Government of **Western Australia**
Department for **Child Protection**

The Signs of Safety Child Protection Practice Framework

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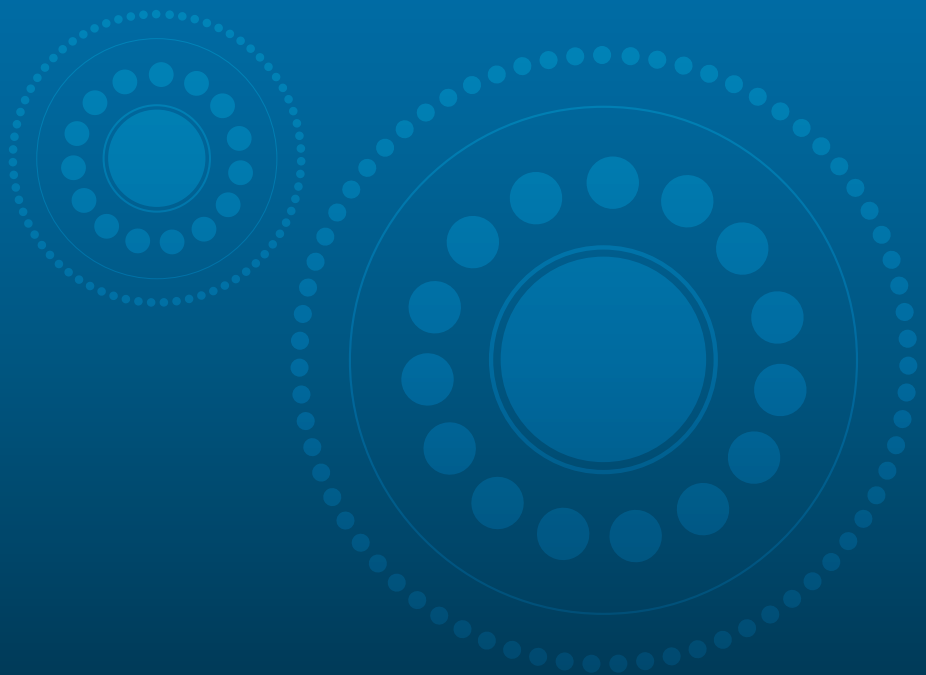


Contents

1. Introduction

The Department for Child Protection (DCP; the Department) adopted *Signs of Safety* as its child protection practice framework in mid-2008.

The adoption of the *Signs of Safety* is set out in the policy statement to that effect, and a reform project plan extending over five years (2008 to 2013) outlines the core elements of implementation.

The Department has substantially achieved the application of *Signs of Safety* across the breadth of its child protection work.

Creating good outcomes for vulnerable children relies on depth of practice. Growing the depth of practice (the effective application of all aspects of *Signs of Safety* - the principles and disciplines as they affect assessment and planning, safety planning specifically, and working with children) among all child protection staff, from the new and relatively inexperienced to those with substantial experience, is the current and will be the continuing overarching challenge in implementing *Signs of Safety*.

This is the second edition of the *Signs of Safety* framework paper that underpins practice. The framework paper was originally prepared by Andrew Turnell for DCP, and revisions have been made by DCP drawing on further work by Turnell.

2. Safety organised practice - the goal is always child safety

One of the biggest problems that bedevils child protection work, identified in many child death inquiries, is the Tower of Babel problem, where everyone is speaking a different language (Munro, 2002, Reder, Duncan and Gray 1993). *Signs of Safety* is designed to create a shared focus and understanding among all stakeholders in child protection cases, both professional and family, it is designed to help everyone think their way into and through the case from the 'biggest' person (often someone like a director general, a judge or child psychiatrist) to the 'smallest' person (the child).

However, completing *Signs of Safety* assessment and planning - 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 documents can become a highly prized, over-valued performance indicator. While consistency of assessment is a critical factor in good outcomes in child protection casework, it does not of itself equate to on-the-ground child safety.

Completing the *Signs of Safety* assessment and planning 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 in places in which the child lives.

3. Three core principles of *Signs of Safety*

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 client 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.

Signs of Safety 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 family members can engage with each other in partnership to address situations of child abuse and maltreatment. Three principles underpin *Signs of Safety*.

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 'naive' (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 minimises 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 and colleagues suggest:

> 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 professionals decide 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 error (*in child protection practice*) is to admit that you may be wrong (Munro 2002: 141)[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.

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 tendency 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 *Signs of Safety* has been developed hand-in-hand with practitioners, first in Western Australia and then in USA, Canada, United Kingdom, Sweden, Denmark, The Netherlands, 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 client descriptions of what on-the-ground good practice with complex and challenging cases looks like is a key to learning.

[1] Italics added for contextual clarity.
[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.

4. History: how *Signs of Safety* evolved

Signs of Safety was developed through the 1990s in Western Australia. It was created by Andrew Turnell and Steve Edwards in collaboration with over 150 West Australian child protection workers and is now being utilised in jurisdictions in the U.S.A., Canada, United Kingdom, Sweden, Finland, Denmark, The Netherlands, New Zealand and Japan.

The impetus to create *Signs of Safety* 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. Edwards was very dissatisfied with most of the models and theory regarding child protection practice that he had encountered. Despite 16 years of frontline practice, Edwards felt that most of the policy, guidance and books he read and most of what he learnt at university and in training (essentially the theory) had little correspondence with his experience of actually doing child protection work (undertaking investigations, deciding when and how to remove children, working with wards of the state, dealing with angry parents etc.). As a result of this, throughout his child protection career, Edwards always sought out new ideas that might better describe his experience of practice. In 1989 Edwards and Turnell began to collaborate after Edwards became interested in the brief therapy work Turnell was doing with families referred to a non-government counseling agency by the then Department of Community Welfare. Each week, for over three years, Edwards would observe the brief therapy work from behind a one-way mirror and then began to apply these brief therapy ideas and techniques into his practice as a child protection worker. Edwards and Turnell's collaboration and Edwards' use of the brief therapy ideas in his own child protection practice between 1989 and 1993 were the beginnings of *Signs of Safety*.

In 1993, Edwards and Turnell began the process of working with other child protection practitioners, training them in what they had learnt from the previous three years of collaboration. Between 1994 and 2000, Edwards and Turnell undertook eight separate six-month projects with over 150 West Australians in which *Signs of Safety* to child protection practice was initially evolved and refined. During the first month of each six-month project, Turnell and Edwards would provide 5 days training in *Signs of Safety*, as it had evolved 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 *Signs of Safety* describing their experiences to the current group of trainees.

Following this initial training, each six-month project shifted into action learning mode. Edwards and Turnell would spend at least one day a month looking closely with the workers at where they had been using *Signs of Safety* 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 *Signs of Safety* and making progress, Turnell and Edwards learnt directly from the practitioners themselves about where, when and how they were actually able to use *Signs of Safety*. Edwards 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 Turnell has come to describe as 'building a culture of appreciative inquiry around frontline practice' (Turnell 2006; 2007a; 2007b and In Press). This is a core practice and organisational development strategy underpinning *Signs of Safety*. Turnell and Edwards brought two publications to press, which directly describe the West Australian 1990's period of the evolution of *Signs of Safety* (Turnell and Edwards 1997; 1999).

5. International use and data

5.1 International use

Since 2000, Turnell has been working overseas for at least three months each year providing training and consultancy in the *Signs of Safety* approach and safety-organised child protection practice. By this process tens of thousands of child protection practitioners have been trained in the approach in Finland, Sweden, Denmark, The Netherlands, France, United Kingdom, Canada, USA, Japan and New Zealand. Sustained implementations of the approach have been undertaken or are occurring in: Zeeland and Drenthe Provinces, The Netherlands; Botkyrka Jonkoping, Spanga-Tensta, Umea, Vaggeryd, Malmo, Skaerholmen, Ekerö, Haninge and Upplands Vaesby in Stockholm plus Växjoe and Trollhatten Communs, Sweden; all Copenhagen Boroughs, Denmark; Gateshead, Coventry, West Berkshire, Brighton-Hove, Solihull, North Yorkshire and Oxfordshire Boroughs, England; Edinburgh Council, Barnardos Dundee, Scotland; Olmsted, Carver, Isanti, Hubbard, St Louis, Shurburne, Scott, and Stearns Counties, Minnesota, Massachusetts Department of Children and Families; Sacramento County Department of Health and Human Services; County of San Diego Child Welfare Services; State of Maine Child and Family Services; Child Youth and Family Services, Open Home Foundation and Family Works Tauranga, New Zealand; many Children's Aid Societies in the greater Toronto area including Hamilton Brant, Mississauga, Toronto, London and Guelph; Ktunaxa Kinbasket Child and Family Services, British Columbia, Xyolhemeylh Child & Family Services British Columbia, Canada; Satiama, Yokohama, Osaka and Nagoya Prefectures, Japan.

During this period, the *Signs of Safety* 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; Koziolek 2007; Myers 2005; Parker 2009; 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; Westbrock 2006; Wheeler, Hogg, and Fegan 2006). 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 / supporting data

5.2.1 Professional identity and job satisfaction

In the 1990s Edwards and Turnell undertook small 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 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 month period. 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/carveraiinterviewmarch2008.

The Department surveyed its child protection staff in 2010 after two years implementation. Almost two thirds (64%) reported that using *Signs of Safety* had caused their job satisfaction to increase greatly or somewhat, with 22% saying greatly. When elaborating on the reasons for this, the most frequent responses were that families better understood the issues and what was expected of them, the framework provided clarity and focus to child protection work, it provided useful tools, encouraged more collaborative work (including with other agencies), supported better decision making, and was open, transparent and honest. The rate turnover of service delivery staff has remained steady at around 12% since 2008.

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.

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 and 2008 the county recorded a recidivism rate of less that 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 (CCCSS) began implementing the *Signs of Safety* approach in late 2004. Westbrock (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 CCCSS practitioners to improve their skills, particularly in providing choice and in involving parents in safety planning. By the end 2007, termination of parental rights reduced significantly, out of home placements and children in long term care reduced with new placements in 2008 more than half the 2005 rate, and recidivism rates had been trending downwards. 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 Koziolek (2007).

A substantial independent evaluation has been undertaken by the Wilder Research Group (Wilder 2010) which describes the successes and struggles experienced by the 19 Minnesota counties involved in the statewide project. It reports the outcomes in Shurburne County as one of the early adopters where the use of court in child protection cases was halved and placement of children reduced by 19 percent in the first two years.

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 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.

Between 2005 and 2008 a three-year project in the Danish Borough of Copenhagen to equip the city's child protection workers with a higher level of skills to better engage families, was independently evaluated (Holmgård Sørensen, 2009) and found the following:

- 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%)

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 project 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.

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
- this 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 strengths and meetings could focus on how to achieve safety (Gardner, 2008, p 78).

Keddell (Keddell submitted and Keddell in preparation) undertook an in-depth qualitative study with the Open Home Foundation New Zealand using *Signs of Safety* in building safety for reunification, and found that the key elements in enabling the successful reunification work were:

- strong working relationship between worker and parents
- strong focus on parental and family strengths
- sustained and detailed exploration of what exactly safe parenting looked like and how it could be achieved
- time to build the relationship and do the casework.

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) found that the resolutions program had been successful in helping protect the vast majority of the children in the sample, with 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 to 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; 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 through the principles, disciplines, tools and processes that assist practitioners both to undertake their statutory role and to do this collaboratively.

In Western Australia, the Department's rate of growth in the number of children in care has slowed from 13% in 2007/08 to 5% in 2009/10, 2010/11 (average). In some districts there has actually been a reduction in the number of children in care in the year to mid-2011. Whereas

the response to child protection assessments was family support in only 9.5% of cases in 2007/08, it was the response in 21% of cases in 2010/11, with the proportion of assessments proceeding to intensive (child centred) family support increasing four-fold from 2.5% to 13% in 2010/11. The number of child protection applications proceeding to court has reduced steadily since mid-2008, from 9% of all assessments to less than 7% in mid-2011, a fall in actual cases of 24%. The recidivism rate (averaging substantiations occurring after both previous substantiations and non-substantiations following assessment) has remained steady at 6.9%, just greater than the USA standard. Section 10 outlines the Department's key performance indicators being used in monitoring the impact of *Signs of Safety* over time.

5.2.3 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 applying 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). 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/.

Signs of Safety 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 deliverers and clients. 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. *Signs of Safety* has evolved and continues to do so through the application of practice-based evidence, appreciative inquiry into practitioner and recipient-defined best practice. Building a culture of appreciative inquiry and research around frontline practice is critical. This is considered further in section ten of this document.

6. *Signs of Safety* assessment and planning - 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, until such time elapses that permanent out of home care becomes the priority, 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 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 is easier to see things differently (sport being such a core part of the Australian psyche). Roger Federer doesn't run from Wimbledon, Dawn Fraser didn't run from Tokyo in 1964. These players champ at the bit to get to these places because while they may fail spectacularly, on the biggest stage, in front of millions, it is actually very possible they will succeed gloriously. The analogy isn't exact, particularly because no one dies at Wimbledon 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 maxim 'protect your backside'.

Signs of Safety seeks to revision this territory and reclaim the risk assessment task as a constructive solution-building undertaking, a process that incorporates the idea of a win as well as a loss. *Signs of Safety* does not set problems in opposition to strengths and solution-focus, nor does it set forensic, rigorous professional inquiry off against collaborative practice. Quite simply, the best child protection practice is always both forensic and collaborative and demands that professionals are 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 Signs of Safety assessment and planning

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

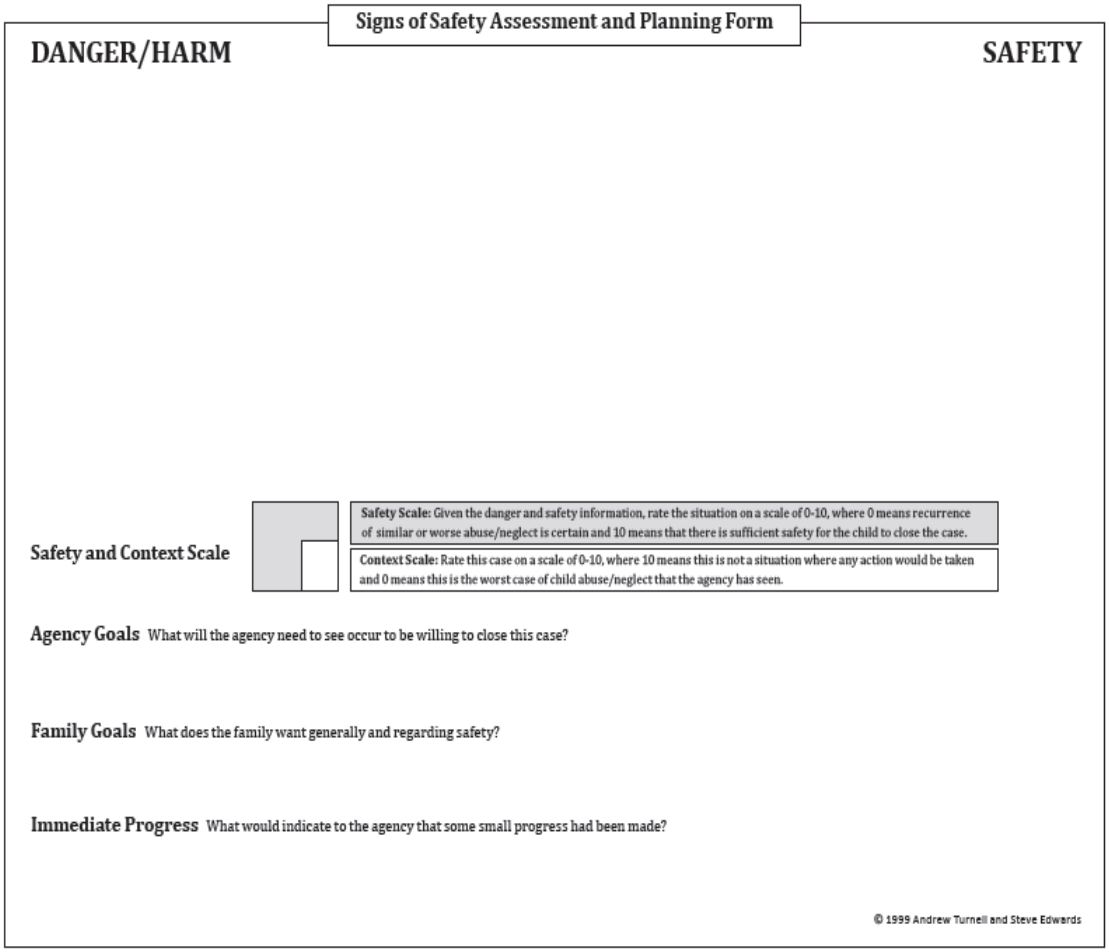
- Is simultaneously forensic in exploring harm and danger while at the same time eliciting and inquiring into strengths and safety.
- Brings forward clearly articulated professional knowledge while also equally eliciting and drawing upon family knowledge and wisdom.
- Is designed to always undertake 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 since it brings everyone, (both professional and family member) to the assessment table. (Some assessment frameworks trumpet their holistic credentials but often do so by slavishly and obsessively gathering vast amounts of information about every aspect of a family and child's life that then swamps the assessment process and everyone involved with too much information.)

Signs of Safety grounds these aspirations in an assessment and planning protocol that is the template for the Department's assessment and planning form.

The *Signs of Safety* assessment and planning protocol 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.

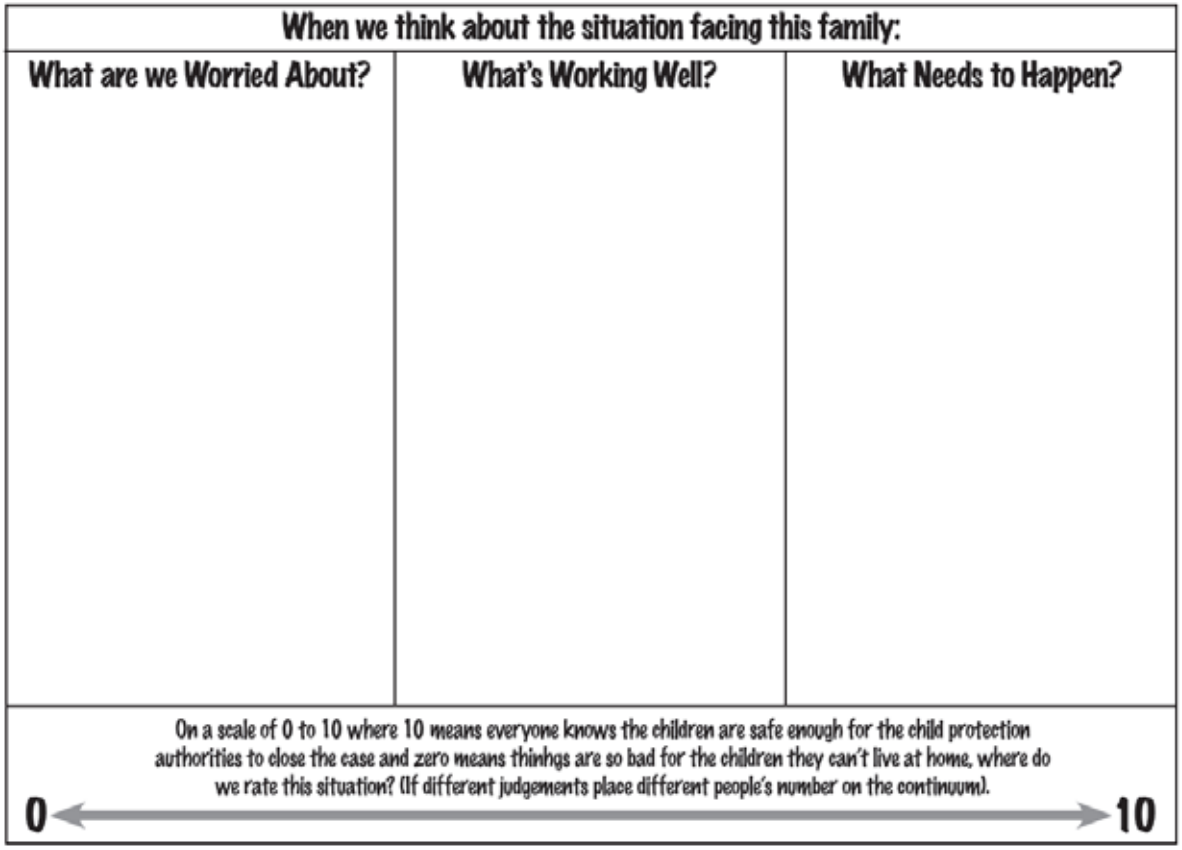
At its simplest this framework can be understood as containing four domains for inquiry:

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)[4].



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

The four domains operating in the *Signs of Safety* assessment and planning are more clearly identified in a simplified protocol that Turnell developed while working with Child Youth and Family New Zealand practitioners in 2004/5. This assessment and planning protocol is as follows.

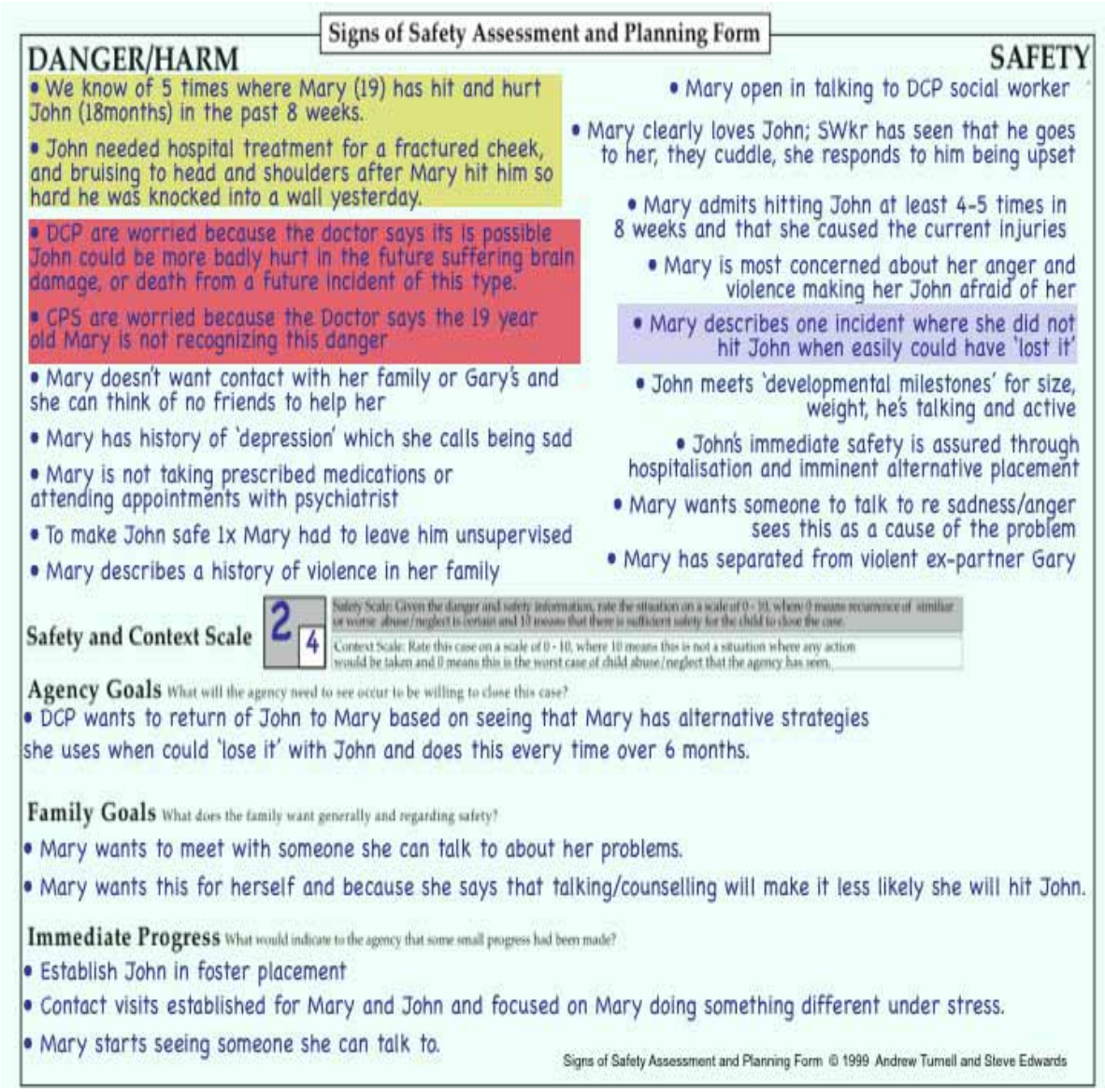


This 'three columns' alternative is not a different approach to the earlier one – it is simply a different version of the assessment and planning protocol within the same framework. The first provides a more formal structure and is more suited to court and more formal contexts. It is also more appropriate 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 planning tool providing a very clear and focused map for reviewing case practice. The Department has two *Signs of Safety* assessment and planning forms based on these two protocols.

Alongside these two versions of the *Signs of Safety* assessment and planning protocols, several additional protocols consistent with the framework have been created specifically designed for use with children and young people (see section 8).

6.4 Case example

The following is an example of a completed *Signs of Safety* 'map' involving a 19 year-old mother 'Mary' and her 18-month-old son 'John'. The *Signs of Safety* assessment and planning for this example is an amalgamation of two fairly equivalent 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[5].



Signs of Safety Assessment and Planning Form

DANGER/HARM

- We know of 5 times where Mary (19) has hit and hurt John (18months) 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 its is possible John could be more 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 recognizing 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 history of 'depression' which she calls being sad
- Mary is not taking prescribed medications or attending appointments with psychiatrist
- To make John safe 1x Mary had to leave him unsupervised
- Mary describes a history of violence in her family

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

Safety and Context Scale 2 / 4

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.

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

- DCP wants to return of 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.

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 *Signs of Safety* to arrive at the sort of assessment and plan presented above.

[5] A DVD: *Introduction to the Signs of Safety* (Turnell, 2005) explores this case example in closer detail and describes the relational and investigative processes involved in creating this assessment and case plan together with the mother.

7. Disciplines for using *Signs of Safety*

Together with the application of the principles, the disciplines for using *Signs of Safety* underpin the effective use of the assessment and planning protocol or tools. 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 are 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.

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

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

- **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 *Signs of Safety*.

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

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

8. 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 children in care tell researchers that they do not understand why they are in care. Visiting CREATE's[6] 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 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 *Signs of Safety* has been the development with practitioners of tools and processes designed to more actively involve children in child protection assessment, in understanding why professionals are intervening in their lives and in safety planning. These include:

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

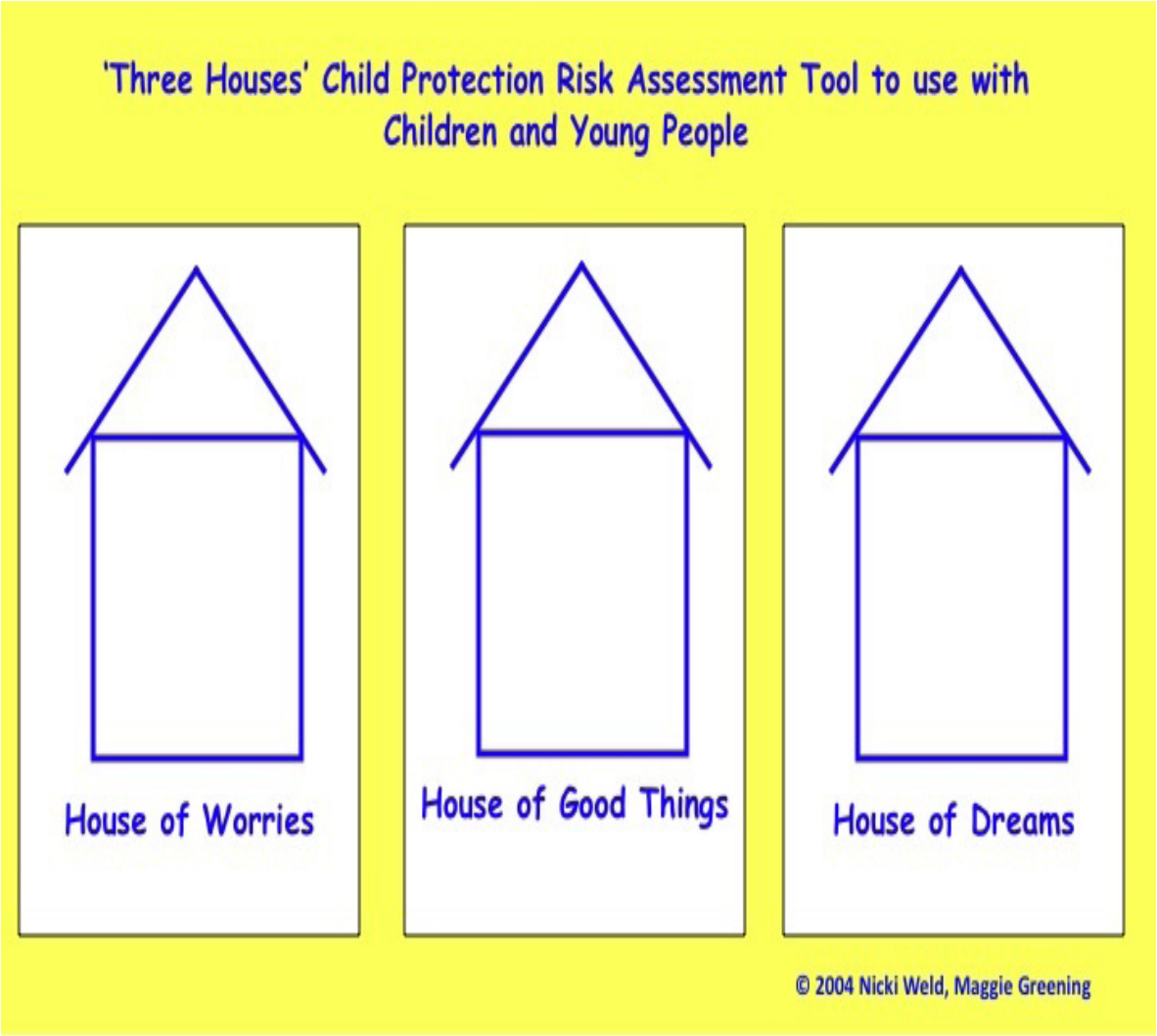
These four tools can involve children and young people throughout the life of the child protection case.

[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.

8.1 Three Houses tool and the Fairy/Wizard tool

8.1.1 Three Houses tool

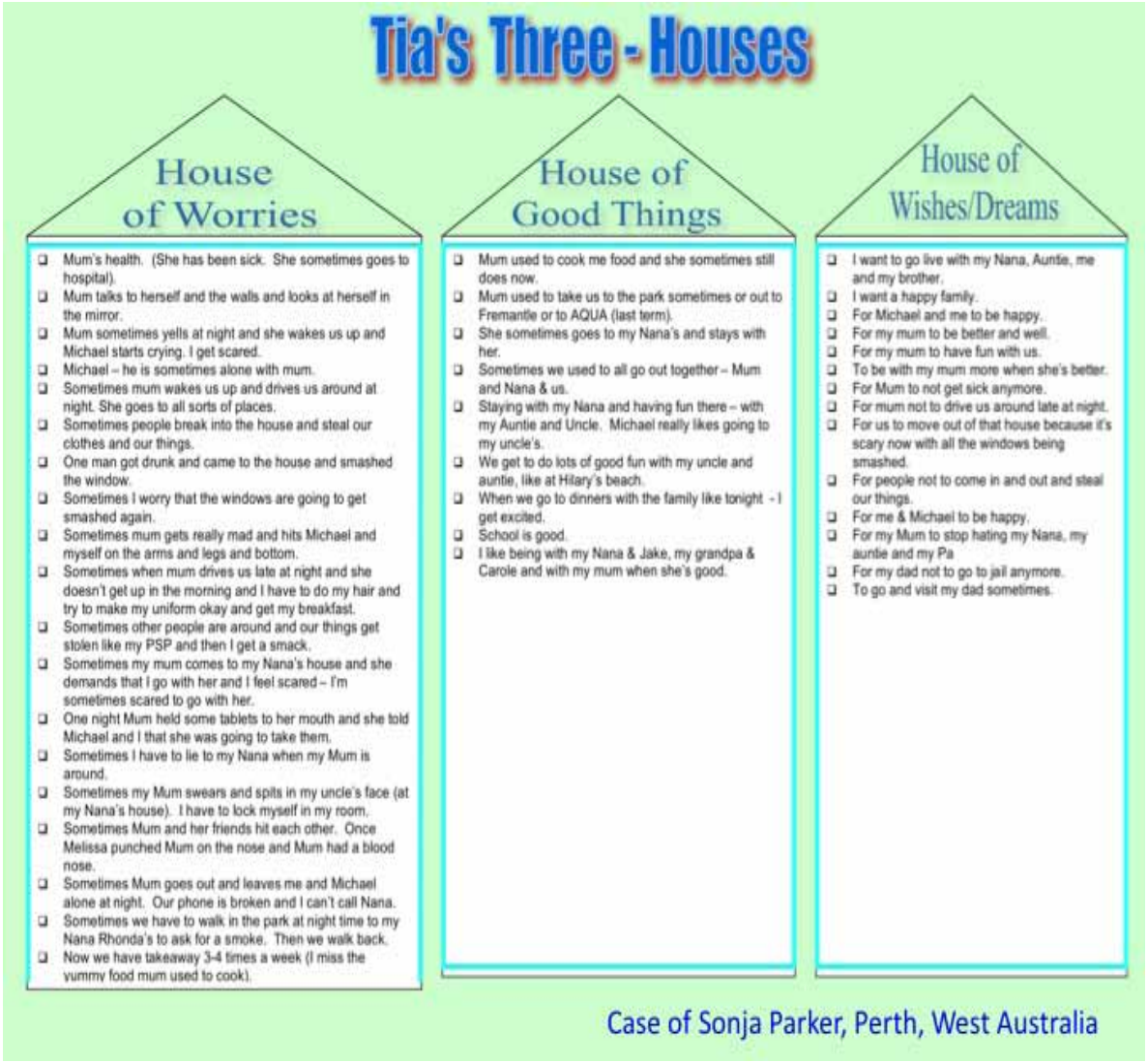
The Three Houses tool was first created by Nicki Weld and Maggie Greening from Child Youth and Family, New Zealand and is a practical method of undertaking child protection assessments with children and young people (Weld, 2008). The Three Houses method takes the three key assessment questions of *Signs of Safety* assessment and planning - 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:

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 the child is anxious or uncertain.
6. Once finished, obtain permission of the child to show to others - parents, extended family, professionals. Address any safety issues for the child in presenting to others.
7. Present the finished three houses assessment to the parents/caregivers, usually beginning with 'house of good things'.

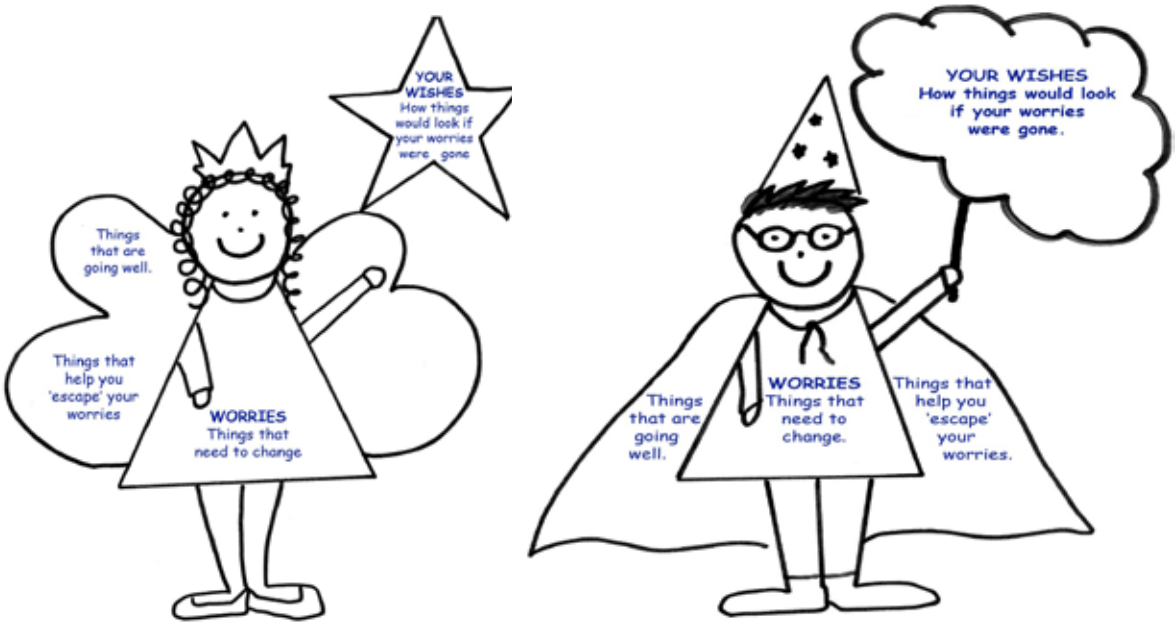
The following is an anonymous example of the Three Houses tool, created by Princess Margaret Hospital Child Protection Social Worker Sonja Parker with an eight-year-old girl 'Tia' who was bought into the hospital by her grandparents. The assessment speaks to the power of locating children in the centre of the assessment process.



8.1.2 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.

Vania Da Paz of DCP, 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). Da Paz has always been determined to find ways to involve children and young people in her child protection practice and following the initial training in *Signs of Safety* she developed a very similar tool that serves the same purpose as the Three Houses tool but with different graphic representation. Rather than Three Houses, Da Paz explores the same three questions using a drawing of a fairy with a magic wand (for girls) or a Wizard figure (for boys) as follows:



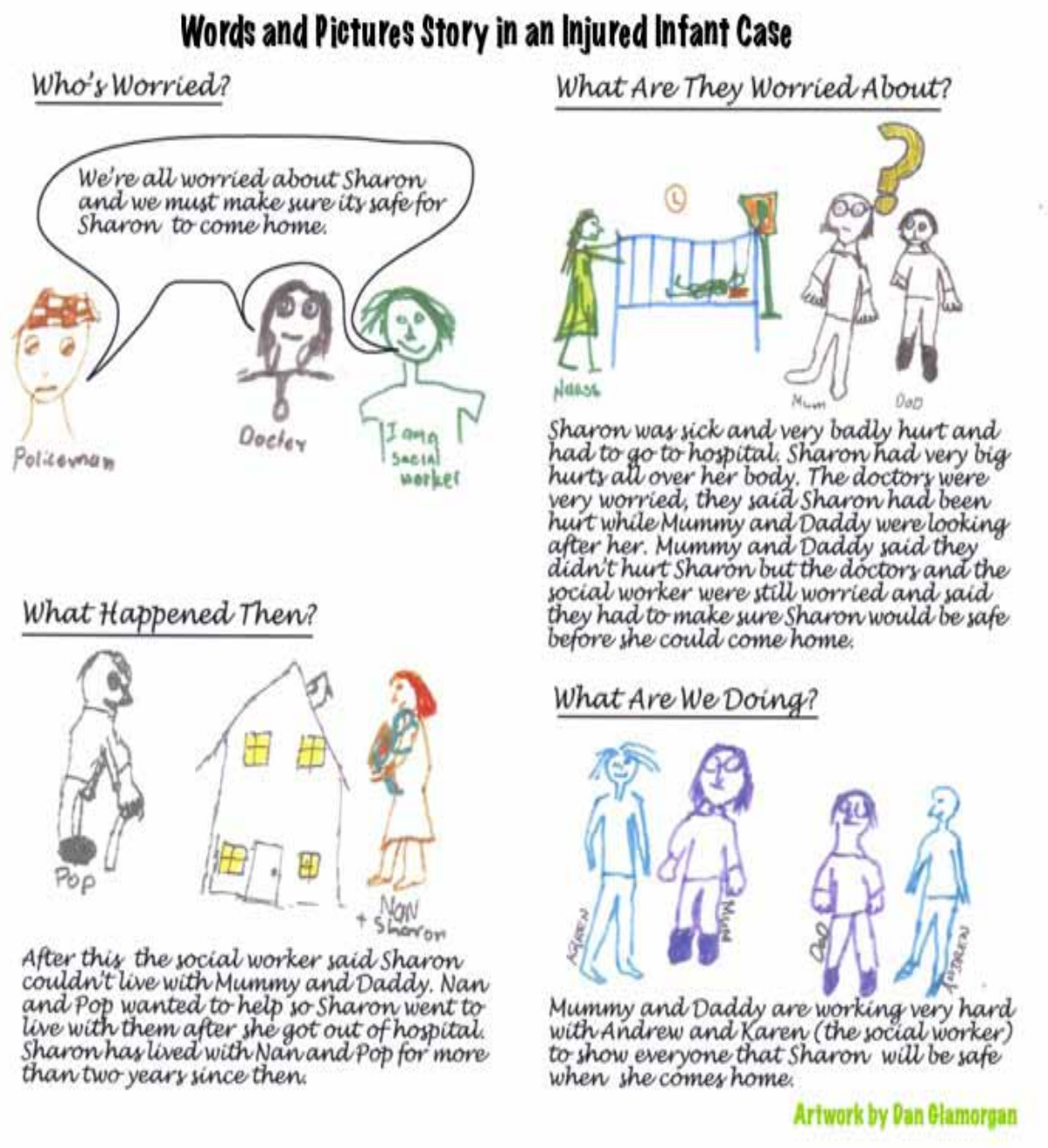
Fairy and Wizard Outlines, drawn by Vania Da Paz

Da Paz 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 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, (In Press a).

8.2 Words and pictures explanation

Turnell and Essex (2006) describe a 'Words and Pictures' explanation process for informing children and young people about serious child protection concerns that both involves and directly speaks to children. The following illustration is anexample excerpted from Turnell and Essex (2006). The example is presented to give a feel for age-appropriate explanations 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' method also offers a powerful method of creating a meaningful explanation for children in care and young people who are typically very confused or uncertain as to why they have come into the care system. One example of this adaptation of the words and pictures method can found in Turnell and Essex (2006, pp 94-101).

9. Safety planning

Safety planning 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 the safety and the care for their children the statutory agency requires of them. To sustain hope and constructive professional-family engagement and avoid the inertia of long-term child protection involvement and placement it is best if the safety planning opportunity is provided to the parents as quickly as possible after the initial investigation or removal of the children.

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 safety planning process.

9.1 Preparation

The more complex and risky a child protection case, the greater the tendency for more professionals to be involved. When DCP is considering undertaking a safety planning process with parents it is vital that all key professionals have discussed, are committed and know what their role will be in the process. Professional agreement and role clarity creates a secure foundation to explain and offer the safety planning opportunity to the family.

9.2 Establishing a working relationship with the family

Building safety plans that are meaningful and last the test of time requires a robust working relationship between the DCP 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 they can see 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.

9.3 A straightforward, understandable description of the child protection concerns – danger statements

To create a safety plan depends on DCP being able to articulate danger statements 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.

9.4 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 DCP is clear about the danger statements it can then articulate straightforward behavioural safety goals to tell parents what is required of them.

Here is one example of a safety goal:

Mother with history of debilitating depression and numerous suicide attempts The child protection service will return Billy to Kylie's care when Kylie is able to cope with her 'depression' and is able to provide good care to Billy even when she is depressed / sad and do this consistently over six months.

The detailed safety plan can then be developed from this goal. In this case it would likely include concrete behaviours that demonstrate what constitutes 'coping with depression', what is 'good care' and the strategies for making sure this happens even when feeling 'depressed / sad'.

9.5 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' and 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 involve in helping them create a safety plan. The higher the risk in the case in general the greater the number of people that DCP would expect to be involved.

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. However, families and parents, certainly those raised within a western culture rarely welcome the idea of involving others in their problems with child protection. Involving a network will almost always require skilful use of authority and persistence on the part of the professionals.

9.6 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 to ask the parents and network to come up with their best thinking about how to show everybody, including DCP that the children will be safe and well cared for .

This is an evolving conversation as the professional constantly deepens the parents' and networks' thinking, using questions that bring forward all the issues the professionals see might be in play, at the same time exploring the challenges the parents and network foresee. Throughout this process the parents and their network should be asked for every idea they have about how these issues can be addressed and what rules need to be in place to achieve this. 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.

The rules of the safety plan must address, in behavioural terms, the concerns that are identified in the danger statement and the desired outcomes stipulated in the safety goal/s.

9.7 Bottom lines and non-negotiables in safety planning

While the Department works within the collaborative processes of *Signs of Safety*, as a statutory agency it is required to make final decisions about whether children can or cannot stay with their parents. Bottom lines are those statements that indicate a minimum requirement to avoid the

child(ren) being removed. A subsequent decision to remove the child would be a consequence of parents, or family, to meet the bottom line.

It is critically important for the family, and everyone involved in the safety plan to be aware of the bottom lines the Department has set. It is also critical that there be a clear pathway for working to avoid the family situation reaching this line.

Non- negotiables are conditions that must be met as part of the safety plan. They comprise actions that must be taken by the parents and/or the safety network, or aspects of how actions must be implemented, to satisfy the Department that the child is safe and being cared for properly.

Safety planning addresses both the minimum requirements that constitute bottom lines and the non-negotiables. All the other means of keeping the child safe should be identified by the family and the safety network working with the professionals. It is essential that the bottom lines and the non-negotiables are kept to the minimum necessary and that they are introduced into the safety planning process in a way that is clear but does not compromise the collaborative effort of building the safety plan, as this process itself enables hope to be generated and a vision created.

Example of a bottom line the Department would use:

- That the baby must never be left alone in the care of the mother's boyfriend who has a history of violence and may have inflicted the injury that brought DCP into contact with the family; should this be the case, the baby will be taken into care immediately.

Examples of non-negotiables include:

- The parents must involve a certain number of people who are fully aware of the child protection concerns to assist them in demonstrating the children will be safe.
- The parents must work with the professionals to create a words and pictures explanation for the children to explain the child protection concerns.
- The safety plan must have rules that address particular stressors, triggers or issues.
- In some instances DCP will require that a particular parent or person, usually an alleged or convicted perpetrator never be alone with a child or any children and that a certain parent or person will be the primary carer of the children.

9.8 Steps towards reunification

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 and refining it 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 DCP 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.

Generally, the reunification process would optimally occur within a three to nine month period. While this will not always be the case given the individual circumstances of the family, if the family remains effectively engaged following the removal of child(ren), maintaining both professional and family focus on safety planning for longer than 12 months is difficult though certainly possible.

9.9 Involving children

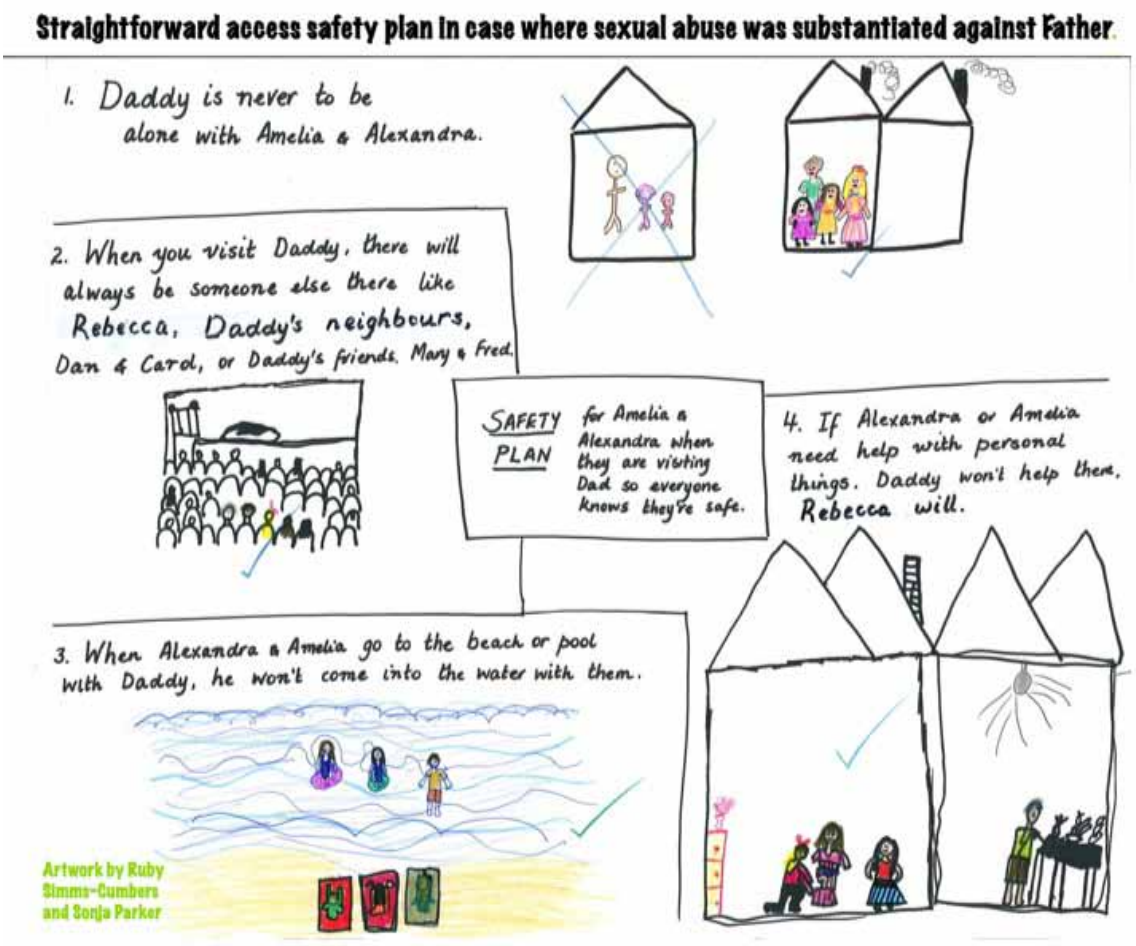
Given that safety plans are all about the children and are also about setting up family living arrangements so everyone knows the children will be safe and cared for its important to involve the children in the safety planning and make the process understandable to them.

The Three Houses/Wizard and Fairy Tools, the Words and Pictures Explanation and Words and Pictures Safety Plans

The Three Houses or Wizard/Fairy tools can be understood as a means to capture the child's experience of the problems and communicate this to the parents and adults. The Words and Pictures explanation works in the opposite direction and is a method to communicate the parents' and professionals' explanation the child protection concerns and events to the children in age appropriate language. These methods will inevitably deepen everyone's understanding of the issues and thereby make the safety planning process more focused on the children and more effective.

A key mechanism for deepening the parents' and networks' engagement with the safety plan is to work with them to distil all the adult safety planning work into a final safety plan the children can readily understand. This work ensures the children understand the rules of the safety plan

The final safety plan can be presented to the children at a big meeting attended by the parents, all of the safety network and the relevant professionals, which increases the significance and importance surrounding the plan. In preparing the plan for the children and presenting it to them, the parents are making public commitments to live by these rules in front of their children and people from their everyday life. This is a far more powerful process than having parents make commitments to professionals alone.



9.10 Managing safety plans over time

The development of safety plans can cause anxiety for practitioners trying to address those high risk factors that impact directly on a child's safety. This can cause emphasis to be placed on the plan itself rather than seeing the plan as a dynamic document.

The plan needs to be meaningful for the family and needs to be owned by the family, and it needs to involve everyone in the safety network in managing it over time.

The same rigor that applies to making assessments and bringing a child into care must also be applied to the use of safety plans. The plan must contain the detail around the what, how, who, where and when, and adapt to progress and changing circumstances. Therefore, safety plans are effective only if they are regularly reviewed. Otherwise, how do we know the plan is working and keeping the child safe?

In managing the plan over time, the safety network should be able to respond to five main areas:

1. Positive changes in behaviour
2. Responding to crises
3. Addressing social isolation
4. Separation from the child(ren)
5. Accessing and using resources

People in the safety network need to be tuned in to the changes they need to see in order for everyone to know that the child is safe. Questions such as the following should be regular asked: What are the changes in behaviours they need to see by the parent(s)/caregiver? Does the parent(s)/caregiver have some strategies to cope when faced with a crisis? Who will step in and support? What needs to be put in place (resources, services, people) and when, in order for the parent to reach the goal of keeping the child safe?

Additionally, it needs to be remembered that because a service the a parent attends can never of itself deliver safety, when DCP makes a service mandatory the professionals need also to describe the behavioural change they expect to see that will create increased safety for the children. This will need continuing attention through the life of the case and the safety plan.

9.11 A safety plan as a journey not a product

The most important aspect of safety planning is that the plan is co-created with the family and an informed safety network, it is operationalised, monitored and refined carefully over time and the commitments involved in 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?

10. Creating a culture of appreciative inquiry around child protection practice

Competency is quiet; it tends to be overlooked in the noise and clatter of problems (William Madsen 2007, p.32).

Child protection can, above all else, suffer 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 Middlesbrough, 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 can 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, *Signs of Safety* 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 *Signs of Safety* and how has it been useful to them? In this way the writings about *Signs of Safety* 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 *Signs of Safety* but also describe good child protection practice more generally.

This inspiration to inquire into worker-defined successful practice arose initially for Steve Edwards and Andrew Turnell from the 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 frontline child protection practitioners in an organisational development agenda. As well, this approach is increasingly being seen in academic circles as a critical method of researching professional theory. As described in section 5.2.3 the literature refers to this as practice-based evidence or critical best practice theory (see for example Ferguson 2001 and 2003; Healy 2006).

This organisational development methodology can also be seen as a form of appreciative inquiry. Appreciative inquiry (AI) 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 AI author describes it as 'change at the speed of imagination' (Watkins and Mohr 2001). Perhaps the title would be more accurate if it was 'change at the speed of detailed awareness/knowledge of your best practice'.

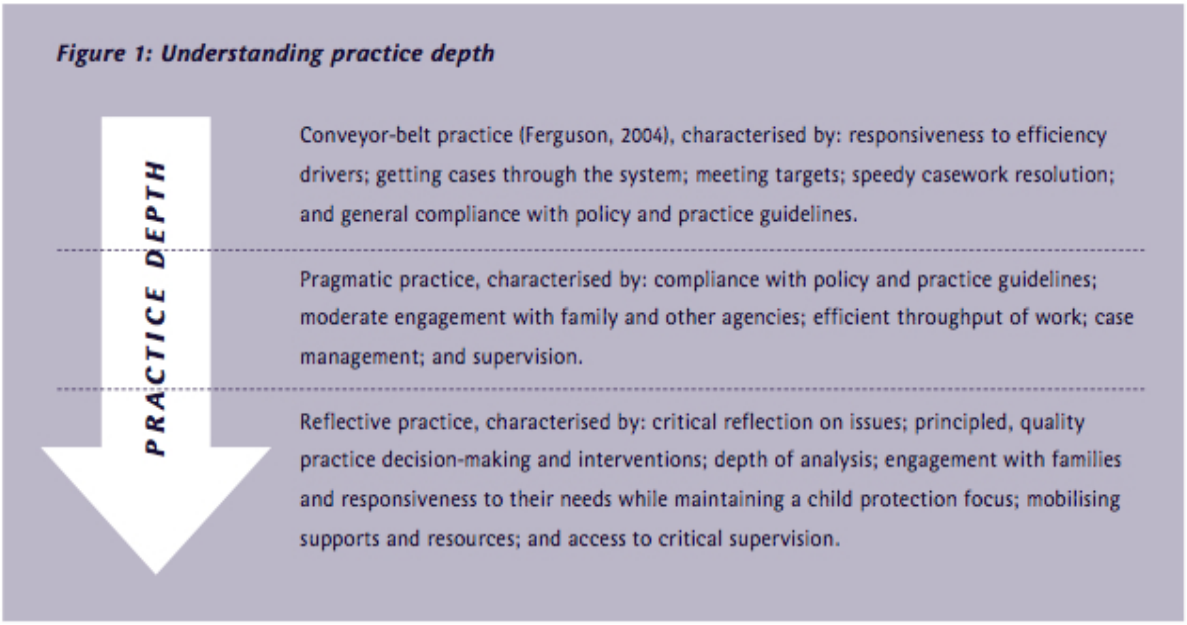
Turnell has drawn together the ideas of solution-focused brief therapy and appreciative inquiry, using the questioning methods of the former and the organisational change agenda of the latter and thus often speaks of 'creating a culture of appreciative inquiry around frontline practice'. This is a powerful mechanism for the Department to make *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 the process of building a culture of appreciative inquiry around frontline practice is grounded in the week-in, week-out appreciative inquiry work of the practice leaders it is also vital that senior management understands, supports and can replicates this process particularly when case crises come to the fore.

In a direct parallel process to what the department is asking 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 one 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 have articulated the lessons learnt during an eighteen-month implementation of the strengths-based practice and *Signs of Safety* within the Tauranga and Otara offices between 2003-05. 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':

Figure 1: Understanding practice depth



Too often child protection organisations fall into perpetuating what Chapman and Field (2007) are describing as 'conveyor-belt' or 'pragmatic' practice alone. Practice of this form may be expedient and is necessary for all sorts of reasons but it rarely of itself 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 *Signs of Safety* are designed to directly address this problem by creating a culture of appreciative inquiry around practice and practitioners, and to build 'practice depth' within practitioners, teams, district offices and the Department as a whole. It is only the creation of increasing practice depth that will enable all staff to claim pride and confidence in their work and enable DCP to deliver services that are valued highly by service recipients (even where intrusive statutory interventions are necessary) and that will deliver transparently safer outcomes for vulnerable children.

10.1 Management style that grows practice depth and builds a culture of appreciative inquiry around frontline practice

An important development around the *Signs of Safety* in the past decade has been the distillation of managerial and strategic leadership and process that best enables organisational implementation of the approach. The reality is that models of practice have only limited impact unless organisational procedures, strategies and managerial style complement the practice approach. A collaborative, strengths-based practice approach that demands rigorous thinking, emotional intelligence and compassion will be undermined in an organisational culture that privileges audit compliance and command and control leadership. Experience clearly indicates that where an agency's CEO and senior management have a deep acuity to the realities of front line practice and a strong connection to their field staff this always creates a deeper and more sustained implementation of the *Signs of Safety*. Conversely, where senior management take and/ or communicate the attitude that direct practice and practice theory and frameworks are something for practitioners, supervisors and perhaps middle management to deal with, the organisational ground for growing depth of practice is significantly less fertile.

Child protection practice is always uncertain and this is often a very uncomfortable reality for managers and directors. Morrison (2010) and Munro (2010) in the Part One Report for the Review of Child Protection in England speak to the issue. One of the biggest challenges of the *Signs of Safety* approach is that it is a questioning approach. The approach asks professionals to step away from the myth of certainty. This does not mean that anything goes or that professionals know nothing— quite the reverse. Letting go of the 'cheap grace' of the easy answer in the face of wicked problems, fraught with complexity and anxiety is a sign of organisational maturity and the ground on which practice depth can grow.

The *Signs of Safety* asks professionals to adopt Munro's maxim and rather than try and assert a definitive truth, to ask penetrating, rigorous questions focused on the four domains of worries, strengths, goals and judgment. When cases come to the attention of senior management these will almost inevitably be cases in crisis. In these circumstances, the understandable and usual tendency of senior managers is to make fast judgments and give immediate strong directions about what needs to happen in the case. This is command and control social work taken to the highest organisational level. There are undoubtedly times when senior management need to take control of case practice and case management. As often as not this occurs because of the political realities that are always in play around child protection services. However, when senior managers do this they need also to be mindful that such action easily has an adverse effect on field staff and can leave them feeling disenfranchised and defensive. Fundamentally, the *Signs of Safety* asks an agency's executive and its management to use its authority skilfully by adopting a questioning approach to leadership.

The four domains of worries, strengths, goals and judgment constitute a very powerful strategic management mechanism for thinking the way into and through all aspects of organisational functioning, whether related directly to case practice or not. Utilising a risk assessment framework and a questioning practice style that is replicated in a three column strategic planning and questioning management style creates a powerful organisational parallel process to *Signs of Safety* child protection practice.

11. Implementing *Signs of Safety* - a learning journey

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

While 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 organisation, Senge's motif of the learning organisation is important. Senge argues that organisational change and development is not a product but rather a process of bringing forward peoples' best thinking and energy that is created relationally within the organisation. Senge invokes the notion of the 'learning journey' to suggest that organisational (and individual) change and development is not an entity that can be bottled, or disbursed in a training program, rather it is a process of continual inquiry, reflection and learning, that needs to be fostered in the culture, procedures, and 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 practices. While the first step in implementing the *Signs of Safety* framework and practices necessarily involved training for all staff, meaningful implementation across all of the Department's child protection casework has required sustained organisational commitment to an organisation-wide 'learning journey'. Formally, this is set out in the reform project plan that extends over five years (2008 to 2013).

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. Meaningful system-wide implementation of the *Signs of Safety* involves engaging and supporting team leaders and senior practitioners as practice leaders in undertaking an extended, ongoing learning journey in their understanding and use of the approach.

11.1 Practice leadership

The Department is committed to supporting the development of strong practice leaders (PLs) who have an in-depth understanding of *Signs of Safety* in all districts and child protection practice contexts. There is a rigorous ongoing process for training and developing *Signs of Safety* practice leaders.

PLs include all Senior Practice Development Officers (SPDO), a large number of Team Leaders (TL) and other senior practitioners to ensure that each district have sufficient *Signs of Safety* practice leaders to enable them to work in pair, help each other grow their skills and to hold each other accountable to using *Signs of Safety* consistently, and undertaking Appreciative Inquiry work.

PL core training will enable PLs to:

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

Following this training the PLs will participate in ongoing development to support and deepen their practice leadership of *Signs of Safety*.

In districts, PLs lead regular group sessions with field staff in which they cases using the *Signs of Safety* assessment and planning tools and undertake appreciative inquiries. Working in pairs, with one facilitating, the other adopting an advisor's role, and video recording session, and reviewing tapes with peer PLs, are strategies to maximise learning. 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 of practitioners. 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 SPDO's and Team Leader's 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.

Over time, increasing numbers of PLs will learn and grow in 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 emphasise 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 process since 2002, with Gateshead Access and Assessment (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).

11.2 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'. A child protection agency the size of the Department for Child Protection is a highly complex organisation and there will be many significant challenges and obstacles to sustaining an extended learning journey with *Signs of Safety*. Not the least of these challenges will be the habit and allure of moving on to the next new thing when *Signs of Safety* begins to seem like yesterday's initiative. Embedding *Signs of Safety* as the organising framework for all child protection practice requires, above everything, a sustained commitment by everyone, from the CEO to the front-line practitioner. All departmental staff need to be involved in maintaining, nourishing and growing the use of the approach through a continuing organisational learning journey.

12. Key performance indicators

The Department collects a number of performance indicators that should be impacted over time by the progressive growth in depth and effectiveness of child protection practice. These indicators and a regular staff survey will inform the following key performance indicators for the use of *Signs of Safety* as the Department's child protection practice framework.

Case Practice Monitoring and Outcomes

- Number of children in care.
- Proportion of safety and wellbeing assessments proceeding to child centred family support vs intervention action.
- Re-substantiation rates (following both previous substantiations and non-substantiations).

Case Practice Qualitative Information

- Descriptions of good practice by families, including being understood, involvement in decision making and understanding of departmental goals and next steps.
- Descriptions of good practice by front line practitioners.

Staff Measures

- Service delivery and case worker separation rates.
- Survey data reflecting impact of *Signs of Safety* on job satisfaction and professional pride.

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