2 Involving Children in Safety Planning

8.2.1 Safety House

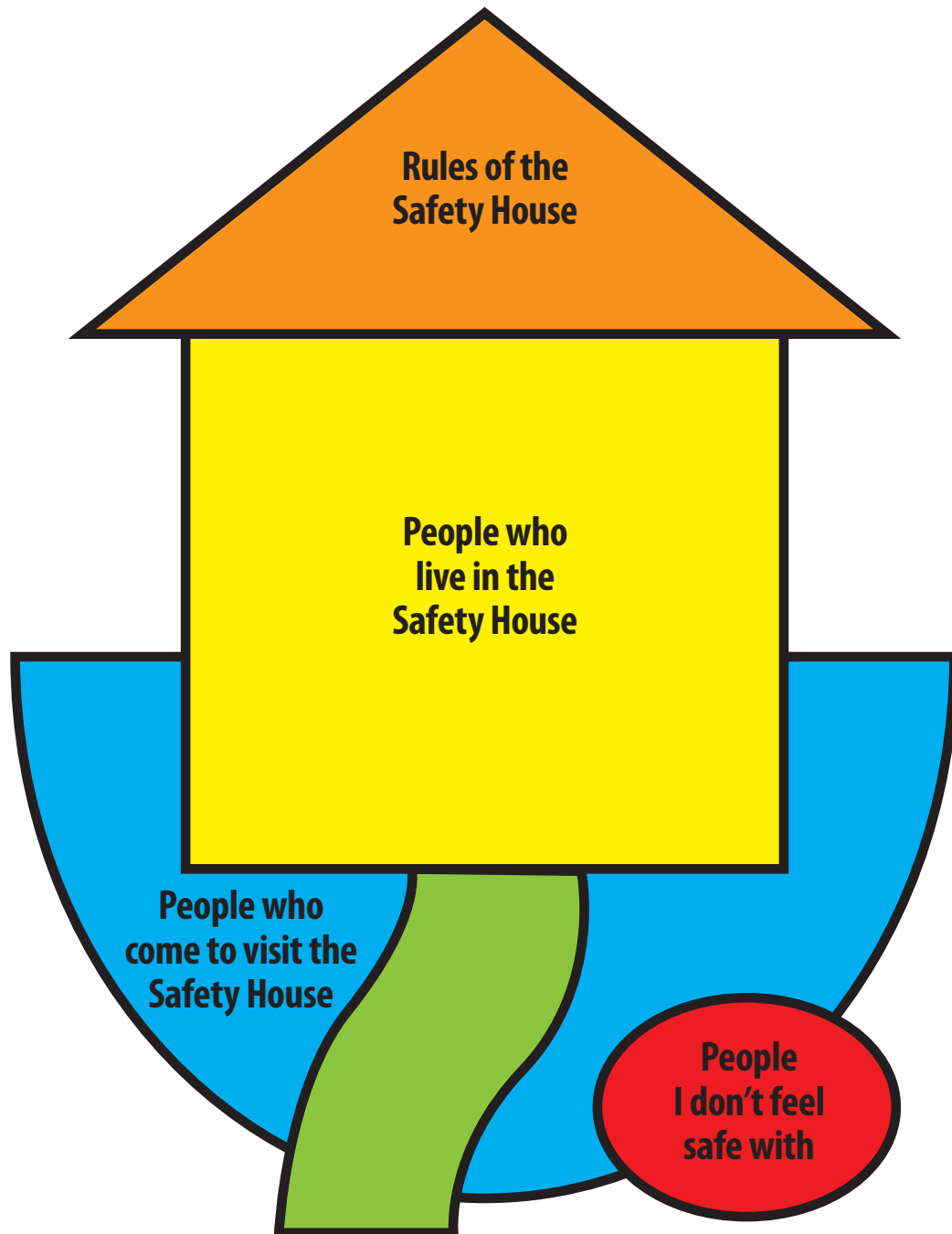
Sonja Parker from Perth has developed a Safety House tool (Parker, 2009) that extends the Three Houses process and visually engages children in creating the safety plan.

The Safety House explores five key elements with the child:

1. What life will look like in the child's safety house and the people who will live there.
2. People who the child thinks should visit and how they should be involved.
3. People the child sees as unsafe.
4. Rules of the Safety House.
5. Safety Path: using the path to the house as a scaling device for the child to express their readiness to reunite or 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 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.





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8.2.2 Words and Pictures Explanation and Child Relevant Safety Plans

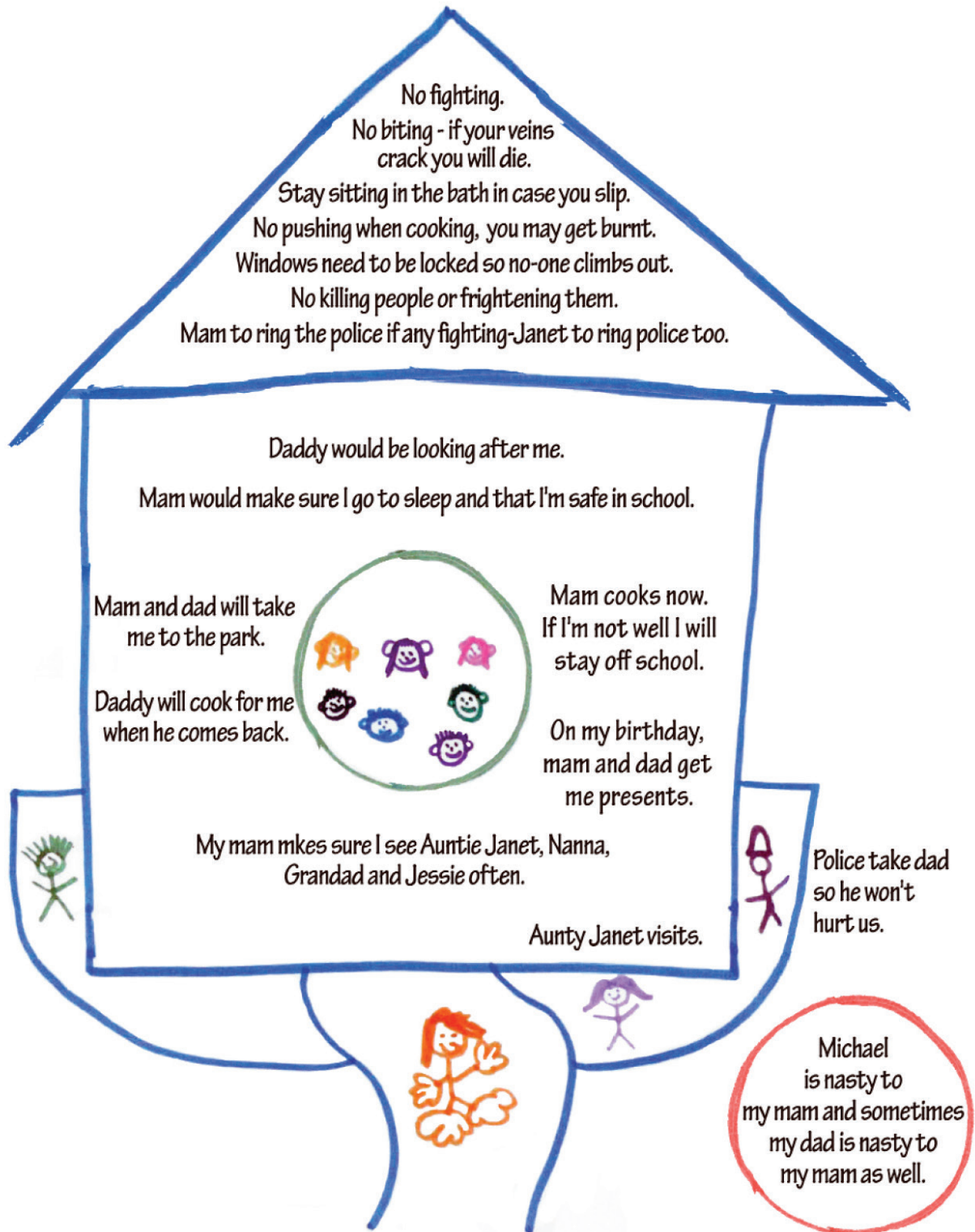
Turnell and Essex (2006) describe a 'Words and Pictures' explanation process for informing children and young people about serious child protection concerns and a safety planning method that both involves and directly speaks to children. The following illustrations are one example of each. The examples 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 be found in Turnell and Essex, 2006, pp 94-101, another in Devlin, 2012.

Given that safety plans are all about the children and are also about setting up family living arrangements so everyone knows the children will be safe and cared for it's 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.

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 the family and an informed safety network. The plan is operationalised, monitored and refined carefully over time and the commitments of the plan are made and owned by the parents in front of their own children, kin and friends. This is not something that can be done in one or two meetings and a safety plan that will last, most certainly cannot be created by professionals deciding on the rules and then trying to impose them on the family. Meaningful safety plans above everything are created out of a sustained and often challenging 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 creation of a family owned safety plan is best thought of as a journey, for a child protection agency to consistently undertake this sort of safety planning, particularly in the highest risk cases, it will need to build its vision, capacity and skill base in using these methods through a multi-year learning journey.



Safety House Created by Sarah (aged seven) with Laura Brennan from Gateshead England.



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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.

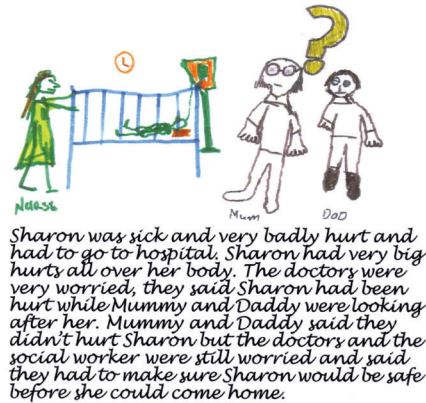


Above: Straightforward Access Safety Plan in Case Where Sexual Abuse was Substantiated Against Father

Who's Worried?



What Are They Worried About?



What Happened Then?



After this the social worker said Sharon couldn't live with Mummy and Daddy. Nan and Pop wanted to help so Sharon went to live with them after she got out of hospital. Sharon has lived with Nan and Pop for more than two years since then.

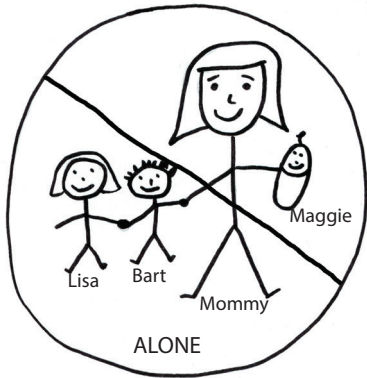
What Are We Doing?



Mummy and Daddy are working very hard with Andrew and Karen (the social worker) to show everyone that Sharon will be safe when she comes home.

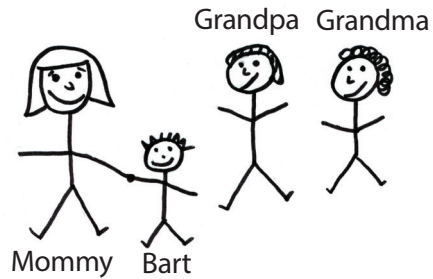
Above: A words and pictures story in an injured infant case

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

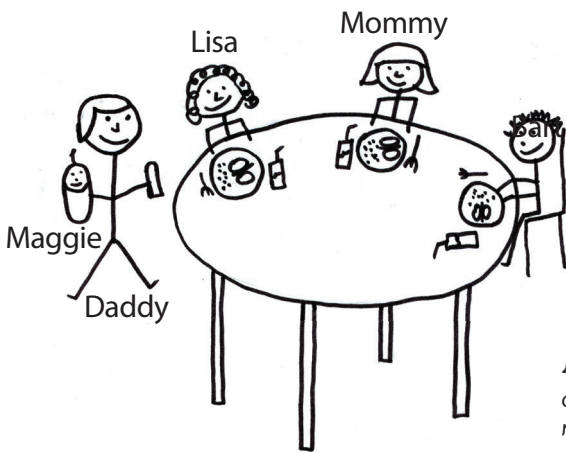


2. When you spend time with Mommy there will always be someone else there like Auntie Kate, Bill, Fred, Mary, Joe, Lyn – the pastor's wife, Margaret, Grandpa or Grandma. These are the safety people who love you and want to be sure you're safe.

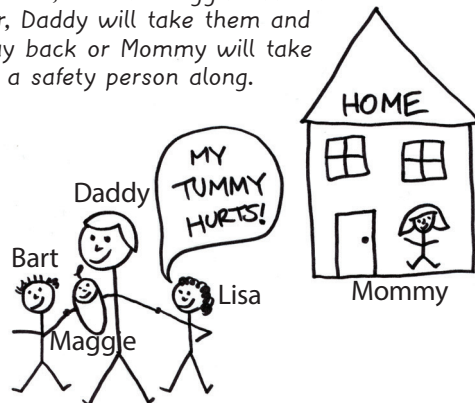
With Mommys safety people



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.



Above: Safety Plan for children aged four years, two years and six months in a Munchausen-by-Proxy case



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9. Creating a Culture of Appreciative Inquiry

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

(William Madsen 2007, p.32)

Child protection above all else suffers 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 constructively achieve 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—you do this for long enough you'll have a plane that will never get 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 front-line 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 e.g. Munro 2004; Parton 2006).

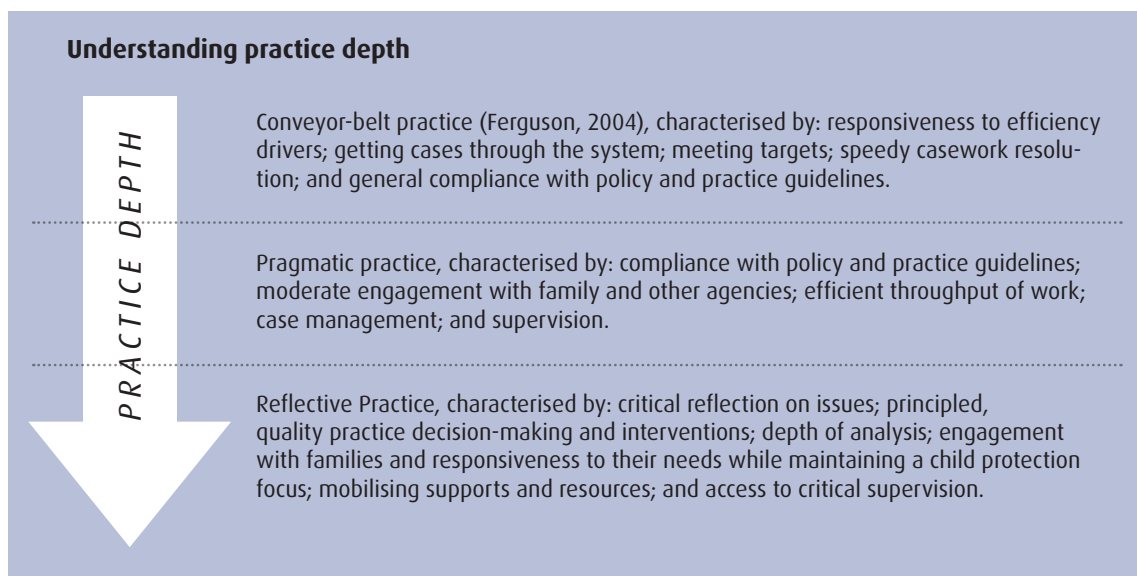
While this is an all too familiar story, there is another story that can be told:

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).

As described above, the Signs of Safety approach has progressively evolved through the process of training practitioners in ongoing projects, first in Western Australia and then internationally. Following this initial training the next step in growing the model is to shift from training to action-learning mode by inquiring with the workers into the question: Where have they been using the approach and how it has been useful to them? In this way the writings about the Signs of Safety approach present examples of good practice with difficult cases from statutory practitioners in Europe, North America, Japan and Australasia that not only depict and evolve the use of the approach but also describe good child protection practice more generally.

Steve Edwards and I drew the inspiration to inquire into worker-defined successful practice from solution-focused brief therapy methods of focusing on what works with clients as the key means to energise them in dealing with their problems. This methodology is much more than a process for looking at case practice. It is also a powerful mechanism to engage front-line child protection practitioners in an organisational reform or change agenda. As well, this approach is increasingly being seen in academic circles as a critical method of researching professional theory. As described in section 4.2.3 the literature refers to this as practice-based evidence or critical best practice theory (see for example Ferguson 2001 and 2003; Healy 2006).



Above: Practice depth. This illustration is taken from Chapman and Field (2007).

This organisational change methodology can also be seen as a form of appreciative inquiry. Appreciative inquiry is an approach to organisational change first developed by David Cooperrider (see for example 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 accurate framed as ‘change at the speed of grounded, detailed and shared attention to your best practice.’

In my work over the past decade with agencies seeking to implement the Signs of Safety I have drawn together the ideas of solution-focused brief therapy and appreciative inquiry, using the questioning methods and technology of the former and the organisational change agenda of the latter and now often speak of the importance of ‘creating a culture of appreciative inquiry around frontline practice.’ This is the most powerful mechanism I know of



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for child protection agencies to make any implementation of the Signs of Safety land and stick [Heath and Heath (2007) speak about making ideas and practices 'sticky' in their recent book, *Made to stick: why some ideas survive and others die*]. In the child protection context building a culture of appreciative inquiry around front-line practice acts to antidote to the anxiety-driven defensiveness and the obsession with researching failure that bedevils this field.

While in the first instance the process of building a culture of appreciative inquiry around frontline practice will be grounded in the week-in, week-out appreciative inquiry work of practice leaders it will be vital that senior management understand, support and can replicate this process particularly when case crises come to the fore.

In a direct parallel process to what the Signs of Safety approach asks workers to do in their Signs of Safety work 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 from the Chief Social Worker's office in Child Youth and Family, New Zealand recently wrote a paper, in part to articulate the lessons learnt during an eighteen-month implementation of the strengths-based practice and Signs of Safety approach work within the Tauranga and Otara offices between 2003-05 (Chapman and Field 2007). This paper describes some of the organisational and strategic issues 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 are describing as 'conveyor-belt' or 'pragmatic' practice. Practice of this form may seem expedient and necessary for all sorts of pragmatic reasons but it rarely makes a sustainable, significant difference in the lives of vulnerable children and it inevitably ignores the experience of the practitioner. When frontline workers and supervisors become solely focused on the immediate case, the anxiety of worst outcomes and the delivery of key performance outcomes their working life in child protection will inevitably be short or their work will be overtaken by a hard-bitten cynicism. The appreciative inquiry developmental processes at the heart of the Signs of Safety approach are designed to directly address this problem by creating a culture of appreciative inquiry around practice and practitioners, and to build 'practice depth' within the team, the office and the agency as a whole. It is only the creation of increased practice depth that will genuinely enable child protection staff to reclaim pride and confidence in their work and enable a child protection agency to deliver services that are valued more highly by service recipients (even where intrusive statutory interventions are necessary) and that will deliver transparently safer outcomes for vulnerable children.

10. Implementing Signs of Safety

A Learning Journey of Many Years

The concept of the 'learning organisation' was first articulated by Peter Senge (1990) in his book *The Fifth Discipline*, in which he describes learning organizations 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 there is a touch of breathlessness in Senge's writing, which can feel somewhat disconnected from the day-to-day reality in a large bureaucratic organization, Senge's motif of the learning organisation is important. Senge argues that organisational change is not a product but rather a process of bringing forward peoples' best thinking and energy that is created relationally within the organisation. Senge invokes the notion of the 'learning journey' to suggest that organisational (and individual) change is not an entity that can be bottled, or disbursed in a training programme, rather it is a process of continual inquiry, reflection and learning, that needs to be fostered in the culture, procedures, and everyday habits of the organisation.

Child protection organisations have a tendency to equate the provision of staff training as the beginning and end of implementation, when in fact training staff in new ideas and practices is simply the first step of organisational learning and implementation. For training to make a difference, the ideas and practices must be supported by supervision and ongoing organisational processes that support and embed the new training and practices. While the first step in implementing the Signs of Safety framework and practices will necessarily involve training for all staff, meaningful implementation across all of an agency's child protection casework requires sustained organisational commitment to an organisation-wide 'learning journey' of at least five years duration. In child protection organisations the team leader or supervisor level are the primary leaders of the practice culture of the organisation. Supervisors all over the world often report that while they seek to do the best they can to supervise the workers they are responsible for, the primary supervision they typically receive is focused on procedural compliance not on case practice. A meaningful system-wide implementation of the Signs of Safety must always involve engaging and supporting practice leaders in undertaking an extended, ongoing learning journey in their understanding and use of the approach.

10.1 Growing Practice Leaders

The role of supervisor or team leader has many titles in many systems and is often located in different ways across different positions so in the remainder of this document I will use the more generic term 'practice leader'. The implementation of the Signs of Safety will largely succeed or fail depending on the success in creating and developing strong practice leaders (PLs) who have an in-depth understanding of the approach across all practice contexts and can consistently lead the practitioners they are responsible for in using the approach. A rigorous ongoing developmental process for training and then growing PLs in using and leading



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the Signs of Safety practice leaders is at the core of any implementation. Within agencies looking to implement I encourage each office, district, or practice unit to have at least two Signs of Safety practice leaders to enable them to work in pairs and help each other grow their leadership skills and to hold each other accountable to consistently using the Signs of Safety framework and undertaking the Appreciative Inquiry work.

All PLs should receive thorough training in the use of Signs of Safety. Within the Western Australian implementation that involves an initial two day introductory training followed by a five-day intensive Practice Leader training on leading and implementing the Signs of Safety. This training enables PLs to:

- ‘Map’ cases using the Signs of Safety framework.
- Undertake Appreciative Inquiry consultations with practitioners to build a constructive culture around frontline practice in their office and teams.
- Have a good beginning understanding of safety planning.

After the initial five-day training, the PLs begin leading regular fortnightly or monthly (but if possible weekly) group sessions with field staff in which they ‘map’ at least one case using the Signs of Safety framework and undertake at least one appreciative inquiry. Wherever possible the PLs do this by working in pairs, with one facilitating, the other adopting an advisor’s role. Working in pairs provides a ‘feedback loop’ to assist the practice leader to be able to stand back from the direct exercise of the role while still engaged with it.

Once a month PLs gather in small groups of 6 to 10 to review their work with their peers and receive supervision and further guidance and training. These monthly Practice Leader groups are coordinated and led by Practice Leader Facilitators (PLFs). Three times each year PLs gather in a large group of up to 60 to receive specific training, review progress and plan for the future.

These processes:

- Create an ongoing group learning process for establishing, consolidating and refining the Signs of Safety mapping and AI work as the central activities to deepen the practice culture. This prioritises robust collective assessment and decision-making, builds a shared practice culture and breaks down the sense of isolation that so often bedevils child protection practice.
- Locate practice leadership and supervision at the centre of the team leader and supervisor role by providing them with specific tools and techniques to work alongside practitioners and engages the practice leaders in a learning journey that enables them to supportively and quickly grow their practice leadership skills.

Through this sort of process PLs learn and grow their capacity to:

- Undertake their supervisory/practice leading role utilising inquiry and a ‘questioning approach’ as their primary mechanism of guiding practice. This will diminish the more usual ‘command and control’, senior practitioner as expert approach to practice

leadership. (It is important to note that utilising a ‘questioning approach’ does not preclude giving specific advice or direction where necessary).

- Understand and lead workers in building rigorous, on-the-ground safety plans, particularly in high-risk cases.
- Understand and lead practitioners in involving and placing children/young people at the centre of case practice.

Having undertaken this sort of process since 2002, with Gateshead Referral and Access (Investigation) teams, Manager Viv Hogg writes:

“We have weekly team meetings where we use the Signs of Safety as the tool to focus on a case. In this process, the whole team works really hard to know the family and understand what’s going on. Everyone chips in with their worst fears, their best hopes and their optimism. The use of a shared framework that we can also then use with the families is energising. It encourages creativity, it gives us a safe environment to challenge and appreciate practice and it builds cohesion and closeness within the team”.

“I’ve realised it’s all about being able to evidence what you think and the decisions you make; it’s about rigour. The conversations we have in our team make me feel safe because we can evidence our decisions. I know things can still go wrong, but as long as we can evidence what we do, we’re fine. This shares the anxiety and leads to a much better, broader, stronger view. It shares the accountability, the risk. I know at the end of the day it comes down to my responsibility and that’s fine, but it’s the team all working together that gives us confidence to make our decisions.”

Turnell, Elliott and Hogg 2007, pp. 115-116

10.2 Executive Leadership

For the Signs of Safety to be used effectively and substantially by practitioners and for it to make a significant difference to an agency’s practice culture and outcomes requires organizational commitment to a long-term implementation of the approach. Any meaningful long-term implementation must be driven by an agency’s executive and by leaders who understand the approach well. While the Signs of Safety can be utilized as a ‘model’ or product which is bought and trained, the approach delivers most benefits when it used as the foundation for a whole-of-agency learning journey to create increasing depth in its child protection organization and practice. This can only happen where agency leaders are in the middle of the learning journey connecting the practice realities with grounded intelligence about possibilities, priorities, limitations and the real politics of their agency context.

The Signs of Safety constantly directs the agency’s focus back to the work it is set up to deliver: increasing the safety and wellbeing of vulnerable children through the work and interactions



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of frontline practitioners and the parents and children on the receiving end. This is challenging for everyone. Social work and the broader helping professions have built a strong culture of keeping practice private so that senior managers, researchers and policy makers can often wonder what do they actually do? Many commentators have written about the privatization of social work (see for example Clark, 2000; Ferguson, 2011; Gilgun, 1994; Saleeby, 1989; Weick, 2000) but one of the strongest motivators for the child protection practitioner is that they know their work is never perfect, always messy and never conforms to ideal standards. Like the dilemma of assessing parenting standards and family functioning, child protection work practitioners also never know if their work is 'good enough'. Where a vulnerable child is left in the family home there is always the nagging doubt – did I miss something and what if something goes wrong? If the child is removed from their parents the practitioner will always wonder, could I have done more to keep the child at home? Is the child's life going to be worse away from their parents?

Directors and child protection leaders who want to transform child protection need to have deep acuity and compassion for the lived experience of the child protection practitioner and understand that they are managing an anxious environment (Morrison, 1995) and that they are always managing uncertainty (Munro 2011). Child protection senior management has tended to resolve this struggle with uncertainty by acting as if it is possible to erase risk, to find programmes, policies and models that will deliver certainty. This is a management strategy that leads to the dumbing down of an agency's child protection intelligence and to escalating a risk averse, defensive culture. To challenge and address this culture Eileen Munro argues that child protection leaders need to grapple with determining in their agencies what it means to be 'risk sensible' (Munro 2012).

The cutting edge of the Signs of Safety is the focus on future safety this is where the biggest benefits and biggest challenges of the approach lie. Child protection agencies the world over are struggling with the fact that they are taking increasing numbers of children into care for longer and taking more families to court. Social workers are being turned into social police. This reality demonstrates a risk averse system. To turn these outcomes around requires a different vision of engaging with families facing the crisis of child abuse.

The most critical point at which agency leadership must have an intimate understanding and involvement in a Signs of Safety implementation arrives when (and if) the organisation wants to utilize the safety planning methods of the approach. These methods allow and encourage reunification or maintenance of children in the family home with the support of naturally occurring networks focused on plans that are not about service attendance but focused on changing the daily living arrangements of the family to make sure the children will be safe.

Here's an example that demonstrates the paradigm shift offered by the Signs of Safety approach:

An investigator from Ktunaxa Kinbasket Child and Family Services, an agency that has been implementing the Signs of Safety since 2007, went

out on a case involving a three year old that had suffered severe facial bruising and scratches where the mother's partner had hit and dug his fingers in the boy's cheeks. The following day after overnighting in hospital, the boy went back home with the boyfriend and mother. The investigator and agency was able to support that decision because of all the strengths the investigator identified with the parents and the extended family and the safety plans they all came up with to satisfy the hospital, the child protection agency and the extended family that nothing like this could happen again to the child.

The Signs of Safety is often portrayed by proponents and opponents alike as a soft, strengths-based approach to child protection. It is an approach that seeks to genuinely put the responsibility for child maltreatment back with the people the children belong to. That aim sounds very mother hood but when the aspiration lands in the reality of a three year old in hospital with facial injuries from an assault by the mother's boyfriend, the human challenge of the approach comes sharply into focus. This Signs of Safety requires practitioners that can think and feel at the same time, who can quickly, respectfully and honestly lay the ugly reality of the abuse before the family and their own network and genuinely give them an opportunity to come up with their best thinking to solve the problem. To make any real difference to case outcomes this has to be done in the highest risk cases not simply in the cases that seem safe. This in turn requires agency leadership that actively understand and are committed to taking the risk of giving families and naturally occurring network the first opportunity to solve their problems and who understand how to set up and lead an agency that can manage the risks of doing so.

Professor Eileen Munro has stated that to turn around the rigidity and defensiveness that characterises western child protection and to build a genuinely put children back in the centre of the work requires,

“Designing a system that supports the cognitive, emotional, and communicative capabilities of human workers so that they can most effectively protect children and enhance their welfare.”

Munro, 2012

Created and refined by practitioners, the Signs of Safety is designed to do just that. However, the Signs of Safety can only deliver this value to a child protection system where its senior leadership have a grounded understanding of the approach and are actively engaged in leading their organization in its implementation.



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10.3 Sustaining the Learning Journey

Child protection organisations the world over have a habit of cycling through new policy and practice initiatives on something like a two-year rota. This creates a cynical attitude toward new initiatives among frontline staff where they often take the view that, 'if we keep our head down, tell the bosses what they want to hear, this will all blow over within twelve to eighteen months'. Child protection agencies are highly complex organisations with complex agendas and there will always be many significant challenges and obstacles to sustaining an extended learning journey with the Signs of Safety. Not the least of these challenges is the habit and allure of moving on to the next new thing when this approach begins to seem like yesterday's initiative. Embedding the Signs of Safety approach in a system-wide implementation across all child protection services above everything, requires a sustained commitment by everyone, from the CEO to the front-line practitioner. All agency staff need to be involved in maintaining, nourishing and growing the use of the model through an organisational learning journey that will at minimum be at least five years in duration.

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The Signs of Safety

A Comprehensive Briefing Paper

DVD/Workbooks Available from Resolutions Consultancy

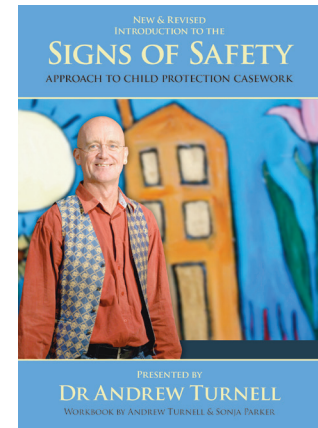
The following DVD/workbooks are available from Resolutions Consultancy (www.signsofsafety.net) to assist professionals in using the Signs of Safety approach to child protection casework.

Signs of Safety DVD and Workbook

In this DVD, Andrew Turnell:

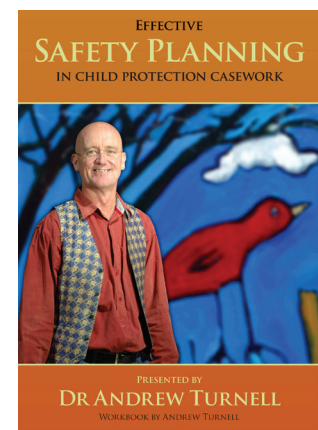
- Provides a short history describing the development of the Signs of Safety approach
- Presents and explains the two versions of the Signs of Safety assessment and planning framework and the analysis process for using the protocol as a comprehensive child protection risk assessment tool.
- Uses a case example of a suicidal mother and four year-old son to demonstrate the Signs of Safety assessment process as a map that enables both professionals and family members to think themselves into and through the situations of child abuse and neglect.
- Details the questioning skills that bring the Signs of Safety approach to life for professionals and family.

The DVD includes electronic copies of the Signs of Safety assessment forms and the completed assessment example from the DVD case study.



Safety Planning DVD and Workbook

Building meaningful safety plans is probably the hardest of all tasks in working with high-risk child protection cases. It is far easier for professionals to send parents to another course or treatment programme than to define what constitutes enough safety to close the case and involve family and professionals in working to realise that goal. Without clear safety goals, cases tend to drag on and child protection systems find they have increasing numbers of children in care for longer time. For parents the process is particularly frustrating because they feel that they don't know what they need to do to get child protection services out of their lives. In this DVD and workbook Andrew Turnell takes direct aim at these issues presenting a specific vision and process for creating effective safety plans together with families and naturally occurring support network.

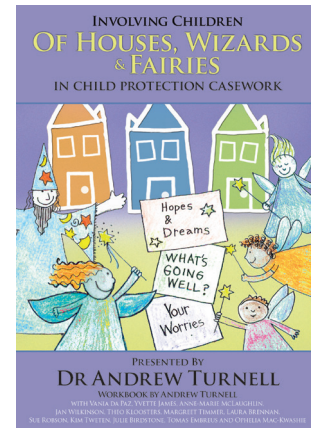


Words and Pictures DVD

Informing and Involving Children in Child Abuse Cases

Children and young people who are caught up in the child protection system often tell us that they don't understand why statutory professionals intervened in their lives and in their family. These youngsters also tell us that they commonly feel they have very little say in the decisions that are taken about their lives.

The Words and Pictures approach to working with children provides a concrete, tried-and-tested method for professionals to provide these children and young people with age-appropriate, clear information about the actual or alleged maltreatment that has occurred in their family. The Words and Pictures document then becomes a historical document that the children and their carers can draw upon in the future, and offers a clear foundation to involve the young people in planning for their lives, whether they live with their family or separate from them.

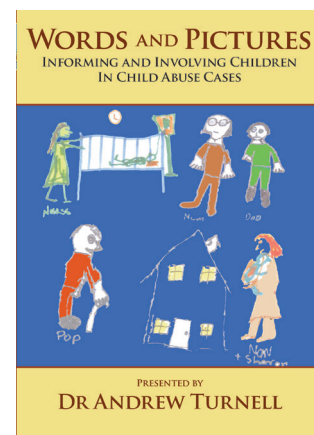


Of Houses, Wizards and Fairies DVD and Workbook

Involving Children in Child Protection Casework

This DVD and workbook:

- Introduces the Three Houses, Wizard and Fairy tools, that are designed to directly involve children and young people in child protection assessment and planning
- Provides detailed guidance about how to use the tools with the children and how to use the information generated by the tools in the subsequent work with parents and other professionals
- Is grounded in detailed case examples provided by 15 practitioners from nine different countries.



Available from:

www.signsofsafety.net



www.signsofsafety.net