Signs of Safety
Comprehensive Briefing Paper

4th edition

Professor Andrew Turnell & Terry Murphy

Signs of Safety® Comprehensive Briefing Paper (4th edition)

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Significant updates in the 4th edition:

- New case material in Chapter 5 to present the Signs of Safety assessment framework and the safety planning practice that flows from it.
- Completely new Chapter 6 that details the Signs of Safety Practice Theory of Change.
- Comprehensively revised Chapters 9 and 10 detail the most recent developments in Signs of Safety organisational implementation.

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Cover Artwork

> *"The Signs of Safety approach to child protection casework is indigenous to Australia. It is appropriate then that Signs of Safety practice involving the professionals and the children, parents, and their naturally connected networks is represented in this briefing paper by the Aboriginal Australian leaf painting that graces the front cover."*
>
> **Andrew Turnell**

The cover image was commissioned and painted to represent the fluid, interactional nature of the Signs of Safety Practice Theory of Change. The image speaks for the focused work of recent years to formulate more precisely the organisational and practice theories of change presented for the first time in this 4th edition of the Signs of Safety Briefing Paper.

The artwork was created by Roseanne Paine, a Wongutha (Australian Aboriginal) from the Cosmo Newberry Community. She is a Teacher (early childhood education) and artist, painting stories of her childhood and the Dreaming as well as contemporary Aboriginal art.

About the artwork – Roseanne Paine

This painting represents the Signs of Safety framework. It is shown as a leaf to represent its growth and life. The blue horseshoe shape at the base of the leaf represents the services, with the statutory children's services at the centre, surrounded by the court and legal systems which in turn are surrounded by the extended professional network. The orange and red horseshoe shape near it symbolises the vulnerable child or young person, surrounded by the immediate family, and then the extended family and support people. From both horseshoe shapes, there are footsteps to represent the journey both go on together to support the vulnerable child or young person and their family. On this journey, there is the assessment and analysis cycle, represented by four of the green and white circles.

The elements of this cycle are leadership, organisational alignment, learning and meaningful measures. There is also the Action Cycle on this journey, which is represented by the other four white and green circles. The Action Cycle includes:

- informing, listening to, and involving the children;
- establishing a permanent, naturally connected support network;
- regular checking by support people to ensure the plan will be permanent; and
- parents, support people and children enacting the everyday plan to ensure wellbeing, safety and success when things get difficult.

The white and black line running through the leaf and around the circle is the vein of the leaf and represents the fluidity and life force of the approach to support growth and to support the elements of the framework. As the footsteps reach the bottom of the leaf, the blue footsteps stop (the services) as the yellow footsteps (the children/young person and their family) continue having been strengthened through the Signs of Safety work and the journey. The final horseshoe shape, as before, represents the vulnerable child or young person, followed by the immediate family, and then the extended family and support people. They are now larger, having grown, and continue the journey without the direct support of the framework.

The red circular background represents the coming together of families, and the services and the strength of this collaboration in helping support vulnerable children and young people.

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Introduction: A Constantly Evolving Approach

The Signs of Safety approach to child protection casework is now widely recognised internationally as the leading available participative approach to child protection casework.

Although the approach has been developing since Steve Edwards and Andrew Turnell began collaborating in the late 1980s, the last eight years have seen an explosion of interest and engagement with the approach around the world. This momentum has come about because the Signs of Safety approach is first and foremost grounded in, and continues to evolve from, what works for the front line practitioner. Currently there are nearly 200 agencies in 15 countries undertaking some form of implementation of the Signs of Safety. This includes large-scale, long-term, system-wide implementations in Australia, New Zealand, Japan, Europe, Canada, USA, and Cambodia.

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

> ***If the nation had deliberately designed a system that would frustrate the professionals who staff it, anger the public who finance it, and abandon the children who depend on it, it could not have done a better job than the present child welfare system. (Cited in Thompson, 1995, p. 5)***

Framing the child protection task primarily as a procedural challenge has led almost universally to systems across the developed world becoming increasingly expensive and defensive, facing rapidly escalating numbers of children in care for longer periods, experiencing increasing numbers of parents being taken to court, and seeing increasing staff turnover alongside decreasing staff morale. (This should not be taken to mean that rates of actual child abuse have increased in certain countries. Determining that is much more difficult.) The Sacramento Grand Jury (2010),

inquiring into child protection services in Sacramento County, released a report entitled *'Child protective services: Nothing ever changes ever'*. While that title sounds pessimistic, the reality is that almost all child protection jurisdictions everywhere in the developed world have indeed changed — they have all become worse!

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

As a named entity, the Signs of Safety is now 23 years old. It is a mature and yet still evolving professional approach. The practice approach and its methods continue to grow in their acuity and applicability across the entire continuum from intake and assessment to closure, within alternative care and permanency work, and across the full spectrum of abuse profiles, complicating factors and populations that child protection work encompasses. The following are some of the most notable changes that have occurred within the Signs of Safety since the release of Turnell's and Edwards' 1999 book:

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

Alongside the practice developments, significant parallel developments continue focusing on creating the organisational conditions that can support Signs of Safety use and implementation. The most important of these are:

- supporting research and evidence base;
- formalising the practice model for research, practice and training purposes;
- standardising training programs and arrangements; and
- formalising organisational implementation processes that enable optimal use of the approach in practice (Munro, Turnell and Murphy, 2017; Turnell, Munro and Murphy, 2013).

This fourth edition of the Signs of Safety Briefing Paper offers a comprehensive overview of the Signs of Safety approach and underpinning theory, as well as detailing the research and implementation science that supports it. Chapter One begins by underlining what the whole endeavour is about: child safety. Chapter Two locates the Signs of Safety within its values base by exploring the three core organising principles of the model. Chapter Three offers a brief history of the Signs of Safety to provide the reader with some context about how and why the model was created. Chapter Four details the international use of the approach together with the evidence base that supports it. Chapter Five goes to the heart of the Signs of Safety practice framework, describing how it frames and undertakes the core child protection task of risk assessment and planning. Chapter Six outlines the Signs of Safety Practice Theory of Change. Chapter Seven looks at the tools the approach draws upon to locate children in the middle of the practice. Chapter Eight looks at safety planning, which is the crux of the approach and all child protection work. The final two chapters focus on systems issues, with Chapter Nine looking at the learning theories and approaches that inform Signs of Safety being a vehicle for organisational learning and transformation; and Chapter Ten addressing the details of organisational implementation and leadership.

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

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

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

Completing the Signs of Safety assessment and planning is, 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 where the child lives.

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

2. Three Core Principles of Signs of Safety

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

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

2.1 Working Relationships

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

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

While concerns about a relationship focus in child protection practice usually centre on working with parents, relationships between professionals themselves can be equally, if not more, problematic. Child death inquiries consistently describe scenarios where professional relationships

and communication are dysfunctional. Meta-analyses of child death inquiries — such as Department of Health (2002); Munro (1996 and 1998); Hill (1990); Reder, Duncan & Grey (1993) — reveal that poorly functioning professional relationships 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 in practice. Too often, proponents of relationship-grounded child protection practice have articulated visions of partnership with families and collaboration amongst professionals that are overly simplistic. To be meaningful, it is crucial that descriptions of child protection working relationships closely reflect the typically messy lived experience of the workers, parents, children and other professionals who are doing the difficult business of relating to each other in contested child protection contexts.

2.2 Munro's Maxim: Thinking Critically, Fostering a Stance of Inquiry

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

> ***Whether or not we think there are absolute perpetrators and absolute victims in child abuse cases, and whether or not we believe in a single uncontaminated 'truth' about 'what happened', powerful forces pull us towards enacting a script, which offers us these parts and these endings.***
> **(Baistow et al., 1995: vi)**

The difficulty is that as soon as the professional decides they know the truth about a given situation, this begins to fracture working relationships with other professionals and family members, all of whom very likely hold different positions. Furthermore, 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 recognised for her work in researching typical errors of practice and reasoning in child protection (Munro, 1996, 1998), states:

> ***The single most important factor in minimising errors [in child protection practice[1]] is to admit that you may be wrong.***
> **(Munro, 2008: 125)**

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

2.3 Landing Grand Aspirations in Everyday Practice

Just about everybody, from taxi drivers to parliamentarians, wants to tell a child protection worker how to do their job. The problem is that most of these people have never knocked on a door to present a child abuse allegation to a parent and most of the advice comes across like *'voices from twenty-seven thousand feet'*[2].

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

1 *Text in square brackets added for contextual clarity.*
2 *This is an expression used by Russell Martin, Director of Open Home Foundation, New Zealand.*
3 *An expression coined by another New Zealander, former Child Youth and Family Chief Social Worker, Craig Smith.*

3. History: How Signs of Safety Evolved

The Signs of Safety approach to child protection casework was developed through the 1990s in Western Australia. It was created by Steve Edwards and Andrew Turnell in collaboration with over 150 West Australian child protection workers and is now being utilised around the world.

Above: Signs of Safety Approach to Child Protection Casework ——illustration by Mary Brake (www.reflectiongraphics.com).

The impetus to create the Signs of Safety approach arose from Steve Edwards' experience of 16 years as a front line statutory child protection practitioner, eight of these working primarily with Aboriginal communities. Edwards was very dissatisfied with most of the models and theory regarding child protection practice that he had encountered. 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 and capture his experience of practice. In 1989, Edwards and Turnell began to collaborate after Edwards became interested in the brief therapy work Turnell was doing with families referred to a non-government counselling agency by the then Department of Community Welfare. Each week for more than three years, Edwards would observe the brief therapy

work from behind a one-way mirror and began to apply these solution-focused and problem resolution brief therapy ideas and techniques (Berg, 1994; de Shazer, 1984, 1985, 1988, 1991; Weakland and Jordan, 1990; Watzlawick et al., 1974) into his practice as a child protection worker.

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

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

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

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

4. International Use and Data

4.1 International Use

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

During this period, the Signs of Safety model has continued to evolve as it has been applied and utilised in many countries, across all aspects of the child protection task, and as it has been consistently used in increasingly higher risk cases (Amelse et al., 2014; Bunn, 2013; Bunn et al., 2016; Chapman and Field, 2007; Fleming, 1998; Hogg and Wheeler, 2004; Gardeström, 2006; Lohrbach and Sawyer, 2004; Inoue et al., 2006a; Inoue et al., 2006b; Inoue and Inoue, 2008; Jack, 2005; Keddell, 2014; Koziolek, 2007; Lwin et al., 2014; Myers, 2005; Nelson-Dusek et al., in Press; Shennan, 2006; Simmons, Lehman and Duguay, 2008; Turnell, 2004, 2006a, 2006b 2007a, 2007b, 2008, 2009, 2011, 2013; Turnell, Elliott and Hogg, 2007; Turnell and Essex, 2006, 2013; Turnell, Lohrbach and Curran, 2008; Turnell, Vesterhauge-Petersen and Vesterhauge-Petersen, 2013; Turnell et al., 2017; Weld, 2008; Westbrock, 2006; Wheeler, Hogg, and Fegan, 2006).

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

4.2 Current Major International Research Initiatives

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

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

4.2.1 Results logic

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

A results or program logic formalises what the Signs of Safety is and how it works for research purposes. (For more information, see http://www.theoryofchange.org/what-is-theory-of-change/.) Defining what the model is provides the foundation for establishing a robust evidence base regarding the impact and extent to which the Signs of Safety approach delivers reliable improvements and outcomes (Salveron et al., 2014). This research work was completed in 2016 and the results will be published soon. The findings showed that consistent use of the approach was dependent on organisational arrangements. This has led to significant rethinking and reworking of the Signs of Safety theories of change, presented in Chapters 6 and 10.

4.2.2 Fidelity research

Once the model of Signs of Safety is defined for research purposes, the next research question that inevitably follows is: Are the agency, the practitioner, supervisors, managers and leadership doing it right? For more information about fidelity research, go to https://yftipa.org/high-fidelity-wraparound/.

Drawing on the expertise, vision and leadership of Casey Family Programs (CFP) in the USA, the Signs of Safety Fidelity Research Project began in mid-2012. The project was established to create a series of validated assessment tools that will enable agencies to evaluate in real-time the fidelity of Signs of Safety practice of workers, supervisors, leadership, and the supporting organisational climate. The project will also incorporate a parent's fidelity tool to provide real-time feedback from parents about their experience of the approach from the receiving end. Measuring how well and to what degree the Signs of Safety approach is implemented is critical to facilitating quality and

effectiveness of improvements, ensuring accountability, and reflecting progress toward attaining the shared goals of providers, individuals, and families served within the system.

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

4.3 Evidence Base/Supporting Data

4.3.1 Professional identity and job satisfaction

In the 1990s, Andrew Turnell and Steve Edwards undertook two follow-up studies with participants in the first two six-month Signs of Safety development groups. Those studies focused on professional identity and job satisfaction. Participants rated their sense of professional identity and job satisfaction as front line child protection workers at the beginning and end of the six-month project and then again in a follow-up survey 12 months after completing the project. These studies involved 31 participants and showed an almost two-point increase average (on a ten-point scale) in the workers' sense of professional identity and job satisfaction over the 18 months from project commencement to 12-month follow-up. While this was a low key and informal study of workers' experiences, the same findings are reflected in all the jurisdictions where the Signs of Safety approach has been applied systematically. Two separate worker and supervisor descriptions of the impact of using the Signs of Safety can be found in Turnell, Elliott and Hogg (2007) and Turnell, Lohrbach and Curran (2008). Systems that implement the Signs of Safety consistently experience increased worker morale and job satisfaction. See particularly information presented below from Minnesota, Western Australia, Drenthe in the Netherlands, and Copenhagen.

4.3.2 Case and system change data

Western Australia

Until the Canadian province of Alberta formally began its implementation in early 2014, the Department for Child Protection and Family Support (CPFS) in Western Australia was undertaking the largest system-wide implementation of the Signs of Safety. CPFS serves a state of 2.5 million people that covers one third of Australia's landmass, stretching almost 4000 kilometres from

north to south. The agency employs over 2,300 staff. While the Signs of Safety approach was created in Western Australia in the 1990s, the approach was not adopted as CPFS's child protection assessment and practice framework until 2008. The following outcome data have been gathered through internal and external evaluation.

The number of children in care across Australia almost doubled between 2000 and 2010. The average increase was 9.7% each year (Lamont, 2011). The rate of increase in the Western Australian system was above the average in the four years to 2007, running at 13.5%. With the implementation of the Signs of Safety, that rate has been cut to an average of 5% between 2009 and 2013 (just a little above the population growth rate of 4.4%). Alongside this, the percentage of child protection assessments that have been referred to intensive family support has almost tripled, increasing from 1,411 in 2009 to 4,558 in 2013. The percentage of protection and care applications taken out increased by only 16% during 2009-2013, while child protection notifications themselves doubled. In this same period re-referral rates declined slightly from 6.9% to 6.5%, suggesting the more collaborative approach to families has not increased the risk to vulnerable children.

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

- families' understanding the issues and expectations better;
- the framework providing clarity and focus for child protection work;
- useful tools;
- encouraging more collaborative work including with partner agencies;
- better decision making; and
- practice being valued by practitioners as more open, transparent and honest.

As part of its system-wide implementation of the Signs of Safety, CPFS uses Signs of Safety meetings as a key mechanism for building and focusing professional and family collaboration on child safety. These meetings, with graduated degrees of formality, include pre-birth and pre-hearing court conferences.

CPFS evaluated the first year of using Signs of Safety meetings for pre-birth planning with pregnant mothers facing high-risk situations. The outcomes were impressive, including a 30% reduction in child removals for this cohort and a significantly improved working relationship between CPFS and Western Australia's primary maternity hospital (DCP, 2009).

Using Signs of Safety meetings as a court diversionary process through structured pre-hearing conferences has been similarly successful. The independent evaluation found the pre-hearing meeting process improved collaboration between professionals and families and received resounding endorsement from attorneys, judges, CPFS, and other professionals. Matters referred to conference resulted in 30% fewer court events and less time spent from the initial application to finalisation of the matter. Cases brought to conference also resulted in fewer matters proceeding to trial and more consent orders and negotiated outcomes (DCP, 2011).

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

- A children's study to test a rating tool that gathers the views of children and young people about the degree to which their case workers engaged them and enabled their participation in child protection investigations. The first part of this study was completed in 2013, in which 6 children under the age of 12 were interviewed about their experience of child protection investigation and subsequent casework (Salveron et al., 2013). This work is the first time that research has been done anywhere in the world with children about their experience of child protection investigations. This methodology will be repeated and the research widened to actively look at the impact of the Signs of Safety children's tools.
- Using the methodology of Implementation Science to describe the system-wide implementation process of the Signs of Safety within CPFS (Salveron et al., 2015).

British Columbia, Canada

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

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

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

- Overall compliance to child protective investigations standards increased from 73% to 92%.
- Overall compliance to family services standards increased from 81% to 94%.
- Determining if a child needs protection increased from 67% to 93%.
- Recording and reporting the results of an investigation increased from 50% to 90%.
- Meeting timelines for investigation increased from 33% to 75%.
- Completed Support Service Agreements with families increased from 45% to 95%.
- File documentation increased from 48% to 82%.
- The overall increase in compliance is attributed to these two main variables:
    - Implementation of Signs of Safety as the practice model.
    - The creation of a complementary information management system.

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

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

Toronto Children's Aid Society (TCAS) Ontario

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

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

Olmsted County Minnesota

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

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

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

Carver County Minnesota

Following the lead of Olmsted County, Carver County Community Social Services (CCCSS) in Minnesota 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.

As of the spring of 2014, Carver County was showing significant improvements in several meaningful data measurements. Incidences of six- and twelve-month repeat maltreatment, which had been 2–3% per year before Signs of Safety, initially more than doubled in 2006 and 2007 as the

agency was learning safety planning. Such incidents then quickly declined to fewer than before as safety planning became more rigorous and the County's incidence of repeat maltreatment dropped dramatically with no re-referral whatsoever for over four years beginning in 2011. Removals during child protection assessments dropped from around 60 per year before Signs of Safety to fewer than 30 per year for each of the past six years. Termination of parental rights and permanent transfers of custody reduced by 30% over the same period. Before implementation of the Signs of Safety, six to eight youths per year remained in foster care, whereas this number has been reduced to a total of only four youths in the past 6 years. The most significant improvement has been a two-thirds reduction in the number of families determined to need ongoing casework services due to the robust development of safety plans and networks as an integral part of the County's assessment process.

More information about the Carver implementation can be found in Koziolek (2007); Idzelis Rothe (2013); Skrypek et al. (2010; 2012; 2015).

Other Minnesota Counties

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

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

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

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

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

Sacramento

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

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

- creating a Theory of Change to reduce entry rate of children and then implementing that logic model;
- explicitly analysing disproportionality of African American children in care; and
- implementing and integrating both the Signs of Safety and SDM.

The Netherlands

Bureau Jeugdzorg, Drenthe (BJZD) in the Netherlands implemented the Signs of Safety from 2007 to 2015, when the agency was disbanded because of a nationwide restructure of children's services. The agency surveyed its staff regarding the benefits of using the approach and workers reported the following:

- Feeling that the responsibility for the child's safety was shared with the family and their support network, as well as the professional network.
- More openness among practitioners about their practice and providing each other with more support.

- Practice was more transparent because the professional anxieties were talked about openly.
- Families understood better the decisions that workers make.
- Using the Signs of Safety framework made work faster and led them to focus on plans clients made with their own support network.
- Focus on good practice brought energy and connection and enabled practitioners to learn from each other.
- Greater pride and joy in the work that they did with families.

Between 2007 and 2014, the total number of long-term statutory child protection cases (the agency also worked with voluntary cases) increased from 426 to 702, while the percentage of children taken into care from these cases reduced from 54% to 34% and continues to trend downwards. In the Netherlands, the average length of agency involvement in long-term statutory cases is 2.9 years and between 2006 and 2008 BJZD operated at that average. Since 2008, average involvement reduced by 17.5% to 2.4 years. In 2007, the investigative arm of BJZD, the AMK, directed 18.5% of its cases to the court. By 2013, this had reduced to only 3%.

William Schrikker Groep (WSG) has almost 1,000 staff and 4,000 children in care and is the principal Netherlands agency providing statutory child protection services to families with developmentally delayed parents or children (or both). WSG commenced a system-wide implementation of the Signs of Safety in 2011. The implementation began as part of a reform agenda following evidence of poor practice and adverse outcomes, including high rates of placement and the longest case involvement rates in the country.

While WSG undertook a system-wide rollout of the Signs of Safety, the initial implementation was focused on four pilot teams in Amsterdam, The Hague, and Rotterdam. Nationally funded independent research was undertaken to track outcomes within the pilot teams. The data showed that of the 303 new cases commenced within the four pilot teams there was a reduction of more than 50% in 'out placement' of children. The rate of placement across the pilot teams averaged 19% compared with 40% of cases for the control group. Of the closed cases, the re-referral rates compared with the usual rates were halved and the ongoing contact rates of other professional agencies with open cases were significantly reduced within the pilot cohort. Across the agency there was a 20% decrease in placement rates during this same period, which WSG management attributed to the broader Signs of Safety implementation across the agency.

Copenhagen

Between 2005 and 2008, the Danish Borough of Copenhagen undertook a three-year 'Families in the Centre' project to equip the city's child protection workers with a higher level of skills to better engage families. This project involved training and ongoing support for 380 workers in

three successive one-year programs in solution-focused brief therapy and the Signs of Safety. The project was independently evaluated (Holmgård-Sørensen, 2009), interviewing 171 practitioners, and found the following:

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

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

City and County of Swansea, Wales

Swansea Social Care Children and Families Services (SSCS) began its implementation of Signs of Safety at the end of 2011 following preparatory training for staff in solution-focused brief therapy skills. SSCS has published a comprehensive review of the first two years' work, detailing its system-wide application of the approach, including case examples and vignettes, and describing its implementation strategies, arrangements and outcomes for 2013 (SSCS, 2014). Though working in the context of staff and budget cuts, SSCS saw 2013 re-referral rates lowered to 21%, compared with nearly 30% in 2012. 2013 also saw best ever results achieved by front line and specialist teams in completing initial (90%) and core assessments (75%) in timescale. In 2013, only 122 children were taken into care, a reduction from 164 children in 2012. SSCS has reduced its rate of entry to care by 13.6% and the number of children on the child protection register has fallen to 178, compared with 235 at the end of 2012. SSCS leadership have undertaken extensive internal audits, which together with external inspection confirms their belief that these outcomes reflect safe practice.

English Research

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

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

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

Signs of Safety English Innovations Project

In 2010/11, the Munro review of English children's services found that the system had become overwhelmed by a fearful compliance-driven culture that was manufacturing defensive practice. Following this, the English Government established an innovations program to encourage and research methods to re-direct the system toward more child-centred, risk-intelligent practice. Together with 10 local authorities from across England, Munro, Turnell and Murphy Child Protection Consulting secured innovations funding to implement Signs of Safety practice in each local authority and work with each to redesign their organisational procedures and functioning to fully support the approach.

The project led to the design implementation processes addressing leadership, measurement, learning, and organisational alignment. This work is described in a report entitled '*You can't grow roses in concrete*' (Munro, Turnell and Murphy, 2016) and includes detailed description of the action research evaluation. The action research demonstrated a redirection of practice in all author-

ities that was more satisfying for practitioners and was liked by families because it was clear, understandable and direct. Leaders in all local authorities valued the opportunity to work in a large learning community sharing successes and struggles with each other and the consultants. Ofsted reports undertaken in the participating authorities — that were undertaken concurrent with the innovations project — consistently showed improved and clearer decision making alongside more compassionate practice, including better engagement of children and parents (see, for example, CYP Now, 2016).

More information on the impact of the Signs of Safety innovations project will be provided by the independent evaluation that was conducted by a team from Kings College, London. This research report is expected to be available in 2017.

New Zealand

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

- strong working relationship between worker and parents;
- strong focus on parental and family strengths;
- sustained and detailed exploration of exactly what constituted everyday safe care of the children and how it could be achieved; and
- time to build the relationship, do the casework, and ensure the safety plans were sustainable.

Keddel's publications of 2011 and, in particular, 2014 offer a critical examination about risk, authority and power relationships with Signs of Safety practice and safety planning work.

4.4 Research on Working with 'Denied' Child Abuse

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

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

4.5 Constructive Working Relationships

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

4.6 Towards Practice-based Evidence

There is 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 evidence-based practice, there are significant challenges in undertaking research and garnering evidence in child protection work. Within the psychotherapy field, for example, it is at least sometimes possible to undertake 'gold standard' randomised trials to access the efficacy of particular models. Such research is impossible within child protection services, since it is neither ethical nor professionally responsible to randomly assign cases of child abuse to service and non-service

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

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

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

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

5.1 Risk as the Defining Motif of Child Protection Practice

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

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

5.2 Risk Assessment as a Constructive Practice

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

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

If we change the lens to look at sport, it is easier to consider risk differently. Usain Bolt doesn't hide from the World Championships, Serena Williams doesn't avoid Wimbledon, and Dawn Fraser didn't run from Tokyo in 1964. These players champ at the bit to get to such places because, while they may fail spectacularly on the biggest stage in front of millions, it is very possible they will succeed gloriously. The analogy isn't exact, particularly because no one dies at Wimbledon, the Olympics, or the World Championships, and no matter how successful, the outcomes in a high-risk child abuse case are rarely glorious. But in sport we can clearly see the vision of the BIG win.

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

Signs of Safety seeks to 're-vision' 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. This more balanced approach is more risk intelligent because it is, in fact, how life is lived — every significant life decision holds hopes and fears and is informed by pros and cons. Signs of Safety does not set problems in opposition to strengths and solution focus, nor does it set forensic, rigorous professional inquiry against collaborative practice. Quite simply, the best child protection practice is always both forensic and collaborative and always demands that professionals draw upon, and are sensitive to, every scintilla of strength, hope and human capacity they can find within the ugly circumstances where children are abused.

5.3 Comprehensive Risk Assessment and Signs of Safety Assessment and Planning

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

- is simultaneously forensic, exploring harm and danger with the same rigor as exploring strengths and safety;
- brings forward clearly articulated professional knowledge while equally eliciting and drawing upon family knowledge and wisdom;
- always undertakes 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; and
- 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 overwhelms everyone involved with too much information.

Above: Comprehensive, balanced child protection risk assessment

The Signs of Safety grounds these aspirations in a one-page assessment and planning protocol. That protocol — or framework — maps harm, danger, complicating factors, strengths, existing and required safety, and a safety judgment. 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.)
1. 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.)[1]

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

The four domains operating in the Signs of Safety assessment and planning are identified simply and clearly in the 'Three Columns' Signs of Safety assessment and planning protocol, as follows:

Signs of Safety® Assessment and Planning Framework

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

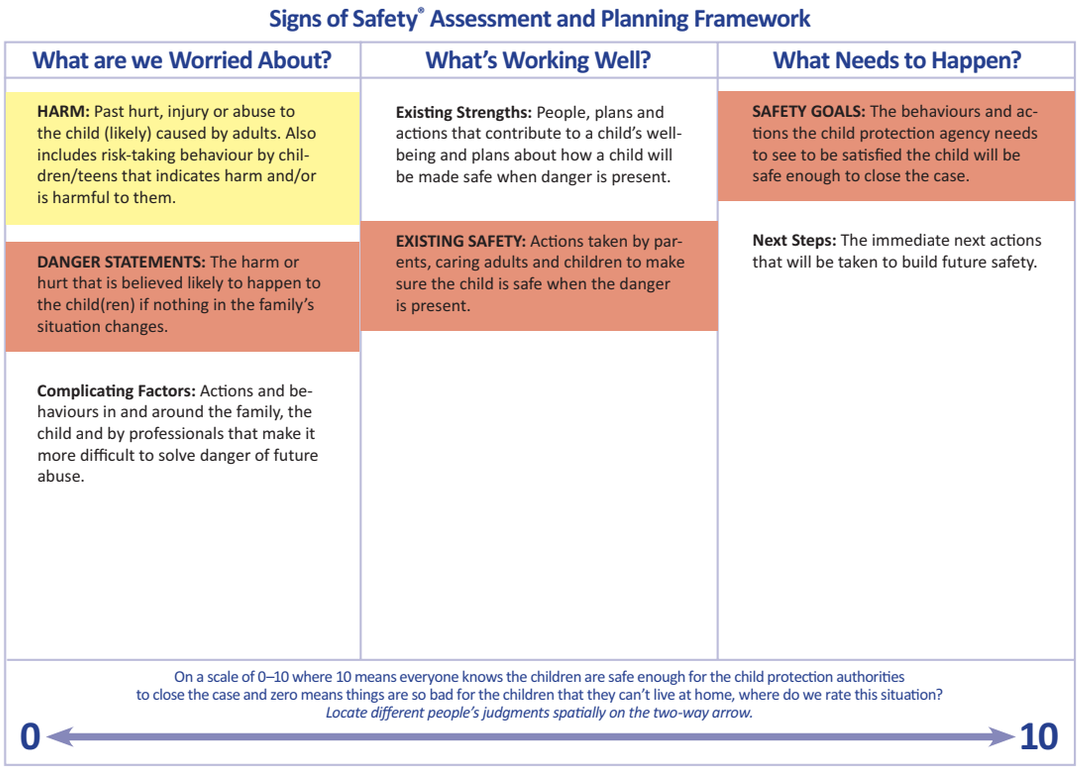
On a scale of 0–10 where 10 means everyone knows the children are safe enough for the child protection authorities to close the case and zero means things are so bad for the children that they can't live at home, where do we rate this situation?
Locate different people's judgements spatially on the two-way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

0 ⟵ ⟶ 10

Above: the 'Three Columns' Signs of Safety assessment and planning protocol

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

The Signs of Safety assessment and planning framework incorporates the risk assessment analysis categories that are described in the illustration on the next page. The shading is used to link with the case example that follows.



Above: the Signs of Safety Assessment and Planning Framework

5.4 Case Example

The Signs of Safety 'map' presented here involves parents Merinda and Eddy, along with their children, six-year-old Darel, four-year-old Alkira, and 18-month Jirra. The example focuses on emotional and physical harm of the children triggered by drinking, drug use, and domestic violence. The Signs of Safety assessment and planning for this case was completed together with Merinda and Eddy. It also draws on the children's exact words from interviews with them[2].

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

2 *For brevity, this is an edited version of the mapping in this case. The full mapping and description of the casework can be found in Turnell and Etherington (2017).*

Signs of Safety® Assessment and Planning Framework

What are we Worried About?

Past Harm

Merinda and Eddy both say that they have had lots of bad fights. CPS have heard about 21 separate fights between 16/10/2012 and 22/09/2013 with Darel, Alkira and Jirra nearby.

On the 13/08/13 Darel called the Police saying that his mother had 'started up again'. When Police arrived, they found Darel, Alkira and Jirra crying and hiding in the bathroom. Merinda had rung Rose and Darel Snr to come and get the kids saying she was going to kill herself.

In the last fight on 22/09/13, Eddy and Merinda were screaming and throwing things at each other. Merinda threw a glass of coke at Eddy, which hit the wall and smashed. Alkira badly cut her foot on the glass requiring stitches
Sally and Diane talked to Darel and Alkira on 23/09/2013. Some of what they said was:

- "When Mum and Dad are arguing, I take my sisters and we hide in the bathroom."
- "Mum and Dad were fighting and smashed the glass that cut my foot. I was really crying. I had a big needle. I was brave."
- "Mum shouts really loud and I don't want baby to die…because Mum stressing out, shouting and throwing things around."
- "Mum was in the car and driving the wrong way, she tried to smash into Dad, Jirra was in the car. I thought she would get squashed."

Danger Statements

Sally and Diane from CPS are worried that when Merinda and Eddy fight they scream, shout, swear, throw things at each other, drive off dangerously with the kids in the car and Darel, Alkira and/or Jirra will be really upset and frightened and get hurt like on Tuesday night when Alkira cut her foot badly on a broken glass or end up in a really bad car accident and die.

Sally and Diane are worried that Eddy and Merinda will hit the children when they misbehave and cause bruises or other injuries.

Sally and Diane, Rose, Darel, Kerri and Pat are worried that Darel, Alkira and Jirra will think it is okay to scream, swear, throw things, hit, drive dangerously, threaten, punch or kick people, because of Merinda and Eddy's behaviour. If Darel, Alkira and Jirra do grow up doing these things they are more likely to have violent relationships, get into trouble with the Police and have the same problems in their future lives.

What's Working Well?

Existing Strengths

Darel, Alkira and Jirra all get plenty of food and have good clothes, Darel is doing well at school and Alkira loves preschool, Jirra is on track developmentally.

Darel and Alkira say they love playing football at the park with Dad and love playing hide and seek and building cubby houses with Mum.

Merinda says she quit smoking weed two months ago and is not drinking alcohol after she went to Mum Rose's for a weekend. Eddy said that Merinda's strongwill helped her to do this.

Merinda and Eddy have talked to Sally and Diane about what triggers their fighting and say they want to make changes. Merinda and Eddy would like to go to a couple/family type rehab place like the one in Wanneroo to help them change their ways.

Rose and Darel live nearby and help the family a lot, looking after the children and can calm both Merinda and Eddy down when they are angry.

Eddy and Merinda haven't had much contact with Eddy's parents Kerri and Pat. Kerri and Pat say now they are back in touch and know what has been happening they are willing to do whatever it takes to help Eddy, Merinda and the kids out. Eddy and Merinda say this would be good and they want the help.

Existing Safety

On 24/09/13, CPS and Police met with Merinda and Eddy and they made a plan to send the children to live with Rose and Darel so they could both work on their problems. Darel, Alkira and Jirra have been staying at Rose and Darel's since then.

What Needs to Happen?

Safety Goals

Sally and Diane from CPS want Darel, Alkira and Jirra to be back with Merinda and Eddy because they all want to be together and there have been so many good times in their family. For this to happen they need Merinda and Eddy to work with Sally, Dianne and other people in their family to create a story that explains to Darel, Alkira and Jirra what all the worries have been about and why they went to stay with nana Rose.

Once the story has been shared with the children Merinda and Eddy and the safety network will work with CPS to make a plan that the children can understand and shows everyone that:
When Merinda and Eddy do argue they can sort things out without hitting or screaming and so none of the kids get scared:

- Darel, Alkira and Jirra will only be in the car with Merinda and/or Eddy when they are safe to drive
- Eddy and Merinda have ways of telling the kids off without punching, hitting and screaming at them
- CPS will close the case when the safety plan has been working for 6 months after Darel, Alkira and Jirra go home.

Next Steps

Merinda and Eddy say they will stick to the safety plan and not visit the kids together.

At the next meeting on Monday Dianne and Sally will talk with Eddy and Merinda about creating an explanation for the kids about why they can't live with Eddy and Merinda at the moment. Over the next two weeks they will work together to create a full words and pictures story for the kids.

After the words and picture story is finished Sally and Diane will help Eddy and Merinda and the safety network work on a long-term safety plan.

Safety Scale: On a scale of 0 to 10 where 10 means, even if Merinda and Eddy do get stressed, angry and drink too much, everyone including the children know what Eddy, Miranda and the support people will do so no one gets screamed at, hit or scared and there's adults Darel, Alkira and Jirra can call and will come if they are worried and 0 means there's no plan to keep the kids safe when things start getting bad so the children can't be living with Eddy and Miranda right now, where would you rate the situation today?

5.5 Signs of Safety Practice Disciplines

Together with the application of the principles listed in Chapter 2, the Signs of Safety disciplines that underpin the effective use of the assessment and planning framework include the following:

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

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

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

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

  Proper analysis of danger and safety creates a platform where professionals can formulate clear safety goals describing what they need to see to close the case and withdraw from the family's life.

  Assessment comprises three steps: gathering information, analysing information, and judgment. The higher the anxiety associated with any given case, the more information professionals tend to want to gather. Usually, though, what is needed most is not more information but careful analysis that will usually show that the professionals know more than enough to make a judgment and move into action. Making clear distinctions between harm,

danger, strengths and safety is always challenging for practitioners, but is the foundation of effective case practice.

- Rendering all statements in straightforward, instead of 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) readily understand each other.

- All statements should focus on specific, observable behaviours.

  In the example above, instead of talking generally about domestic violence, clear details are provided of what happens when Merinda and Eddy fight and the impact on the children. Likewise the strengths and existing and required safety are described in clear behavioural terms.

  The Signs of Safety approach always seeks to tease out facts from judgments by describing events and evidencing opinions with observable behaviours. Sticking to the facts always makes it easier to talk to family members than introducing more generalised meaning-laden terms. The process of arriving at judgment is held in abeyance to be brought forward in a straightforward fashion within the safety scaling activity.

- Skilful use of authority.

  Mapping or assessing child protection cases together with family members almost always involves some level of coercion, which must be exercised skilfully. While oppressive use of authority is often crude and notable, skilful use is usually nuanced and often overlooked because its execution seems simple (Turnell, Lohrbach and Curran, 2008). Honouring parents is one of the quickest ways to gain their attention and respect, as are giving choice and always doing what is promised. Being very clear and explaining bottom line requirements, connecting requirements to what is needed to satisfy the agency and the court, and not taking emotional reactions personally are all part of a skilful practitioner's repertoire. Conscious and skilful use of authority is always a central part of garnering service recipient involvement in the Signs of Safety assessment.

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

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

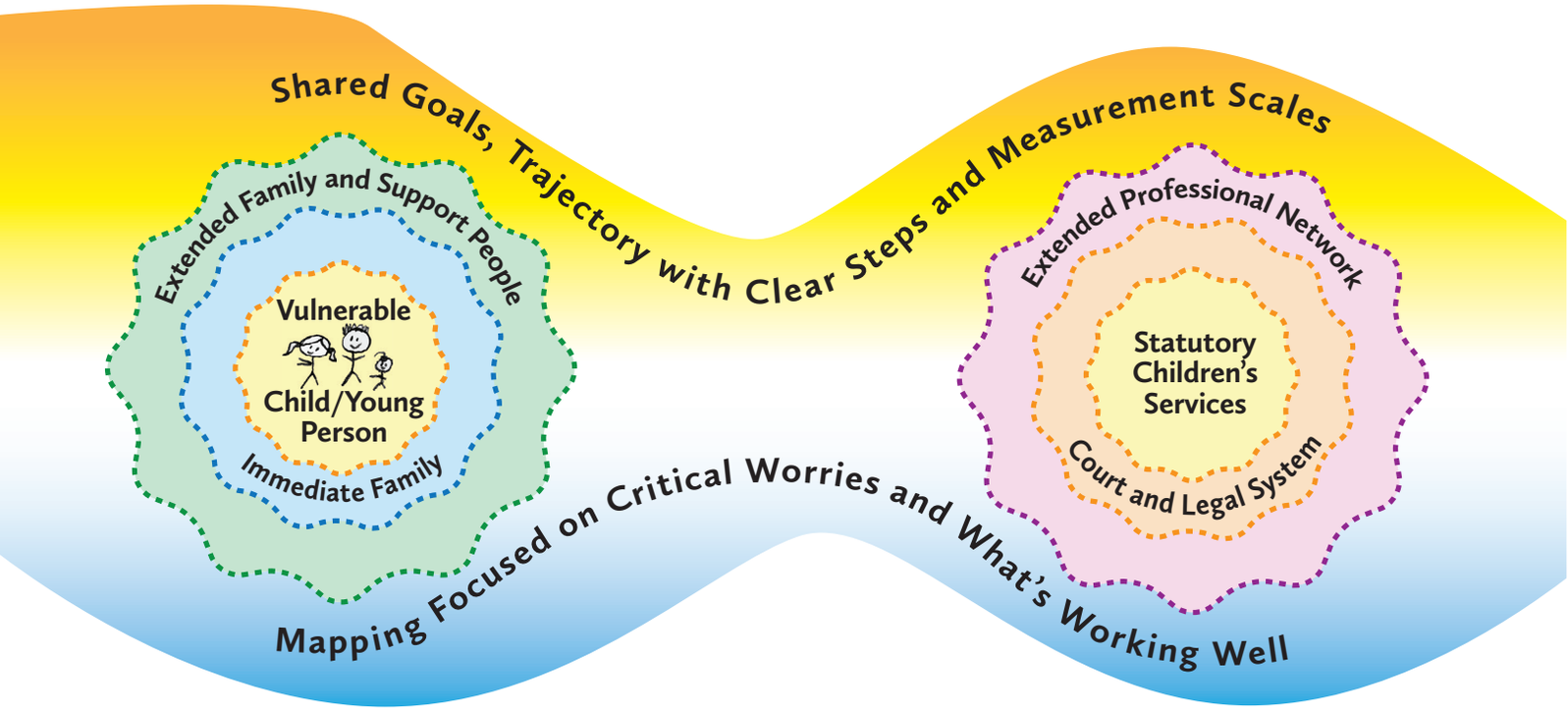
The disciplines and principles underlying the use of the Signs of Safety assessment and planning are more fully described in Turnell and Edwards (1999) and Turnell and Essex (2006).

6. Signs of Safety Practice Theory of Change

To implement the Signs of Safety, it is essential that the minimum steps of the approach are defined clearly so that everyone across the agency understands what it is they are implementing. Defining the approach in this way creates the Signs of Safety Theory of Change, which in turn provides the foundation of research and evaluation, whether internal or external. Children's services practitioners' ability to deliver quality, timely Signs of Safety services is always dependent on the level of support and alignment their agency provides around the practice. Therefore, the Signs of Safety Practice Theory of Change is paired with the Signs of Safety Organisational Theory of Change, which is presented in Chapter 10.

The Signs of Safety Practice Theory of Change involves two interconnected iterative cycles: an Assessment and Analysis Cycle and an Action Cycle.

6.1 Assessment and Analysis Cycle



Above: Assessment and Analysis Cycle

The Assessment and Analysis Cycle involves the following minimum steps:

1. A referral that details concerns about a vulnerable child or young person is made to children's services. The referral usually arises from behaviours of parents or carers that are seen to be harmful to the child or young person. However, a referral may also occur because the child's or young person's behaviour is creating problems and/or is seen as dangerous to themselves or others.
2. Assessment begins with the intake professional inquiring and sorting information into the Signs of Safety map under the What's Working, Worrying and Needed headings.
3. The intake professional inquires judiciously in a risk-intelligent way, gathering needed additional information. The information is then analysed. Initial danger statements and safety goals are formulated and matched with aligned safety scales (establishing the case specific judgment criteria). This stage usually involves work with other key professionals and court proceedings may be initiated.
4. Intake professionals undertake initial mapping (assessment) work with children (My Three Houses or similar), parents, and extended family while simultaneously finding and involving all possible naturally connected support people, be they next door or around the world. See www.familyfinding.org.
5. Once the children, parents and support network understand the professional concerns about harm and danger (even if they don't agree), and the shared goals and aligned safety scales are agreed and finalised, this establishes the key parameters of the assessment map for the case.
6. The final stage of completing this first iteration of the Assessment and Analysis Cycle involves formulating a safety planning trajectory, including critical steps and timeline. Once agreed by all, the Signs of Safety map and trajectory provide the focus for the working relationships between family and professionals.

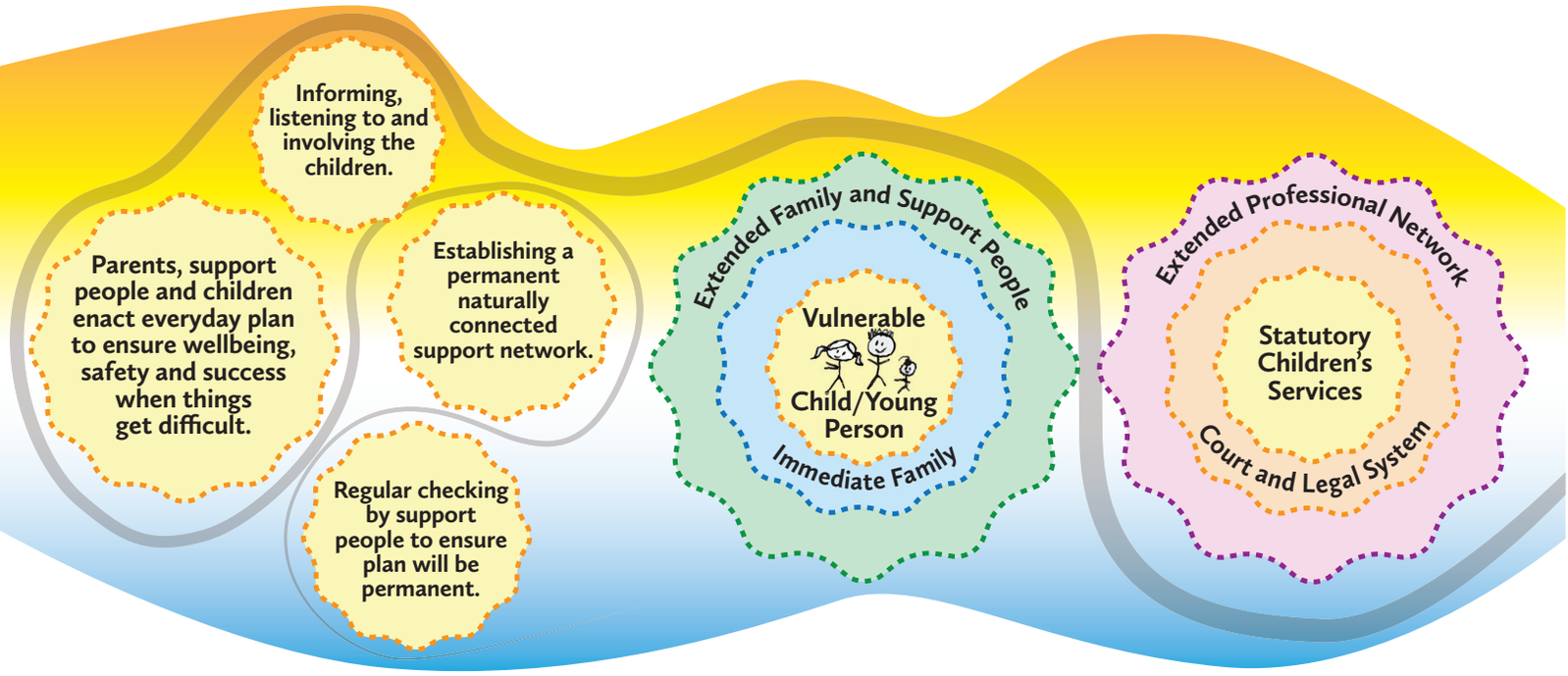
The Assessment and Analysis Cycle steps move interactively through the three stages of assessment:

- Information gathering.
- Analysis.
- Judgment.

Child protection assessment always tends to become bogged down in information gathering, with professionals feeling too anxious to analyse and judge. The Signs of Safety Assessment and Analysis Cycle aims for agility, asking practitioners to move quickly through all three stages. Com-

pletion is expected in around 14 days. The capacity for practitioners and their supervisors to work in this way is supported by a comprehensive framing of risk, considering strengths, existing and future safety, as well as harm and danger, and tools that support this framing alongside structured group supervision methods that build and sustain a practice culture where decision making and risk are shared. The focus throughout is on analysis, family participation, and setting up the whole map and trajectory as quickly as possible, then moving into action. The action and learning from it will iteratively refine the assessment as the solutions are built with the children, family, and support people always at the centre of planning and action.

6.2 Action Cycle



Above: The Action Cycle

The Action Cycle focuses on building the family's and network's capacity to act to ensure the child's safety when circumstances could, or do, become dangerous. The Action Cycle involves the following minimum steps:

1. Listening to, informing, and involving the children through the whole Action Cycle.
2. Finding support people and establishing them as a permanent, naturally connected support network around the immediate family.
3. Professionals leading the parents, support people and children in developing an everyday safety plan to ensure the children will always be safe when family life could, or does, become dangerous.

4. Parents, support people and children demonstrating they can, and will, always use the safety plan.
5. Naturally connected support people providing a watchful eye and all support necessary to ensure the safety plan will be permanent.
6. Professionals leading the parents, support people and children in continually thinking though their current assessment of safety.
7. The iterative action — assessment and analysis — cycles continue (represented diagrammatically by the interactional flows linking assessment and analysis with action) until everyone judges the safety to be high enough and permanent (usually everyone scoring 7 or above on the safety scale). When this occurs, the case is closed.

7. Involving Children

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

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

The Signs of Safety community of professionals and agencies continues to refine and develop tools and processes to give children a stronger voice in child protection work and to more actively involve them in assessment, in understanding why professionals are intervening in their lives, and in safety planning. These tools include:

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

7.1 My Three Houses™ Tool

The Three Houses method 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 My Three Houses tool takes the original method and simplifies it to make it more usable for practitioners. It matches 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 visually within three 'houses' to better engage children in the conversation.

Steps for using My Three Houses include the following:

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. Decide whether to work with the child with or without parents or carers present.
3. Explain the three houses to the child, often using one sheet of paper per house.
4. Use words and drawings as appropriate and anything else useful to engage the child in the process.
5. Often start with the 'House of Good Things', particularly if the child is anxious or uncertain.
6. Once finished, obtain permission of the child to show others — parents, extended family and professionals. Address any safety issues for the child in doing this.
7. Present the three houses assessment just as the child said, wrote or drew it. For parents/caregivers, it is often helpful to begin with the 'House of Good Things'.

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

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

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

Craig

House of good things

I don't get shouted at when I am with dad.

I like living with daddy because I get lots of hugs.

When I'm with daddy I can play with my toys.

House of worries

I was not happy at my mam's house because she shouted at me a lot.

Mam locked all of my toys away and I didn't get all of my Christmas presents they were put in mam's wardrobe.

House of wishes

My wish has come true. I'm living with my daddy and brothers.

I wish we had a big house so we had our own room and didn't have to share our beds.

Martin

House of good things

I like playing with toys at dad's house.

I have lots of toys to play with.

I like it when mam makes veggies for me. I love my veggies.

I like it when dad makes me nice things to eat at his house.

I like playing with my brother on the computer.

House of worries

I worry that my dad won't have batteries for my toys.

I'm scared of dad, shhh no, it's not dad it's mam. Don't tell her she'll put a spell on me, shhh! She's a witch, don't tell her.

House of wishes

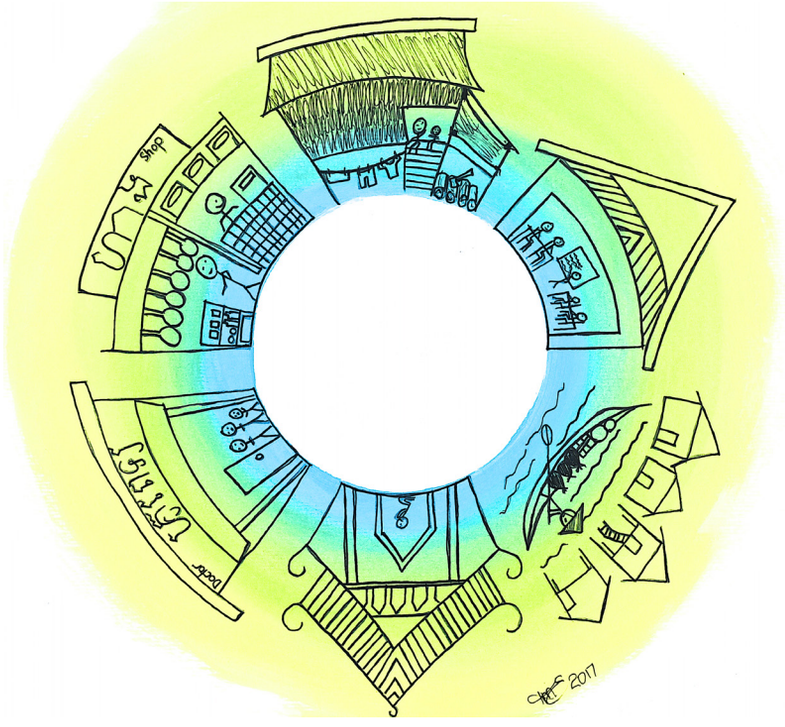
We would have a big family holiday-mam, dad, Timmy and me and Craig would all go to the beach and love each other.

I wish I could live at my dad's house. I'm happy there and can play with my toys and no one shouts at me so I'm not scared.

Above: Craig and Martin's completed My Three Houses

The My Three Houses method can be adapted using other graphical representations that fit for the child and can help explore the youngster's thinking about worries, good things and hopes. Workers have used images like spaceships, planets, tepees, campgrounds, and Boab trees, to name a few (Turnell, 2011).

Recently, Signs of Safety work has been conducted in Cambodia with several NGOs, supporting them in their work to keep children out of orphanages (80% of children in orphanages in developing countries have families and aren't orphans at all). This involves mapping where the whole community, including children, looks at the strengths, worries and hopes so that vulnerable children and families are better supported and protected, and so they may stay in their homes. The image and concept of 'My Three Villages' was used to facilitate this work.



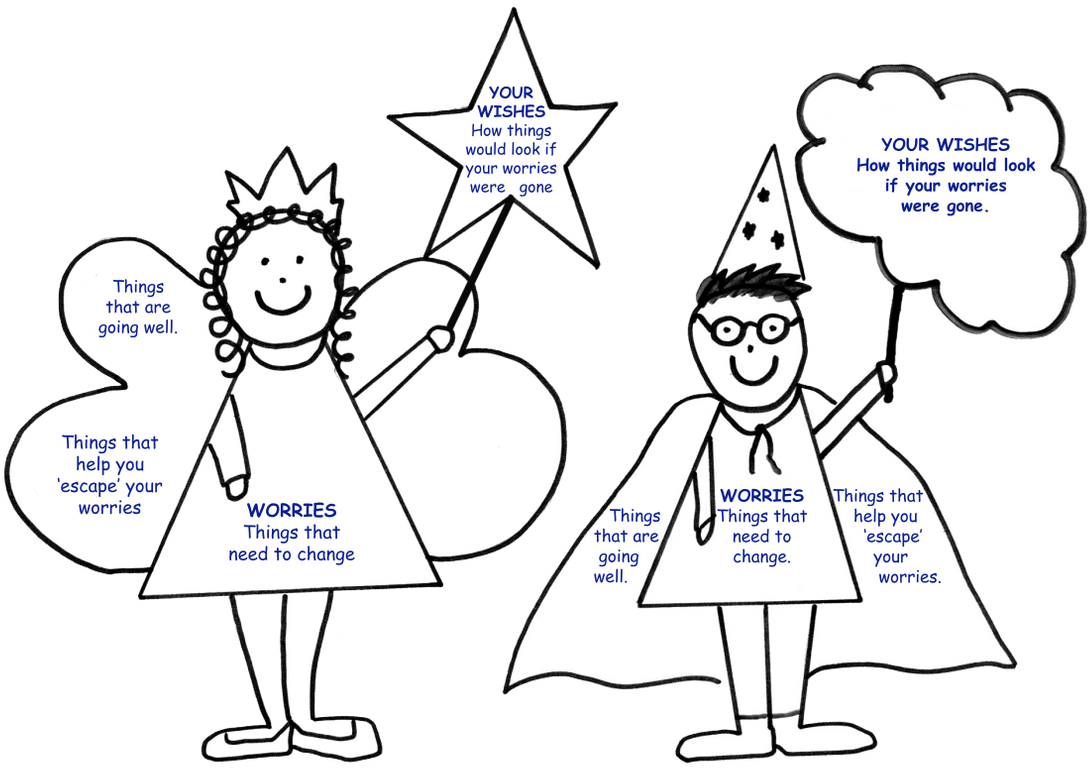
Above: My Three Villages (by Katrina Etherington)

7.2 The Fairy/Wizard Tool

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

Vania Da Paz, a Western Australian child protection practitioner, was involved in the 1990s development of the Signs of Safety. An example of her practice is presented in Turnell and Edwards

(1999, p.81). Da Paz has always been determined to find ways to involve children and young people in her child protection practice and, following the initial training in Signs of Safety, she developed a very similar tool that serves the same purpose as My Three Houses but utilises a different graphic representation. Rather than three houses, Da Paz explores the same three questions using a drawing of a fairy with a magic wand or a wizard figure as follows:



Above: Fairy and Wizard tool example (by Vania Da Paz)

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

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

8. Safety Planning

8.1 What is Safety Planning in Child Protection?

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

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

8.2 Preparation

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

8.2.1 Establishing a working relationship with the family

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

8.2.2 A straightforward, understandable description of the child protection concerns

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

8.2.3 Safety goals

Research with parents involved with child protection services repeatedly reports parents want to know what they need to do to satisfy child protection authorities and so get them out of their lives. Once the child protection agency is clear about its danger statements, these form the basis to articulate straightforward behavioural safety goals to tell parents what the agency needs to see to be satisfied the children will be safe.

8.2.4 Bottom lines

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

8.3 Involve a Lifelong Network

Every traditional culture knows the wisdom of the African saying 'It takes a village to raise a child'. A child who is connected to many people that care and are involved with them will almost always

have a better life experience and be safer than an isolated child. While child protection services typically focus on involving professionals with vulnerable families, the Signs of Safety seeks always to involve everybody that has natural connections to the children to more effectively build lasting safety and healing.

The aspiration to involve every possible person who has naturally connections to the child — including kin, friends, neighbours and professionals (teachers, family doctor, etc.) — is an obvious proposition since these are the people who have primary interest in, and responsibility for, the child. Furthermore, every child deserves to be connected to their family members, yet for so many children in care the professional system has broken their connections to their kin. Though undeniably obvious, involving naturally connected people is a profound paradigm and culture shift for professional child protection agencies and is challenging in many ways.

The best outcomes delivered by Signs of Safety use and the most effective lasting safety plans arise where agencies have embedded a strong culture and methods of involving naturally connected support networks. In a bid to strengthen practitioners' and organisations' capacity to involve naturally connected support networks, and to offer a more comprehensive range of methods and tools to undertake the task, the Signs of Safety has forged a close partnership with the Family Finding approach. The Family Finding approach, created by Kevin Campbell, offers the strongest suite of practical methods to rapidly find and involve support networks available to child protection professionals. For more information, see www.familyfinding.org.

Involving naturally connected networks is the key to creating the details of an effective everyday safety plan because these are the people who have critical insider knowledge about daily life for the children and family. One of the most important aspects of involving an informed naturally occurring network around the family is that this breaks the secrecy and shame that typically surrounds situations of child abuse.

8.4 Negotiating the How: Developing the Details of the Safety Plan

When developing the details of any given safety plan it is important to give parents and everyone else involved (both 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 the child protection agency, that the children will be safe and well looked after.

This is an evolving conversation as the professionals constantly deepen the parents' and networks'

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

8.4.1 Successive reunification and monitoring progress

Within the Signs of Safety approach, safety is defined as 'strengths demonstrated as a protection over time' (Boffa and Podesta, 2004). As the safety plan is being developed, it is important that opportunities are created for the family to test, refine and demonstrate the new living arrangements over time. As this occurs, their success and progress in using the plan is monitored and supported initially by the child protection professionals, but increasingly this role is handed over to the safety network. Most safety plans in the highest risk cases are created when the family is separated, either with the children in alternative care or the alleged abuser out of the family home. As the parents and family members engage in, and make progress with, the safety planning process, it is important that the child protection agency reward the parents' efforts and build their hope and momentum by successively increasing their contact with their children and loosening up the professional controls on the contact arrangements. Once a safety planning process is begun, momentum and focus must be maintained and a completion date identified. Safety planning usually takes between 3 and 12 months.

8.5 Words and Pictures Explanations

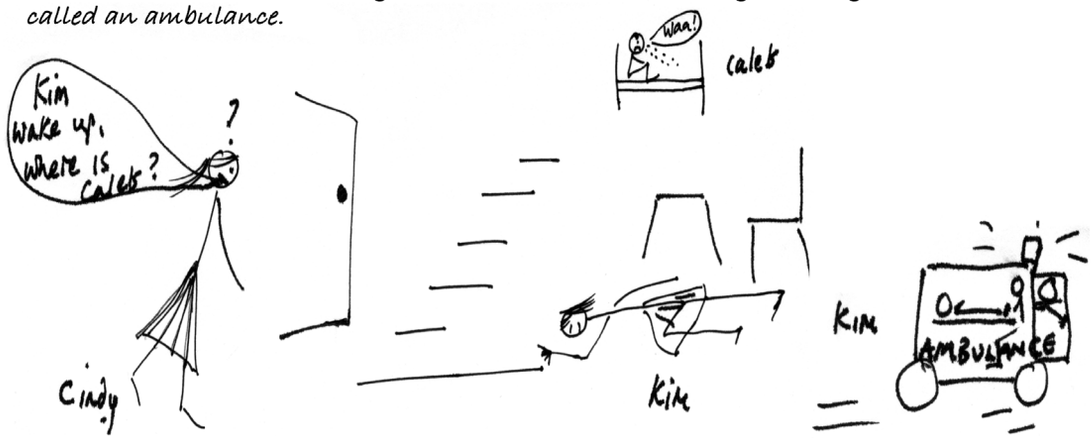
Turnell and Essex (2006) describe a Words and Pictures explanation process for informing children and young people about serious child protection concerns and a safety planning method that both involves, and directly speaks to, children. The illustrations below offer examples of each. The examples demonstrate age-appropriate explanations and safety plans that locate children in the middle of the practice without trivialising or minimising the seriousness of the child protection concerns.

The Words and Pictures example presented here was created to explain the issues to eight-year-old Dylan and two-year-old Caleb in a situation where the parents struggled with addictions and there was a significant history of violence by the father, Joe, against the mother, Kim.

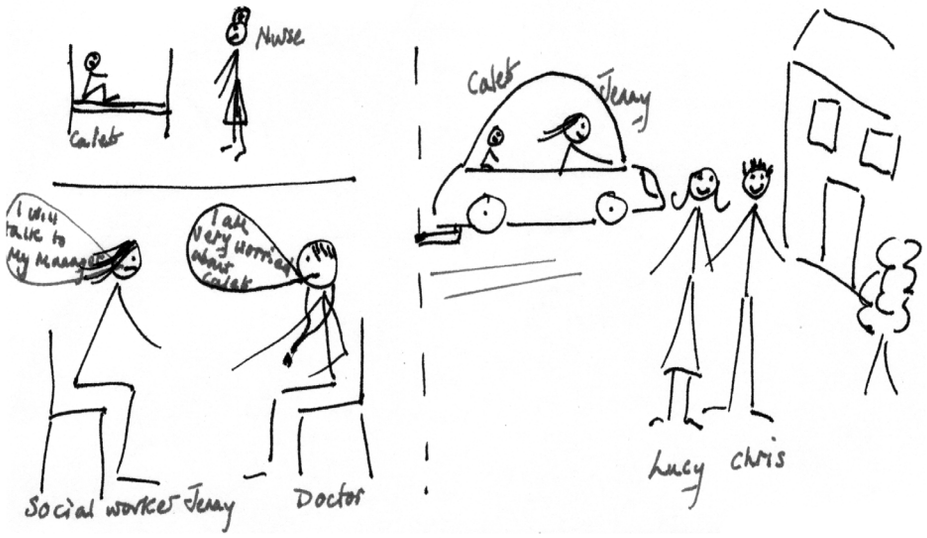
This is a story for Caleb and Dylan so that they know about the current worries

1. Before Caleb was born and when he was a little baby Mum Kim, and Dad Joe had lots of problems with drugs and drinking too much alcohol. Mum and Dad tried hard and for a while things were better. Then one day when Daddy had been drinking lots of alcohol there was a big scary fight. There was a lot of yelling and pushing and Daddy hurt Mummy. Mummy Kim rang the police saying that Daddy Joe had "smacked" her. The police said this was very serious and Daddy had to talk to a Judge. The judge said Daddy shouldn't hit Mummy and said Daddy must live with a friend, while Mummy and Daddy get help to sort out arguments with no fighting or hitting.

2. A few weeks later, when Caleb was still very little, neighbour Cindy heard Caleb crying. When Cindy got into the house she found Mummy Kim laying on the floor, Kim was breathing but Cindy could not wake her up. Cindy was very worried and called an ambulance.

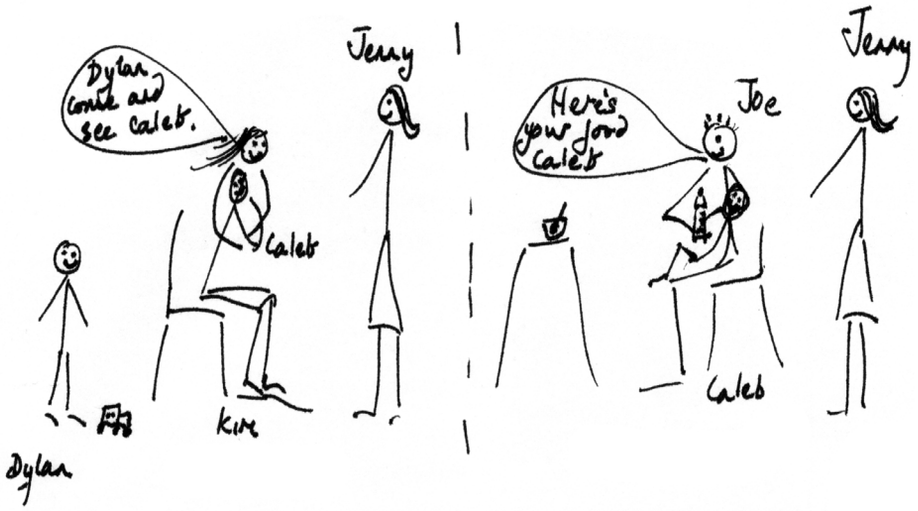


The ambulance took Mummy Kim and Caleb to the Hospital. At the hospital the doctors did lots of tests on Mummy. In the end they said Mummy Kim was so ill because she had taken lots of drugs, Mummy said she hadn't done that and had just collapsed. The social workers were worried that if Mummy might collapse she couldn't look after Caleb properly.

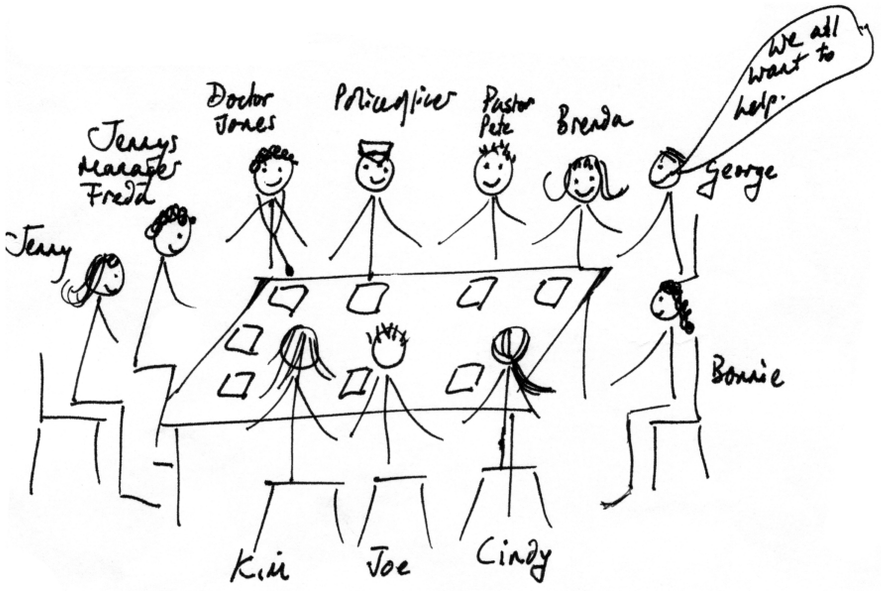


3. The doctors at the hospital also did tests on Caleb and found he had traces of adult's drugs in him. The social workers were even more worried about Caleb. They took their worries to a different Judge. The Judge said Caleb should live with Lucy and Chris, and Dylan should not visit Kim and Joe at home until all the worries with the fighting, drugs and alcohol are sorted out.

4. When the social workers talked to Kim and Joe's doctors they were even more worried. The doctors said they had been trying to help Kim and Joe sort out their drug and alcohol difficulties. In the past things had been better but nothing seemed to help very much recently. Kim and Joe had told the social workers they didn't have big problems with drugs and alcohol, and everything was fine.



5. The social workers were worried but they had also seen good things in Caleb and Dylan's family. When Joe and Kim visited Caleb at Lucy and Chris's house they saw that Mummy Kim cuddled Caleb in a really loving way and that Daddy Joe fed Caleb in a really good way. Dylan also told the social workers he liked going to the park with Kim Joe and Caleb. It made the social workers think we must try to work with Dylan and Caleb's family, and try to help sort out the worries.



6. There was a big meeting, where the social workers told everyone about the worries, the yelling and fighting, collapsing, and worries about drugs and alcohol for Mummy, Daddy and Caleb. Everyone at the meeting said, "We want to help", and Mummy and Daddy said they wanted everyone's help to make things better.

The Words and Pictures method offers a powerful method of creating a meaningful explanation for children and young people in care who are typically very confused or uncertain why they have come into the care system. Examples of this adaptation of the Words and Pictures method can found in Turnell and Essex (2006, pp 94–101) and in Devlin (2012).

8.6 Child-Centred Safety Plans

Considering that safety plans centre around the children and are also about setting up family living arrangements so everyone knows the children will be safe and cared for, it is vital to involve the children in the safety planning and make the process understandable to them.

Below are two examples of Words and Pictures safety plans that children can understand. The Words and Pictures explanations and safety plans are created together with the parents and their support people. Involving them in thinking through how these serious matters can be explained to their children always creates deeper understanding for the adults. This example presents four frames from the safety plan that enabled the children to be reunited with Merinda and Eddy in the case presented in Chapter Four.

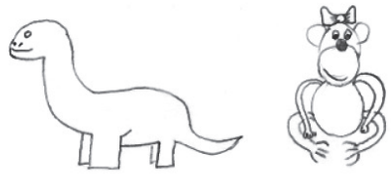
Dad has said if he feels angry he will go to his shed and work on fixing the car until he feels calm. Dad says sometimes this might take at least an hour and everyone should leave him until he comes out.

Dad will call Pop Pat if he needs help to calm down.

Mum and Dad agree that the keys to the car will be kept at Granny Rose and Granddad Darel's so that Mum is not tempted to drive off when she feels angry.

Mum and Dad say they won't drink any alcohol when they are home and need to look after Darel, Alkira and Jirra.

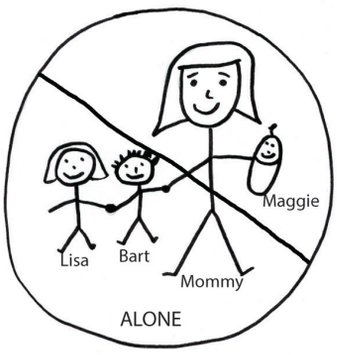
If Mum and/or Dad want to drink they will leave the home and do it somewhere else and one of the safety network people will look after Darel, Alkira and Jirra.



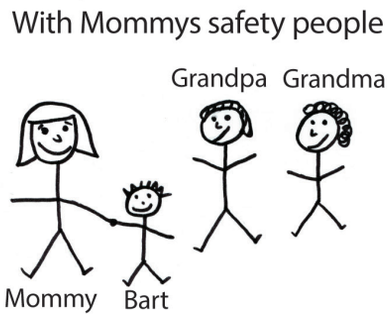
Darel has chosen his dinosaur and Alkira has chosen her knitted monkey as their safety objects. Dinosaur and Monkey will always sit on the kitchen bench by the window.Only Darel and Alkira can move them. If Dinosaur or Monkey are moved or gone, Mum, Dad and the other safety network people have to ask if Darel and Alkira are okay. Darel and Alkira might move their safety object to make sure everyone is paying attention.

The four-rule safety plan below was prepared by the parents and safety network together with the professionals in a Munchausen-by-Proxy case. This plan was distilled from a much more detailed safety plan created with the parents, 15 support people, and professionals over almost two years and was prepared for children aged four years, two years, and six months. This plan is the work of professionals from Safe Generations and Carver County Community Social Services, Minnesota.

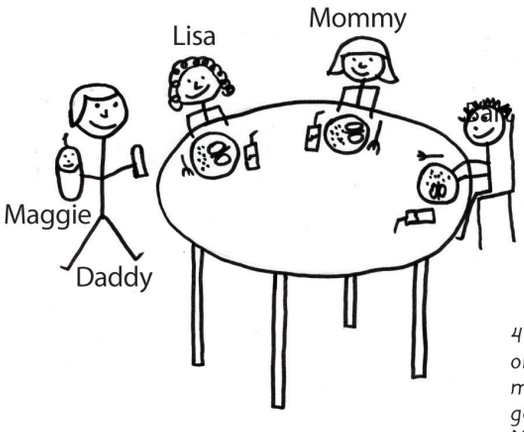
1. *Mommy is never to be alone with Lisa, Bart or Maggie.*



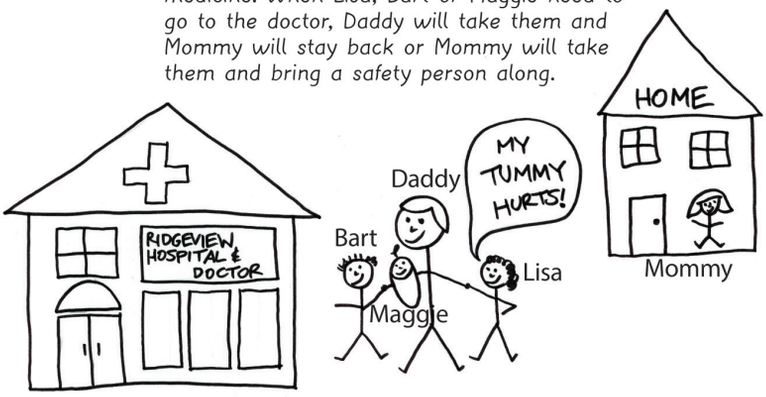
2. *When you spend time with Mommy there will always be someone else there like Auntie Kate, Bill, Fred, Mary, Joe, Lyn – the pastor's wife, Margaret, Grandpa or Grandma. These are the safety people who love you and want to be sure you're safe.*



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



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



8.7 A Safety Plan is a Journey not a Product

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

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

9. Signs of Safety as a Vehicle for Organisational Learning and Transformation

Change in child protection is hard! A practice model, no matter how good, is always at best only a vehicle for the agency, its leaders, managers and field staff to achieve the change they want. Choosing a model and training in it will not, in and of itself, create meaningful improvement. All levels of the organisation must engage with the practice approach, understand and utilise the approach, review their results, and adjust their application of the approach to achieve the change they want. Since ongoing organisation-wide learning is the pivot for securing change, the Signs of Safety draws on four organisational learning theories that are explored in this chapter:

- The Learning Organisation
- 70:20:10 Learning Theory
- Appreciative Inquiry
- Action Learning

9.1 The Learning Organisation

The concept of the 'learning organisation' was first articulated by Peter Senge in his book The Fifth Discipline (1990). Senge describes learning organisations as places 'where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole reality together'. For Senge, organisational change and development is not a product but rather a process of bringing forward peoples' best thinking and energy.

Child protection organisations, like all large systems and bureaucracies, tend to create cultures where the employees' ownership and their desire to learn and improve becomes disconnected from what they do. Alvesson and Spicer (2016) call this functional stupidity. 'Functional stupidity is the tendency to reduce one's focus to the narrow, technical aspects of the job without reflecting on its wider context and purpose. Seized by functional stupidity people remain capable of doing the job but they stop asking searching questions about their work' (Alvesson and Spicer, 2016: p. 7). By contrast, a learning organisation pursues the full engagement of all employees in the work they do, caring about the results for themselves and the organisation.

Senge invokes the notion of the 'learning journey' to suggest that organisational (and individual) change and development cannot simply be bottled or disbursed through a training program. Rather, the journey is a relational process of continual inquiry, reflection and learning that needs

to be fostered in the culture, procedures and habits of the organisation. Creating the learning conditions where professionals adopt a stance of inquiry and ongoing learning in their work is the most important task of the leader if the proceduralisation that bedevils child protection is to be transformed and the delivery of truly human services is to be reclaimed.

Meaningful implementation of the Signs of Safety requires a sustained organisation-wide 'learning journey' that embeds clear processes of action learning focused on how the approach is being used in practice within an agency that is constantly reviewing and refining its organisational alignments with the Signs of Safety.

Senge's idea of the learning organisation can be used by leaders to engage staff with the challenge of continual learning. For this to be more than a mere aspiration, leaders will need to explicitly communicate and drive:

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

9.2 70:20:10 Learning Theory

You don't improve just through doing, you improve through reflecting.

Human beings are action learners, but the learning derived from action is most often intuitive and unexpressed. High performance coaches commonly make the point, 'Practice doesn't make perfect. *Perfect* practice makes perfect.' When humans are in action — whether driving a car, playing an instrument, learning to cook, or relating to others professionally or personally — they unconsciously make a particular way of doing things routine. Once humans do something a particular way, homeostasis tends to set in and they will tend to repeat that practice, whether effective or not.

Creating a learning culture and a learning organisation requires a learning theory much more sophisticated than the implicit, dominant and mistaken 'learning theory' that workers will learn to do something by going to training. The Signs of Safety approach utilises the interactional 70:20:10 learning theory (Jennings, 2013) to underpin the learning component of the Signs of Safety implementation cycle. The 70:20:10 model locates training in its proper place and frames learning

itself as an ongoing process equally applicable to the practitioner as well as organisational leaders.

The 70:20:10 learning model posits that the smallest amount of learning comes from **formal training** (10%). This does not in any way diminish the importance of training, because it serves as the launch pad for implementation, sets the learning content, and offers a clear vision of successful practice. Signs of Safety training encompasses a formal two-day basic training for all staff, five-day advanced training for 'practice leaders' (team managers, senior consultants and in-house trainers), as well as targeted training regarding specific issues and particular groups.

Humans learn in action, so in human services most learning occurs, and habits are formed, through **daily work** (70%) as practitioners, supervisors and other leaders put the skills and methods into everyday practice.

While the action of daily work is 70% of learning and habituates how a skill is used, the pace of doing the work means most learning from action is intuitive and largely unconscious. Improvement and change requires feedback and analysis through structured **reflection methods**. This is the critical 20% of learning where the individual and group can improve by reflecting on what they are doing. To be effective, the reflection must be based on quality timely feedback.

In children's services, feedback and reflection are usually intended to occur within individual supervision. Such supervision is always a necessary part of the children's services learning environment, but it can often foster one-at-a-time privatised worker-to-supervisor learning, which places enormous strain on the supervisor. There tends to be little long-term feedback about the impact on a child of decisions made and actions taken, information that is essential for learning. Individual supervision is also a poor method for developing a shared practice culture. Thus group supervision is the primary vehicle for structured reflection in the Signs of Safety approach. The revised Signs of Safety Organisational Theory of Change includes other participatory ongoing reflection methods, including the collaborative case audit and the Signs of Safety Dashboard that provide both quantitative and qualitative feedback loops for analysis and reflection.

The key point of the 70:20:10 learning theory is that feedback and reflection, with colleagues, is central to learning and improvement.

9.3 Creating a Culture of Appreciative Inquiry

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

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

As well as being over-organised by fear of failure, child protection thinking tends to be dominated by the 'big' voices of researchers, policy makers, academics, and bureaucrats. In this environment, constructive 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.

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

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

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

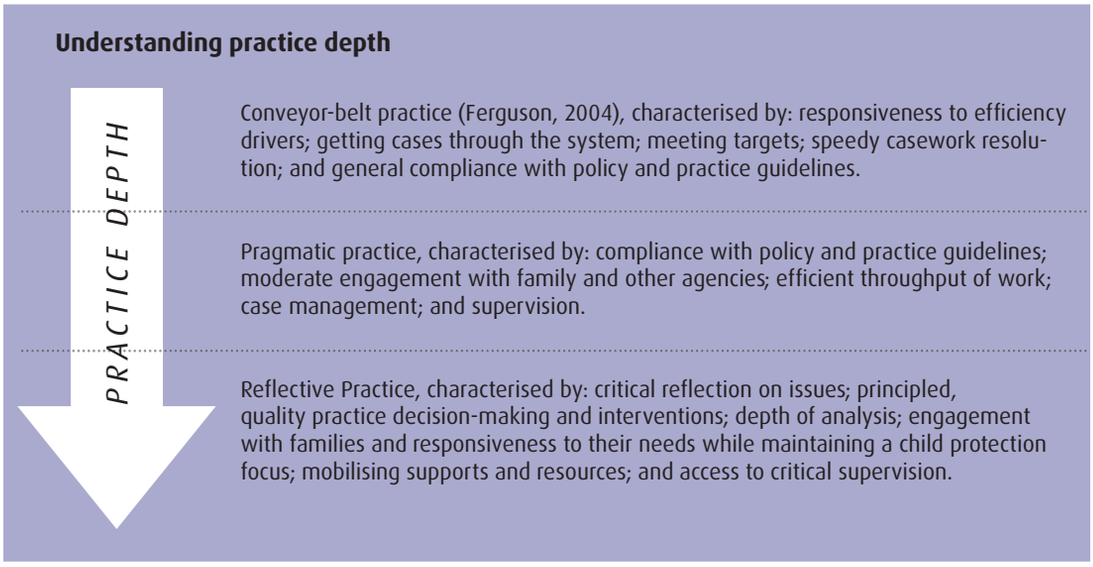
Steve Edwards and Andrew Turnell drew the inspiration to inquire into worker-defined successful practice from solution-focused brief therapy methods of focusing on what works for clients. Applied within a work context, this methodology can also be seen as a form of appreciative inquiry, which is an approach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

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

While the process of building a culture of appreciative inquiry around front line practice must be embedded in regular individual and group supervision, it is vital that senior management replicate this process and practice, particularly when crises occur.

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

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



Above: Understanding practice depth

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

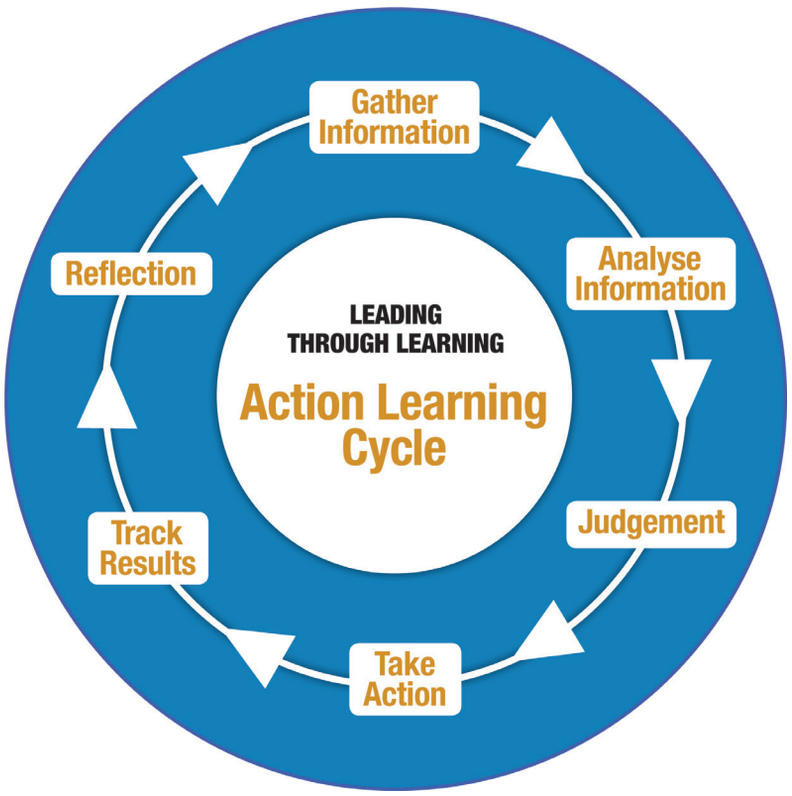
Placing successful practice at the centre of the Signs of Safety implementation directly addresses this problem by challenging practitioners to stake a claim for work they are proud of. Building 'practice depth' within the team, the office and the agency as a whole is truly challenging work. Appreciative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

9.4 Action Learning

In child protection, team leaders or supervisors are the primary leaders of learning and of the agency's learning culture. Through no fault of their own, however, supervisors rarely identify learning as a priority activity. Supervisors usually prioritise 'doing' over learning since they typically feel like the meat in the organisational sandwich, with practitioners constantly coming to them for help with practice and managers pressuring them about compliance, standards and time-

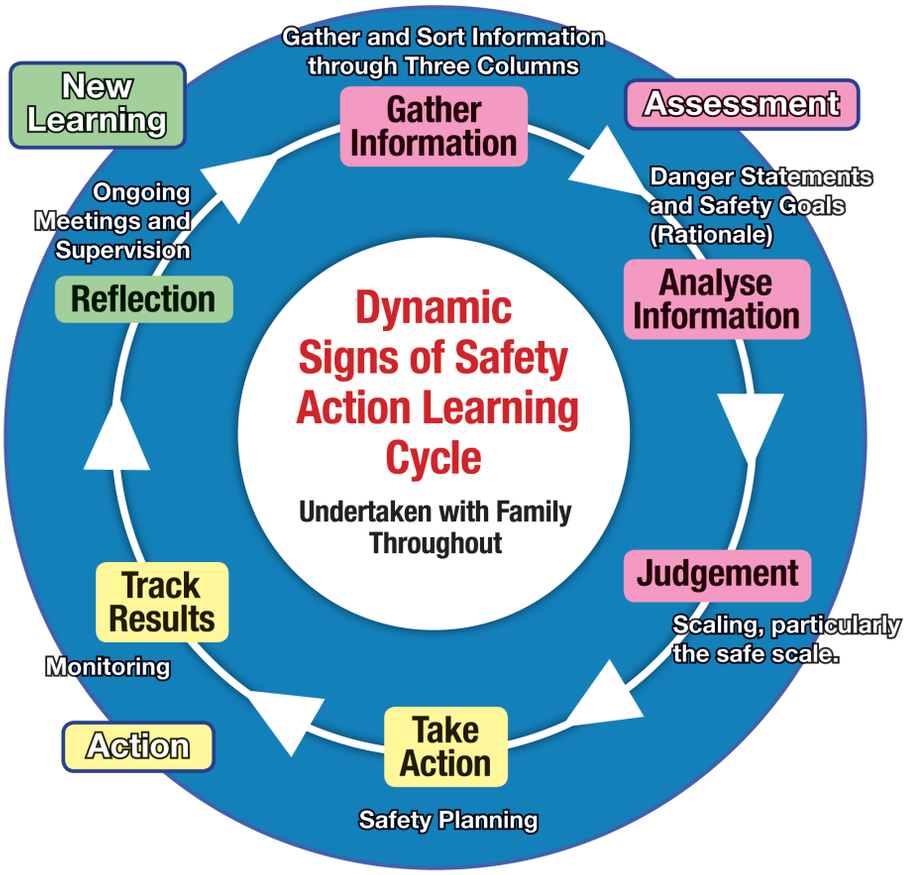
lines. They typically respond to these relentless day-to-day demands on their time by defaulting to telling practitioners what to do and this becomes the implicit embedded learning culture of the organisation.

For learning to be an effective driver of organisational development, an agency must establish and sustain clear processes for action learning around front line practice. While there will always be times when supervisors (and all child protection leaders) must lead by directing, the agency must actively engage supervisors in their own reflective learning to enable them to lead predominantly through action learning. This is a huge organisational challenge as supervisors are always busy and managers tend to explicitly or implicitly support this. So, while supervisors will readily attend initial training, they will typically be less involved in ongoing learning. For supervisors to participate in ongoing learning and development, senior leadership will need to work with supervisors by both requiring and supporting their participation. Leaders will often need to adjust supervisor workloads and priorities so they are freed up to engage in their own learning. The following diagram visually represents the Action Learning Cycle.



Above: The Action Learning Cycle

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



Above: The Dynamic Signs of Safety Action Learning Cycle

Implementing the Signs of Safety requires establishing cycles of action-based learning across the agency, in order to build and sustain a clear vision of what constructive practice and organisation looks like and to drive learning and organisational development based on impact. The following chapter will list the Signs of Safety learning methods that embed the ideas of action learning within the Signs of Safety implementation cycle.

10. Signs of Safety Implementation – A Journey of Learning and Alignment

10.1 The Challenges of Implementation

> ***'Social interventions are complex systems thrust into complex systems.'***
> **(Pawson, 2006: p. 35)**

The challenges of implementation are substantial. Child welfare agencies are invariably mature organisations. As such, they are likely to have layers of procedure and policy, extensive structures for roles, accountability and recording, interlinked with established quality assurance and information technology systems. These systems have usually been established over a long time, may be rarely considered afresh, and are unlikely to be streamlined. When a new approach is adopted, it is usually regarded as an add-on to everything else and rarely integrated effectively.

In addition, organisations will inevitably have strongly ingrained cultural mores and implicit values, some of which will be positive and conducive to the new approach while others may be antithetical. Most child protection organisations around the world feature a defensive, compliance-focused culture that has become embedded.

The cultural change potential of Signs of Safety practice has been emphasised throughout this briefing paper. The goal is to create a system that rigorously addresses the issue of child abuse while doing everything humanly possible to put children, parents and every person naturally connected to the children at the centre of the assessment and decision-making. A defining feature of Signs of Safety involves always giving these people every opportunity to propose and try their ideas to solve the problems before the professionals and agency offer or impose theirs.

This is a fundamental cultural shift in child protection work, both in the practice and the organisation. It takes courage and perseverance to implement.

If child protection organisations are to transform, or drive an improvement journey that has a real impact on outcomes, the transformation must be grounded in the practice of how practitioners actually do the direct work with children and families. The problem with so much past reform work, from national reviews and local strategies, is that they have addressed structures, processes and professional development without addressing the question of how the work actually occurs with families. The corollary of this has been that organisational development has not been built to support how front line work is actually practised.

10.2 The Implementation Framework

The Signs of Safety implementation framework reflects the fundamental but usually overlooked fact that the practice and organisational transformation sought by the adoption of Signs of Safety practice must be built on reforms across the whole organisation, with each aligned and reinforcing the whole.

The framework has been developed from the experience, successes and struggles in leading and consulting implementations of Signs of Safety in jurisdictions around the world. Most recently the framework was purposively refined within the England Innovation Project with ten local authorities (Baginsky, 2017; Munro, Turnell and Murphy, 2016). The beginnings of the implementation approach, in Western Australia, have been critically reviewed and found to be broadly consistent with the tenets of implementation science (Salveron et al., 2014).

The implementation framework endeavours to better reflect the real-world complexity of organisational change than most implementation science thinking. Implementation science tends to frame organisational reform as a linear process rather than wrestling with the complex and dynamic challenges pointed to in Pawson's quote.

We see implementation as a process where an organisation uses the Signs of Safety as a vehicle to drill down into its practice to create a learning organisation focused on how it is implementing the work, how it is reviewing outcomes, successes and failures, and allowing it to continuously adapt to change as necessary while keeping to the key principles of the approach. To achieve this, attention needs to be given to how the new way of working interacts with existing parts of the system, and how the system in turns aligns with the intervention. This a dynamic way of thinking about implementation, contrasting with the common static framing where implementation involves installing a new intervention into a fixed system rather like pumping a new and more powerful petrol into the fuel tank of a car.

The framework illustration below reflects the dynamic nature of implementation, showing how it is a continuous learning and development cycle with the practice approach at the centre.

The infinity loop implies the organisational action learning processes along with the agility and responsiveness required to lead and drive change in large organisations operating within larger human service and political systems.

At its simplest, the diagram illustrates the obvious point that everything an organisation does — its leadership, procedures, measurement and learning — must always focus on what practitioners actually do with children and families.

Above: Signs of Safety Organisational Implementation

The domains for action within the implementation framework are as follows:

- **Learning** — following core training with a drive for continuous learning in the workplace, grounded on what is happening in practice and across the organisation.
- **Leadership** — development that builds congruence between how the organisation is led and managed and how the work is expected to occur with families.
- **Organisational alignment** — so that processes and systems enable rather than impede the practice.
- **Meaningful measurement** — encompassing participatory quality assurance, matched to the results logics of the practice, and information technology to provide case recording consistent with the practice.

The Signs of Safety organisational implementation generally involves:

- a preparation phase;
- two years of intense activity; and
- three years continuing development.

The following sections discuss the preparation phase and then explore in turn the elements of the implementation framework, learning, leadership, organisational alignment and meaningful measures.

10.3 Preparation Phase

Successful implementation requires preparation before the launch date. For a medium to large organisation, a six-month preparation is recommended, although it is understood that the real world may intervene and truncate this time. Preparations will ideally incorporate the following:

- Leadership makes a clear and explicit commitment to the implementation of Signs of Safety.
- Leadership determines a focused set of goals for adopting Signs of Safety practice, with corresponding measures, that are tested and adjusted with the workforce.
- Establishing a Signs of Safety steering group including key members of the executive leadership.
- Targeted advance briefings and introductions to Signs of Safety are provided for a representative group of practice leadership staff, key partners and political leadership.
- Signs of Safety consultation on several typical cases to seed the practice, create examples for the coming training, and begin whole agency learning focused on the practice.
- Formation of an internal learning and development group that will work with the external trainers and consultants to progressively take on the Signs of Safety training tasks for the organisation.
- Developing the implementation plan, including an organisational policy or charter, that describes the practice and reflects the organisational commitment and purpose.
- Consideration and early decisions about the application of the meaningful measures program including the utilisation of the Signs of Safety quality assurance and information communications technology systems.

10.4 Learning

The most frequent recurring error that organisations make in implementing new initiatives is to mistake training for implementation. For most staff in the organisation, training will be the first step in their learning journey with the Signs of Safety within their agency and it is important that training is continually framed in this way.

Signs of Safety implementations start with two key trainings: an introductory training for all staff and an advanced training that focuses particularly on supervisors and leaders of practice.

10.4.1 Introductory and advanced training

The two-day introductory course should be provided to all staff, including senior and executive leaders and key partners. This introduction includes exploring:

- the principles, disciplines, tools and processes of Signs of Safety practice;
- the application of Signs of Safety practice through end-to-end case examples;
- applying Signs of Safety to an agency case; and
- the implementation framework, with emphasis on learning methods that support the practice methods.

Participants in the two-day program should come away with a basic understanding of the Signs of Safety practice methods:

- Mapping
- Questioning
- My Three Houses
- Words and Pictures
- Network building (Family Finding)
- Participatory conferencing
- Safety lanning
- Trajectory/Timeline

Practice and organisational leaders should be the first to be trained so that they can be confident in their leadership of field staff.

Advanced training for practice leaders and ideally senior and executive staff is provided through a five-day course that should normally begin two to three months following the introductory training.

The advanced training focuses on:

- building a deeper understanding of the application of the Signs of Safety across the full gamut of cases and casework processes;
- teaching the group supervision processes focusing on agency cases;
- building the key skills of questioning, facilitation and appreciative inquiry;

- introducing all the Signs of Safety learning methods that the participants will be utilising with practitioners; and
- preparing participants for their participation in the practice leader learning and development program.

Signs of Safety learning methods and sources:

- Group supervision
- Appreciative Inquiry with professional and family
- Learning cases from end to end (commencement to closure)
- Collaborative case audit
- Dashboards
- Parent fidelity/feedback
- Child fidelity/feedback
- Organisational staff survey
- Leadership-organisation fidelity/feedback
- Signs of Safety IT Solution
- Signs of Safety learning journal

10.4.2 Agency Signs of Safety trainers

All implementing agencies need to be able to take over the training task within a clear timeframe. To achieve this, during the preparation phase agencies should identify training staff that will take on this task. This allows the formation of a Signs of Safety trainers development group, led by the external Signs of Safety trainers and consultants, that can learn the approach and learn how to train as the initial training unfolds. These internal trainers can observe, then work alongside licensed trainers and successively start to lead elements of the training. In this way internal trainers should be able to deliver briefing sessions for partner agencies within the first year, lead the introductory training by the end of the second year, and lead advanced training by end of year three. Training and support for the trainers is available as part of implementation.

10.4.3 Practice leader learning and development trajectory

After the advanced training, the practice leaders learning and development trajectory should commence. This involves a formal program of coaching sessions with small groups of practice leaders every six weeks. The program is focused always on how participants and practitioners are responsible for using the approach, looking at successes and struggles. In this environment, su-

pervisors and practice managers build their individual and collective vision of the application of the approach in their agency and learn from each other.

The program successively builds participants' confidence in using the Signs of Safety learning methods to deepen the use of the practice methods.

The practice leader learning and development sessions equip the supervisors and practice managers to lead the learning of field staff. Practice leaders can use the material and activities from their coaching sessions and apply these directly with staff in their own workplaces, and through group supervision, collaborative case audit, appreciative inquiries, and using the Signs of Safety Dashboard and IT Solution (if implemented by their agency).

10.4.4 Leadership learning and development trajectory

Parallel with the practice leaders learning and development sessions, an aligned formal program of activities for leaders begins at the start of the implementation. This program:

- builds the practice knowledge of the leaders;
- develops leadership consistent with the practice approach, equipping leaders in appreciative inquiry, questioning skills, and participatory audit;
- initiates timely planning and review focused on organisational alignment and the systems for meaningful measures; and
- always focuses on what is actually occurring in the organisation and on forming defined cycles of action learning.

The trajectory is designed for the implementation's steering or governance group, for senior and executive leadership, and for service managers and policy (including quality assurance) managers. It should be based on quarterly meetings and workshops, with activity between each session.

10.5 Leadership

The complexity of child protection, and the contentious environment in which it operates, creates enormous potential for confusion and lack of direction, as well as over-reliance on procedures.

For the Signs of Safety to be used consistently across the organisation, and not just among the more enthusiastic practitioners in pockets of the organisation, requires active and engaged leadership. This includes the following:

- A **clear, focused and explicit commitment** to the practice and the implementation communicated by the organisational leadership. This will involve constant reiteration and clarification.
- Leaders that are **strong, visible and demonstrably engaged with practice** and practitioners. Senior managers are pulled in many directions and the main reason they exist — to support, guide and lead the service delivery work of the agency — can become secondary or even be lost. Leading for practice is critical.
- **Modelling Signs of Safety** practices — managing and leading in the same way that staff are expected to work with families is central to this alignment. Sometimes called the parallel process, leadership can model the Signs of Safety approach particularly by visibly:
    - asking questions and being curious, 'inquiring before requiring';
    - applying the Signs of Safety principles (working on relationships across the organisation, being prepared to admit you are wrong, and being guided by the actual experience of families and workers) and disciplines (using plain language, focusing on actual behaviour and avoiding labels) in everyday interactions;
    - using the three-column framework for strategic and operational planning and to address organisational challenges.
- **Fostering a safe organisation** — building staff confidence that workers will be supported through anxiety, contention and crises. All child protection organisations have stories of when workers have not been supported by executive and political leadership. These stories corrode trust and lead to practitioners focusing on compliance and defensive practice rather than on outcomes for families. Fostering a safe organisation for the effective implementation of Signs of Safety involves two imperatives:
    - Practitioners and immediate supervisors must be engaged to share anxiety upwards and never be left feeling that they alone are carrying the risk inherent in cases. This means having a good flow of contentious case briefings through management and ensuring there is rigorous questioning at each stage. When senior management does intervene in decision making, it is important to support and involve the staff by continuing to work through the Signs of Safety processes of analysis and planning.
    - Executive leadership making an explicit commitment that, should a tragedy occur, they will fully back up workers who have done their best, within the capacity of the organisation, and have been frank and open. Sadly, tragedies are part of the child welfare landscape, so this commitment will be tested. With every test handled well, trust and resilience increases. Any failed test has an exponentially greater negative impact. Executive child protection leaders should proactively prepare their response plan for tragedy. Turnell, Munro and Murphy (2013) describe leading for learning through a child fatality, based on a case study, and set out a step-by-step approach that exemplifies leadership that fosters a safe organisation.

- **Fostering a robust organisation** based on openness and inquiry. Some staff will relish the opportunity provided by the Signs of Safety and some will resist for a variety of reasons. Leaders need always to model openness and vulnerability. 'Giving the practice a go' in public learning forums, leading by questioning, and working on relationships are all important in driving openness to challenging professional development.
- **Building a culture of appreciative inquiry**. Deliberately examining practice and organisational strategies that are effective and how to extend them remains the driving force for development. Building a culture of appreciative inquiry requires leaders to demonstrate the norm of looking first for what has worked, even in reviewing critical incidents, and always being on the lookout to promote innovations that increase the uptake and impact of the practice.
- Successful leadership is **distributed leadership** — building responsibility for the work of the organisation from the receptionist to the chief executive. In an organisation where front line and supervisory staff hold substantial authority, leadership must be distributed for the work to be effective. Distributed leadership means senior leaders both confer an organisational leadership dimension to all roles throughout the organisation and expect leadership to be exercised from all roles. Ghandi's exhortation for each of us to be the change we want to see captures this sentiment and possibility as well as the personal responsibility.

Personal attributes do not define leadership. Effective leaders vary enormously. We can only be ourselves. Leadership is about being yourself while acting intentionally and with skills that can be developed.

Goffee and Jones (2000) call this authentic leadership and emphasise that successful leadership is always relational. Drawing on substantial research, Goffee and Jones argue that leaders must do three things:

- Really care about the work and the people doing the work.
- Expose themselves.
- Act as leaders, knowing when to be one of the team and when to rise to define the consensus and/or direct the team.

Followers, in turn, want four things:

- Authenticity, knowing that what you see is what you get.
- A sense of significance in their role.

- Some excitement.
- A sense of being part of something bigger and worthwhile.

In considering authenticity, Goffee and Jones assert that it is built on four things, all of which are readily observable by colleagues and staff: that words and deeds match; commitment; communicating a consistent underlying thread, in the work and the person you are; and personal comfort with yourself.

The concept of authentic leadership fits with Signs of Safety implementation for several reasons. First, all Signs of Safety implementation like practice depends on building good working relationships, a commitment that must be clearly communicated and demonstrated through the leader showing themselves to be authentically vulnerable alongside staff but also strong and clear about direction. Second, authentic leadership is liberating insofar as all leaders are different people and will always be themselves but can be more deliberate and skilful. Third, authentic leadership, being situational and relational, fits well in the context of distributed leadership, remembering that we are all leaders and we are all followers.

10.6 Organisational Alignment

The organisational elements that mark the start of an implementation are:

- a **steering committee** drawing together key organisational and practice leaders as well as policy sections of the organisation and executive level leadership;
- an **implementation plan** with a number of jurisdictions having adopted the implementation framework as the basis of their plan; and
- a **policy or 'charter' reflecting the organisational commitment** to the practice and the implementation, and that can include a summary of Signs of Safety, its evidence, and the implementation approach.

Together with the first tranche of training, these elements should inform when the Signs of Safety implementation is formally launched at a well-publicised organisational event.

Critical to success over time is the alignment of policies, forms and case management processes to match the practice methodology.

Adopting a new practice framework requires the alignment of organisational processes to support the practice. This is where the layers of policy, procedures, guidelines, instructions, accountability

requirements, and reporting arrangements that have been developed over an extended time, and that are often complex, prescriptive and time consuming, must be addressed.

Most important are the forms that workers must fill and record and the case management processes through which workers must progress cases depending on their trajectory. These fundamentally drive how the work is conceived and carried out. Case management processes also typically embed practice assumptions that may not be consistent with Signs of Safety practice, causing workers the confusion of working in two inconsistent conceptual frameworks.

Policies in comparison are not widely read and, even in their slimmest versions, generally constitute a voluminous amount of guidance. They are nevertheless essential, as they are the formal thinking and terminology of the agency. Policies are a pillar for accountability and they provide procedural direction for a wide range of actions.

The challenge is to have as few prescribed policies and procedures as possible, to have forms that match how the work occurs with families and children, and to have case management processes that support how the work proceeds with Signs of Safety practice.

The Theory of Change explicitly recognises that implementation will involve workers and the organisation being caught between 'old' and 'new' policies, processes, systems and cultures. As alignment work proceeds, this disjuncture should be acknowledged. An organisation should seek to realise that the aim of Signs of Safety is to be an approach for how to do the work and not another layer of work.

Coupling clear leadership with engagement of front line staff is necessary in order to proceed with clarity and practicality about how the alignments should occur. New forms and adaptations of existing case management procedures to accommodate Signs of Safety practice and recording are likely to precede more substantial re-engineering of processes.

Continually looking at what to streamline should be the corollary to aligning forma and processes and rewriting policies. This means simplifying, combining and culling processes and policies. It may mean identifying and letting go of policies and procedures that give an illusory sense of security to the organisation, particularly those that may have been developed after a crisis. At least some of these, likely many, are retained largely because of the fear of political and partner reaction to their removal. However, if procedures add only to the process and not to outcomes, they serve no purpose and should be removed.

The implementation trajectory maintains a focus on the alignment of policies, forms and case management processes to match the practice methodology, for the full-two year period and beyond. Review, planning and action will be undertaken by the steering committee with senior, service and policy managers, informed by quality assurance and specific outreach to staff.

When the implementation is underway, developing plans and targeted development for applying the practice to key areas of service, and across the continuum of service from early help to children in care, will occur.

Relatively early in the implementation, the organisation will be able to identify areas where specific implementation plans should be developed to address the particular developmental needs of those areas and focus on aligning their work with the Signs of Safety. These areas of service tend to be:

- initial referral and assessment (the multi-agency service hub in many English agencies, central intake in others around the world);
- front-end child protection where the work is accepted for assessment, planning and protective action;
- individual localities that will each have their own characteristics;
- conferencing (family group conferencing that shares several elements of methodology with Signs of Safety; child protection and follow up conferences that are mandated in England and chaired by independent officers); and
- pre-court diversion and court documentation.

Similarly, specific implementation plans will be helpful for services across the continuum of service to align the work with Signs of Safety. All jurisdictions have some divisions — in structure and practice approach — and therefore different policies and processes between early intervention, child protection and the children in care. The Signs of Safety approach has been adapted to a Signs of Wellbeing approach for family support work and a Signs of Success approach for children in care and youth at risk/youth offending services. These adjusted approaches can be utilised across the service continuum where required by the implementing agency. Each of these areas will need specific plans to align the practice and organisational arrangements that support or impede the practice.

Early in the implementation, it will be possible to gauge whether there is sufficiently **strong staff capacity at the front end where assessment and planning with families and children begins**. As the approach gains traction, jurisdictions generally experience an increase of work occurring at their assessment and intake stages. This front end workload may grow further as Signs of Safety

meetings with families occur at an earlier point and increasingly involve their networks of extended family and social supports, as well as other professionals engaged with the family, and safety planning is brought to bear at an earlier stage. This means that it is necessary to have a well-resourced front end staffed with a good balance of senior practitioners. This may involve shifting existing resources or directing growth resources disproportionately to the assessment and intake functions of the agency. Alignment of policies and procedures, and streamlining these, is also critical for an effective and increasingly consistent front end service response.

From the outset and throughout the implementation, organisations will look to build **engagement with partner agencies**. For example, child protection work often occurs in tandem with law enforcement. Many families are (or have been) working with multiple welfare agencies, all have links with universal education and health services, and many will have or need engagement with specialist services like mental health and drug and alcohol services. Partner agencies need to understand how the child protection organisation works with families and children and look to themselves working in a compatible way.

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

What is required is a combination of:

- formal collaborative arrangements including committees, of which the English Local Children's Safeguarding Boards remain the best example, and the necessary agreements for effective information sharing;
- targeted practice learning, so that partners are introduced to the practice approach, both its philosophy and the methods that they will participate in;
- aligned referral and reporting forms, so that the way of thinking about cases and interacting with families is more consistent between partners and child protection, from referral and as the case proceeds; and
- shared day-to-day practice with the families in assessment and planning as part of family network meetings.

There are significant benefits to national and international engagement, especially sharing resources and learning opportunities across jurisdictions and collaborating in research.

Agencies implementing Signs of Safety drive continuing innovation in the practice and the implementation approach. The community of agencies creates powerful shared practice learning, as outlined throughout earlier chapters of this briefing paper. It also provides the means for sharing policy resources and organisational implementation experience with like organisations.

10.7 Meaningful Measures

Organisations are, to a significant extent, driven by what they measure and record. Many organisations measure and attempt to analyse an enormous amount of data. Most, however, struggle to connect the data they collect with the outcomes for families and children and what is needed to drive improvements in the quality of practice. Similarly, staff struggle to see that their day-to-day work is assisted by much of what they are required to measure and record, particularly closer to the front end.

It is self-evident that what organisations measure needs to be meaningful to the people who do the work and helpful for learning to improve the practice and the organisation.

The section on learning above indicates how Signs of Safety meaningful measures are interwoven with continuous learning throughout the implementation.

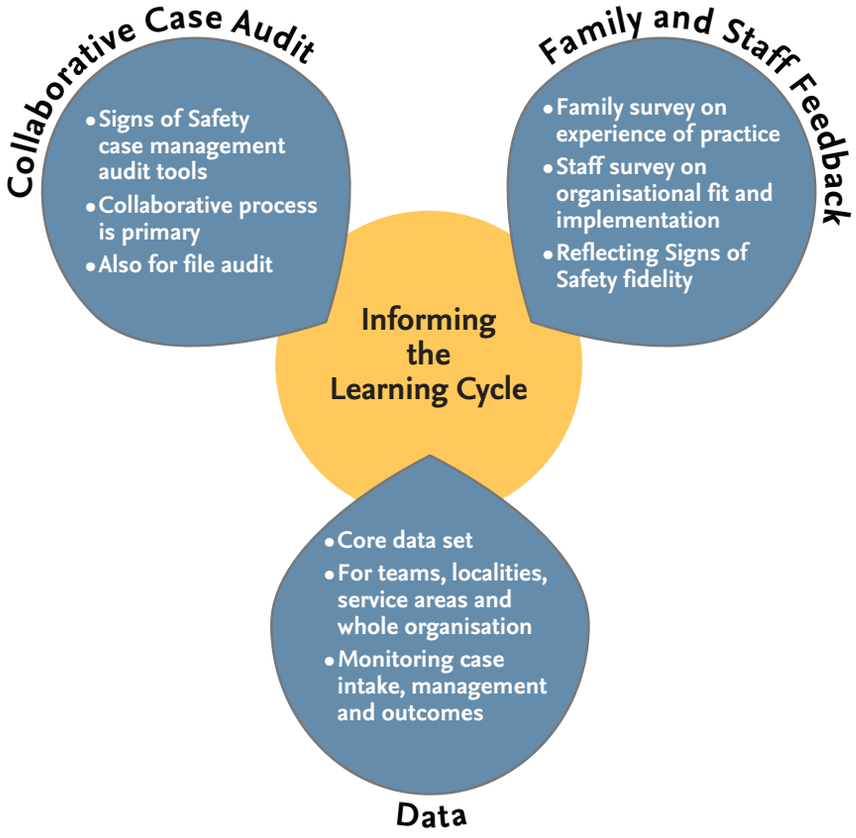
The underlying rationale for the Signs of Safety approach is that organisations understand, learn from, and make implementation decisions and adjustments through careful and ongoing inquiry into the lived experience of service recipients (children, parents, extended family and naturally connected support people) and practitioners. The experiences and interactions of the people who are living the recipient and delivery sides of the practice are the events that the organisation is seeking to shape and are the basis of outcomes.

10.7.1 Signs of Safety Quality Assurance

Initially through the England Innovations Project, and published in 2016, Munro, Turnell and Murphy have sought to operationalise this approach by developing a Signs of Safety Quality Assurance (QA) system to align with Signs of Safety results logic and fidelity.

The Signs of Safety Quality Assurance System encompasses:

- collaborative case audit, reflecting the Signs of Safety Practice Theory of Change;
- Dashboard to monitor application of the Signs of Safety practice methodology in individual case management;
- family and staff feedback on practice and organisational fit and leadership respectively, reflecting Signs of Safety fidelity, through annual surveys; and
- core data for monitoring specific goals, case trends and outcomes with a small set of key indicators that are already collected.



Above: Signs of Safety Quality Assurance System

Case audits have most often been conducted by a supervisor or someone independent reviewing written case material and providing feedback, usually also in written form. The underlying ethos of Signs of Safety always seeks to operationalise the idea of 'nothing about us without us'. The audit methodology is therefore designed to be undertaken through a participative learning process together with the practitioner(s), supervisor(s) or manager(s) responsible for the direct work since this consistently delivers a more robust and detailed picture of the practice, constructed from and with those who have the best intelligence about the case. A collaborative audit methodology that directly involves the responsible practitioners is also far more likely to drive practice improvement and minimise the perverse outcome of increasing defensiveness that audit work can trigger.

The Signs of Safety Dashboard is designed to monitor and measure application of the practice methodology for each open case, providing data at individual, team and organisational levels. Key aspects of the practice in line with the theory of change and results logic constitute the Dashboard categories with simple 'yes/no/how many' reporting. This can include: mapping the assessment and plan with the family, having clear statements of harm and danger, safety goals for each danger statement, identifying family strengths that have been demonstrated as safety, scaling questions about how safe the children are from different people's perspective, existence of a network (of extended family and friends who share a concern for the children), a safety plan to achieve the safety goals, engaging the children (My Three Houses), bringing the voice of the children to the parents, and explaining to the children what is happening (Words and Pictures). The Dashboard shows the extent to which the practice is actually being applied and that can then be correlated with outcomes, assessed by individual practitioners, their teams and the organisation.

The surveys for parents and the workforce, drawing on Signs of Safety fidelity research, provide a formal and quantitative means of collecting the representative view of families on the state of the practice and the staff in the organisation. This will complement action learning cycle information from workers and families, and is rich in detail and useful for timeline comparisons.

The QA system proposes a limited set of data that is already collected for measuring specific goals for the implementation as well as interrelated case trends. The goal is to focus and simplify data collection and analysis rather than establish new elaborate collection and reporting processes. Munro, Turnell and Murphy (2016) report a compact set of data recommended both for agencies and national reporting in England. Core data are likely to include the following indicators:

- Cases referred to child intervention.
- Child intervention assessments.
- Cases managed through intensive family support.
- Child intervention court orders.
- Children being brought into care.
- Re-substantiation of abuse.
- Staff separation rates.

10.7.2 Signs of Safety information communications technology

Over the longer term, Signs of Safety implementation looks to encompass information and communications technology (ICT) that records case management, with forms revised and adapted to match the practice, and provides an interface with the Dashboard.

ICT systems are perhaps the most significant organisational drivers of worker behaviour. Along with the forms and procedures, an ICT system determines the information that must be collected and recorded and can come to be seen as the work itself. As such, ICT can be the biggest impediment to implementing a new practice approach or, if aligned, can be a major enabler. The challenge with integrating the practice approach into ICT is to be consistent with the assessment and planning approach of Signs of Safety without reducing or constraining it to a process of filling in set forms. The construction of the Signs of Safety assessment and planning framework, with its four domains of open-ended inquiry and seven analysis categories, ameliorates this risk.

This is the most difficult alignment to achieve as it potentially involves large capital investments if a legacy system must be replaced. Signs of Safety partnerships with international ICT companies that are major providers in England have been developed for the adaptation of their operating systems at affordable cost.

In the interim, stopgap measures or work-arounds — for example, by attaching direct work documents to the system and referring to these to fulfil data entry requirements — are important.

A longer-term commitment by an organisation to revise the system is necessary in most agencies and the earlier that this can be explored and determined the better.

10.8 Whole of Person, Whole of Organisation

Implementation of Signs of Safety recognises that children's services are very complex human services delivered in highly contested and anxious environments.

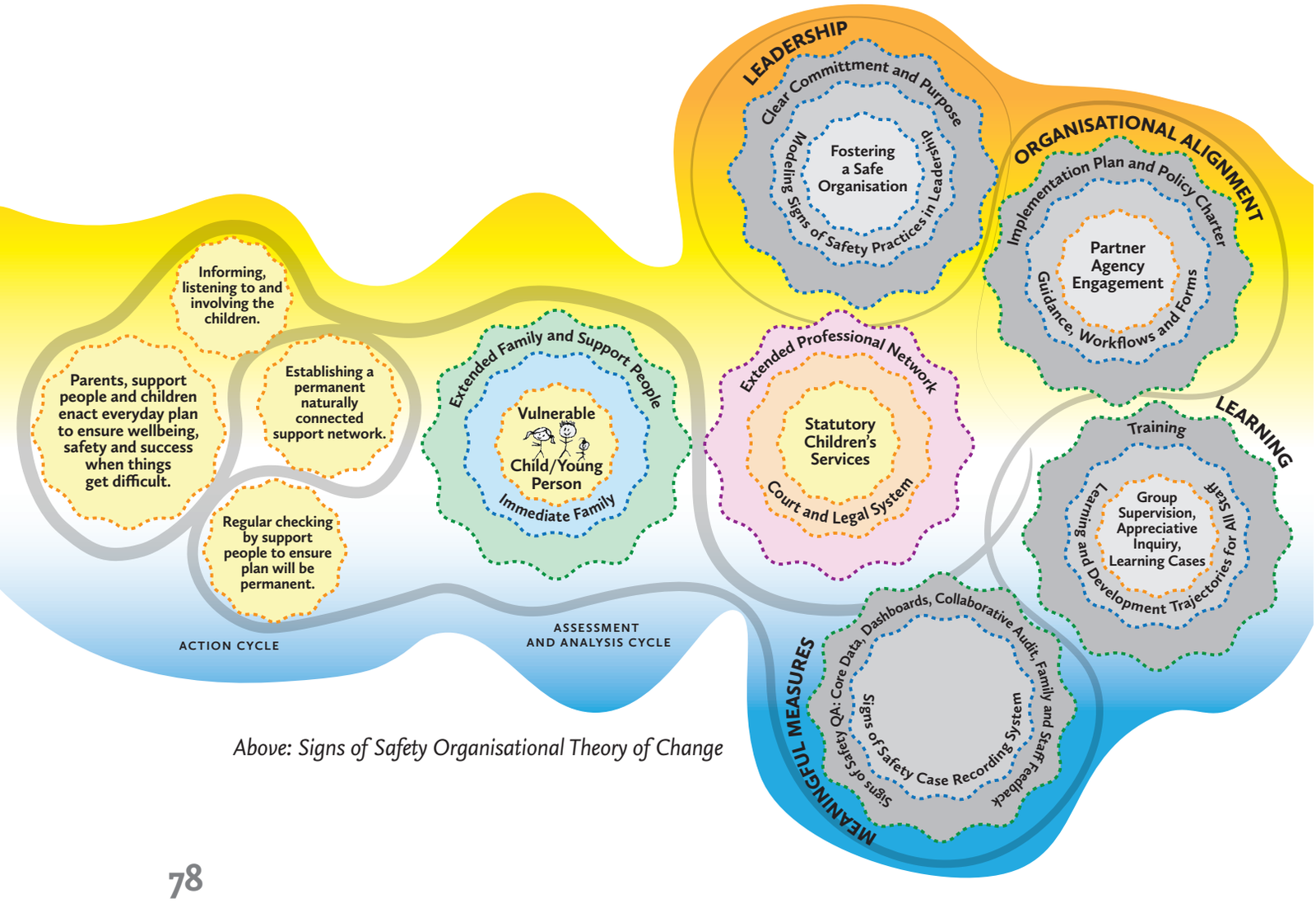
The quality, consistency and reliability of services rest ultimately on the humanity and abilities of the people delivering the services to the children and family. In addition to adopting the practice approach and aligning the organisation to enable the practice, to improve child protection services the agency should also be attuned to a 'whole of person' perspective. Such a perspective aims to support the growth of the analytical, emotional, social, cultural and spiritual intelligence of front line staff, so they can think and act wisely as they navigate the family, practice and organisational complexities entwined in every case.

'Whole of person, whole of organisation' thinking is fundamentally about connection as well as compassion. The aim must be to infuse the child protection endeavour, from the boardroom to the family's living room, with compassionate and holistic intelligence.

So, the implementation framework touches all aspects of how the agency works — the leadership, learning strategies, organisational arrangements, and how the work is recorded and measured. These, as well as the practice model itself, must be fit-for-purpose while the ultimate arbiters of what works are the practitioners and the families.

This does not mean, however, that families on their own somehow magically have the solutions, nor that practitioners know all the answers. Distilling the wisdom of the families requires refined expertise of practitioners, and that expertise develops in organisations that aim to grow and nurture their practitioners. For all staff in children's services organisations, and particularly front line workers, growing that expertise must be aligned with being emotionally, psychologically and physically well.

Developing this focus of implementation is perhaps the final challenge. Distributed leadership sets the context and drives commitment if everyone, from the receptionist at the front counter to the chief executive, shares responsibility for the culture, the context, and the success or failure in the work. Implementation based on the framework as set out, if truly coupled with effective action learning cycles proceeding throughout the agency, provides multiple and continuous activities



Above: Signs of Safety Organisational Theory of Change

through which staff can be challenged and can grow as professionals and as people. However, congruent with the Signs of Safety, the whole of person approach needs to be worked out with the people that it is about. Attention to the holistic development of staff should be deliberate and a shared responsibility of the person and the organisation.

10.9 Signs of Safety Organisational Theory of Change

This chapter has underlined that Signs of Safety implementation involves a comprehensive organisational transformation. The Signs of Safety organisational theory of change illustrates the centrality of the practice and emphasising the continuing organisational action learning process of gathering information, setting strategies, taking action, learning from results, adjusting and starting again. The organisational theory of change is illustrated as flowing directly from, and interlinked with, the practice theory of change. While the theory of change steps are presented here in a notionally linear fashion, in practice they are iterative and interactive.

10.10 Staying the Journey

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

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

Key Signs of Safety Resource Documents for Implementing Organisations

- Signs of Safety Implementation — Comprehensive Theory, Framework and Trajectory
- Signs of Safety Practice Leader Development Trajectory
- Signs of Safety Leadership Development Trajectory
- Signs of Safety Group Supervision Process
- Signs of Safety QA System (including Collaborative Case Audit Matrices)

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