

Risky Business: Child Protection in Canada

By

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BSW, University of Victoria, 2004

Thesis Submitted in Partial Fulfillment of the  
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## **Supervisory Committee**

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## Abstract

### Supervisory Committee

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Risk assessment is ‘risky business’ when we consider that it is based on the individual values, knowledge, experience and personality of thousands of unique social workers throughout the Country. And, combined with the personalities, charisma, charm and manipulative capacities of families we essentially have nothing but a bunch of checklists or ticky boxes. I would argue that the very structure of the organizational capacity to effect change with families in crisis is as senseless as it is useless: We cannot apply a systematized set of procedures, guidelines and solutions to the human condition. People are not mechanical, they are not engines that contain in similar fashion, parts and pieces that can be replaced or even understood. They are unique, they are complex, they contain immeasurable differences in their thinking, doing and believing: They can apply rules, values, and experiences to manipulate, charm, and confuse workers. So, just how do we prescribe a methodology to the madness of crisis? How do we ensure that outcomes are based on a thorough, thoughtful and critical analysis of each and every family who comes to the attention of the child protection authorities and ensure safety while protecting the child’s right to remain in the biological family home?

We have created complexity within the systems that manage us and have thereby made insignificant the significance of human work. What is needed is a complete restructuring of the systems we work within; the way we work, the way we think and the way we approach our understanding of risk and safety. But considering the depth of

practice this would need to reach, the number of workers that would have to change, the belief systems, social systems, bureaucracy and barriers that would have to be overcome, we need to ask, “is this possible?” Can we successfully implement a change of such magnitude in child protection practice today?

The purpose of this research is to support organizations, regions and even entire provinces across Canada in their pursuit of change within the child protection field. It is based on the premise that child protection reforms of the past have ill-addressed the needs of children and families; the deficit based frameworks utilized until recent years have often left families broken and helpless in the struggle to keep their children at home. This study will take an in-depth look at the historical context of social work highlighting the need for systemic, organizational and legislative change while identifying a process for successful implementation of the Signs of Safety practice framework by first exposing the indicators of success. Utilizing an auto-ethnographical methodology grounded in the critical race theory I will provide my personal experiences working within organizations, the successes, the challenges and the barriers to change of this magnitude.

## Table of Contents

|   |      |
|---|------|
| Supervisory Committee .....   | ii   |
| Abstract .....  | iii  |
| Table of Contents .....   | v    |
| List of Tables .....  | vii  |
| List of Figures .....   | viii |
| Acknowledgments .....   | ix   |
| Chapter 1: Introduction .....   | 1    |
| Personal Location .....   | 3    |
| A Historical Context .....  | 5    |
| Research Questions .....  | 10   |
| Rationale .....   | 12   |
| Definitions .....   | 14   |
| Organization of the Thesis .....  | 16   |
| Chapter 2 .....   | 19   |
| The Purpose of the Study .....  | 19   |
| A Review of the Literature .....  | 22   |
| What is the significance of using a solution-focused, strength-based practice in Child Protection work? .....                             | 24   |
| What are the barriers and challenges to a successful implementation? .....  | 33   |
| How could such a change be successfully implemented on a large scale within child protection organizations throughout Canada today? ..... | 38   |
| What would a strength-based, solution-focused model provide within the Indigenous context? .....  | 42   |
| Implications for Indigenous Families .....  | 46   |
| Summary .....   | 47   |
| Chapter 3: Research Design and Methodology .....  | 54   |
| Introduction .....  | 54   |
| Methodology .....   | 56   |
| Narrative Methods .....   | 56   |
| Auto-ethnography .....  | 57   |
| Critical Race Theory .....  | 62   |
| Summary .....   | 65   |
| Research Design .....   | 65   |
| Data Gathering and Analysis .....   | 66   |
| Ethical and Political Considerations .....  | 70   |
| Merits and Limitations .....  | 72   |
| Merits .....  | 72   |
| Limitations .....   | 73   |
| Chapter 4: The Data .....   | 76   |
| My Story as a Frontline Worker in Child Protection .....  | 76   |
| Data Tables .....   | 88   |
| Table 3 – Summary of my experiences of change in an Indigenous organization ...   | 88   |

|  |     |
|--|-----|
| Tables 4 - 6 Notes and experiences of change in Indigenous organizations .....   | 89  |
| Tables 6 - 12 Notes and experiences of change in mainstream organizations: ..... | 93  |
| Summary .....  | 102 |
| Chapter 5: The Findings.....   | 103 |
| Theme one: Support from Supervisors and Managers.....                            | 108 |
| Significance: .....  | 108 |
| Challenges and Barriers: .....   | 108 |
| Successful Implementation: .....   | 109 |
| The Indigenous Context:.....   | 112 |
| Theme two: Structural Change .....   | 115 |
| Significance: .....  | 115 |
| Challenges and Barriers: .....   | 115 |
| Successful Implementation: .....   | 116 |
| The Indigenous Context:.....   | 117 |
| Theme three: Policy Change .....   | 118 |
| Significance: .....  | 118 |
| Challenges and Barriers: .....   | 119 |
| Successful Implementation: .....   | 120 |
| The Indigenous Context:.....   | 120 |
| Theme four: Education for Community Partners.....                                | 122 |
| Significance: .....  | 122 |
| Challenges and Barriers: .....   | 123 |
| Successful Implementation: .....   | 124 |
| The Indigenous Context:.....   | 125 |
| Theme five: Practice, Patience and Training .....                                | 125 |
| Significance: .....  | 125 |
| Challenges and Barriers: .....   | 126 |
| Successful Implementation: .....   | 127 |
| The Indigenous Context:.....   | 128 |
| Chapter 6: Navigating the Outcomes.....  | 130 |
| Conclusion .....   | 135 |
| Bibliography .....   | 139 |
| Appendix A Example of Field Notes in 3 Column Format .....                       | 147 |

## List of Tables

|                |     |
|----------------|-----|
| Table 1: ..... | 6   |
| Table 2: ..... | 7   |
| Table 3 .....  | 88  |
| Table 4 .....  | 89  |
| Table 5 .....  | 90  |
| Table 6 .....  | 92  |
| Table 7 .....  | 93  |
| Table 8 .....  | 95  |
| Table 9 .....  | 96  |
| Table 10 ..... | 98  |
| Table 11 ..... | 100 |
| Table 12 ..... | 101 |
| Table 13 ..... | 104 |

## List of Figures

|                |     |
|----------------|-----|
| Figure 1 ..... | 133 |
|----------------|-----|



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I always thought dedications were particularly cheesy and not necessarily warranted but as I draw this discourse to a close I reflect on those who have sacrificed along-side me knowing that there are others who have suffered. To my beautiful, wonderful and awfully idealized children, Cheyna, Jerrica, Jackson and Caitie, you are the most incredible people I have ever known and I am so much better for having known you. I thank you for your continued sacrifices; the precious, precious time that I have foregone for the sake of this paper is unacceptable, I hope you will forgive me. To my partner, Mike whose patience is wearing incredibly thin, I thank you for standing by me in the worst of times, through all the distraction, the incessant thinking and the lack of texts; you are a trooper. And finally, to my advisors Jeannine, I thank you for your patience, your support and for giving me a good kick in the behind to get this done; and Robina for giving me direction and clarity at a time when I lacked it most.

## Chapter 1: Introduction

‘Change,’ the inevitable winds that blow through the fields of child protection every time a child death inquiry takes the media by storm. It is caused by the vicarious sway of a pendulum that bounces back and forth, back and forth leaving social workers hanging, no grasping on the balance of risk. Edgy, anxious and fearful workers step forward hoping this time they have made the right decision, based on an assessment of risk preordained by our Ministries<sup>1</sup> as, “the one” that ensures safety and thereby saves the lives of children.

This thesis was born of the desire to initiate change within the systems that govern child protection work today. After having spent many years on the ‘frontline’ I grew increasingly frustrated by the limitations of the work and the resulting inability to effect change within the family systems I worked with. Suppressed by bureaucracy and bogged down with procedures, standards, legislations and workload crisis, I became content to perform inadequate work to save myself the insanity that comes from the stress and pressures of a job that lacks the joy and meaning that working with other humans should typically bring. I not only wanted to understand a better, more hopeful and respectful way of working with individuals in crisis but also a way in which to successfully implement such change in the field of child protection.

The title, *Risky Business: Child Protection in Canada*, was chosen because the assessment of ‘risk’ has become so complex and bureaucratized that we have lost sight of what it is we are actually assessing; today it is based on the fear of the worker in balance

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<sup>1</sup> The term Ministries is used here generically to refer to the department of child protection in any given province within Canada.

with the demands of the bureaucracy with little regard for impact to children: The obvious outcome is decisions made in the best interest of the worker – not the children. Risk in itself is two-fold and it needs to be examined as such. Firstly, there is the apparent risk to children that occurs within the family unit itself, however secondly, there is the risk to children and families that is produced from the systematization of risk assessment itself; essentially it is the ‘business’ of assessment and the resulting decisions to remove or not to remove children from their biological systems that can have some of the most devastating outcomes.

We have created such complexity of human work utilizing and employing tools and checklists, processes and standards then applying them to the human condition as though people are assembly line products. “The methodologies of the disciplines and of inquiry not only bring precision; they also inevitably distort the varied state of human affairs by emphasizing patterns of similarity and consistency at the expense of individual variations and uniqueness” (Armitage, 1996, p. 176). Many of these standardized assessment tools are based in fear and implemented after child death inquiries are administered by the systems governing child protection. According to Swift (as cited in Gilbert, Parton, & Skivenes, 2011), the Gove Report of 1995 was one such example that resulted in British Columbia’s Comprehensive Risk Assessment Model. But however well intentioned these structures are, they have had shattering results on children, families, communities and on society itself. “Together with the residential school system, child welfare practices promoted assimilation and cultural genocide” (Pulkingham & Ternowetsky, 2001, p. 78).

The thesis itself describes a process of critical self-reflection and is sought as a result of my own personal frustration with the bureaucracy of the child protection system that exists today and the desire for organizational and structural change. By using an auto-ethnographic method, my hope is to provide organizations and provincial governments with a clear method of implementation based on the outcomes of agencies and organizations that have already begun this transition. After all, if we are relying on thousands of individual values, biases, thought processes and experiences of social workers across the country, then we had better be able to provide them with a method of practice that will not only ensure consistency throughout the field, but also the ability to work across culture, race, and/or socioeconomic conditions. I chose this method of research because it allowed me to include a range of sources including documentary evidence, my own personal experiences and the resulting accumulation of field notes which would provide me the ability to interpret the meanings, functions and consequences of institutional practices in order to determine how these effect the broader context of the organizations studied and provide a concluding narrative of strategies necessary for success (Atkinson & Hammersley, 2007).

### **Personal Location**

As an educated white woman, I come into my research with some form of unavoidable, inescapable privilege. Now, couple that with the fact that I am including my experience working within the Indigenous community, how will this affect my position within the research itself? Having been involved in the Indigenous child protection system as a frontline social worker and later as a supervisor, then consultant, I have certainly gained a respect and an understanding for and of Indigenous communities.

This however, does not negate my responsibility as a researcher to be carefully aware of the power imbalance and the need to ensure a clear and consistent process of researching, evaluating and reporting the results in light of my potential bias toward the research subject.

As a graduate with a Bachelor of Social Work with Child Welfare Specialization from the University of Victoria, I began my career with high hopes for making a difference in the lives of others. The buzz-word during the time I was receiving my education was ‘anti-oppressive;’ we were conditioned, trained and positioned to be anti-oppressive in our approach to working with the marginalized populations, but somehow I still began my career with the feeling that I did, or at least, was expected to know more than the client. This in itself is quite paternalistic: The task of the social worker was to solve the problems of all those vulnerable people marginalized by the unjust systems of society. But who got to decide that they were vulnerable? Maybe they don’t feel vulnerable at all. Whose job is it to assess vulnerability and what is that assessment based on?

I don’t recall a time throughout the duration of my educational experience, where I was actually taught how to make decisions about people’s lives even though my educational experience included an in-depth understanding of the social, economic, and historical experiences of marginalized populations providing me a holistic view and a critical lens no doubt. However there is something vastly different between *reading/thinking* about doing something and actually *doing* it. I felt that when I hit the ground running, I actually didn’t know how to think critically, holistically or thoughtfully in this environment that was so driven by fear and anxiety in order to make a valid and responsible decision about outcomes in child protection. Yet soon after I graduated, I

was sent out to begin removing children from their families with such little understanding about what constitutes harm or safety.

Within the first month of becoming a child protection social worker, I had removed two babies from two different families for two completely different reasons – from the womb to foster care. And, these were only the first of a long list of children I was forced to carelessly disrupt and displace from their homes, their families and their communities with little or no understanding about why I was removing them, all I truly understood was ‘deficit;’ families who had made mistakes, they themselves were careless, and for me, looking at those mistakes and seeing all their deficits inevitably resulted in the need for intervention, sometimes drastic intervention. For those parents it was a long and difficult journey to reunite with their children. I can’t help but wonder, “What did I do to those children?” What did the system do to those children? Is there something that could have been done differently? And, is the risk of removing a child from their home, their community and their culture more likely to result in trauma than it was to leave them in their home environment?

### **A Historical Context**

Not only does child protection work itself play a significant role in disempowering and enabling individuals but it also has the potential to disrupt and further destroy the growth of Indigenous thought, culture and responsibility around childcare and family welfare: Walmsley (2005) reports, “the child welfare system is viewed as both an instrument of colonization and a contributor to the loss of cultural identity, to powerlessness, and to the creation of dependency” (p. 95). He goes on to quote an Indigenous child protection worker who claims that child protection intervention “contributed to genocide as much as

residential schools have, in some respects” (p. 95). Very little has changed or improved for Indigenous children and families in Canada today. Indigenous children continue to be “overrepresented in out-of-care placements in Canada, perpetuating a historical pattern of removing Aboriginal children from their homes that started with the residential school system of the past” (Sinha & Koslowski, 2013, p.1). In spite of legislative and structural changes intended to address this concern, the overall rates persist. The following table speaks to the serious gap between Indigenous and non-Indigenous child protection removal and placement rates:

**Table 1:**

**Placement in child maltreatment investigations in 2008 (Statistics Canada 2008)**

|   | <b>First Nations<br/>Number</b> | <b>First Nations<br/>Rate</b> | <b>Non-<br/>Aboriginal<br/>Number</b> | <b>Non-<br/>Aboriginal<br/>Rate</b> |
|---|---------------------------------|-------------------------------|---------------------------------------|-------------------------------------|
| Informal Kinship<br>Care                      | 1,032                           | 10.3                          | 2,218                                 | 0.9                                 |
| Formal Kinship<br>Care                        | 298                             | 3.0                           | 497                                   | 0.2                                 |
| Family Foster Care                            | 893                             | 8.9                           | 1,872                                 | 0.8                                 |
| Group home/<br>residential secure<br>facility | 172                             | 1.7                           | 322                                   | 0.1                                 |
| Total   | 2,395                           | 23.9                          | 4,909                                 | 2.0                                 |

Historically, child protection practices have consistently done harm to children and families but it seems those most impacted by this system have been the Indigenous populations: The most recent statistic found relating to Indigenous children in care was from *Alberta Human Services' Child Intervention Information and Statistics Summary* (2014), where it is reported that as of September 2014, 69% of children receiving services in care within this province are Indigenous. It furthermore quotes the National

Household Survey of 2011, reporting, “Indigenous children make up approximately 10% of the child population (ages 0 – 19) in Alberta, [yet] accounted for 69% of the children in Care” (Table 5: Indigenous Children in Care). Some of the most recent stats in British Columbia are found in Kozlowski, Sinha, Hoey, and Lucas (2011), who report that “while 2006 census data indicated that Indigenous Children (ages 0 – 19) made up 8% of the population in British Columbia, the British Columbia Ministry of Children and Family Development (2009) reported that 52% of all children in care in 2007/08 were Indigenous” (para. 2). Statistics Canada reports the following substantiated child maltreatment investigations in 2008:

**Table 2:**

**Categories of substantiated child maltreatment investigations in Canada (2008)**

| Category of Maltreatment              | First Nations Children |                         |         | Non-Aboriginal Children |                         |         |
|---------------------------------------|------------------------|-------------------------|---------|-------------------------|-------------------------|---------|
|                                       | Number                 | Rate per 1,000 Children | Percent | Number                  | Rate per 1,000 Children | Percent |
| Physical Abuse                        | 560                    | 5.58                    | 9%      | 6,788                   | 2.72                    | 23%     |
| Sexual Abuse                          | 103                    | 1.03                    | 2%      | 939                     | .38                     | 3%      |
| Neglect                               | 2,781                  | 27.70                   | 46%     | 8,675                   | 3.48                    | 29%     |
| Emotional Maltreatment                | 559                    | 5.57                    | 9%      | 2,589                   | 1.04                    | 9%      |
| Exposure to Intimate Partner Violence | 2,000                  | 19.92                   | 33%     | 10,489                  | 4.20                    | 36%     |

It is quite obvious that it is time for change; Blackstock (as cited in Woods & Kirkey, 2013) is quoted saying “the factors driving these children [Indigenous] into foster care are not abuse related... but neglect fueled by poverty, poor housing and substance misuse, is the main factor behind the over-representation of Indigenous children in care”



(para. 5 – 6). Blackstock goes on to report that it is precisely these types of community concerns and issues that child protection can work to alleviate rather than separating children from their families as we have done historically for so many generations.

Comeau and Santin (1995) discuss key issues of historical domination and alienation as they relate to Indigenous social, political and economic conditions in Canada. Most profound is the authors' description of the child protection experience at the phasing out of the residential schools in the late 60s and 70s where children returned to the homes of their parents who no longer knew the concept of 'family' and whose parental roles were blurred with the increase of drugs and alcohol. According to the authors, the result was another generation of children who fell victim to child sexual and physical abuse and a situation in which "norms of acceptable behaviour broke down... Indian agents and provincial social workers found the situation horrifying, but instead of trying to deal with the underlying cause, they simply removed children from their parents and their communities" (pp. 142–143).

To give context to the extent of the impacts related to the 60s scoop, Comeau and Santin provide readers with statistics, saying, "in 1955, of the 3,433 children in foster care or group homes, less than 1 percent (twenty-nine), were native. By 1964, native children represented 34.2 per cent (1,446) of the total number of children (4,228) in care...[and]...By 1980, 4.6 per cent of all registered Indian children were in care across Canada, compared to less than 1 per cent of all Canadian children" (p. 143). Those rates continued to climb with more and more Indigenous children being removed from their homes and communities, most often placed with non-Indigenous families, and eventually adopted out. The outcomes, as Comeau and Santin confirm, have been shattering, with

teens turning to drugs and alcohol, suffering the scars of emotional harm and eventually, perpetuating the system as adults.

The aims of the colonizer are to break up communities and families, and to destroy the sense of nationhood and the spirit of co-operation among the colonized. A sense of powerlessness is the legacy handed down to the colonized people. Loss of power – the negation of choice, as well as legal and cultural victimization is the hoped-for result. (Maracle, 1996, pp. 93–94)

Though Canada's relationship with the Indigenous populations that first inhabited this continent began as more of a business venture, it very quickly turned to policy-controlled tactics of colonization and assimilation. Aboriginal Affairs and Northern Development Canada (2011) termed the 'Canadian Era' (1867 – present) as "Civilizing the Indian." Led by the Indian Department and "fed by a belief in the superiority of British ideals and society" (para. 11), First Nations people were encouraged to give up their traditional lifestyles for the more British lifestyle of agriculture. This was just the beginning of a long history of assimilation and colonization perpetrated by the Canadian government. Prior to this time "Aboriginal families and communities cared for their children in accordance with their cultural practice, laws and traditions" (Sinha & Koslowski, 2013, p.3). These systems of traditional care were critically disrupted with the imposition of "state practices resulting in the removal of tens of thousands of Aboriginal children from their homes" (Sinha & Koslowski, 2013, p. 3) and placed in Residential Schools intended to assimilate these children. Mandated by the Indian Act of 1876, these initiatives became the first mechanism for a state-sponsored child welfare initiative (Sinha & Koslowski, 2013).

In her report to the Legislative Assembly of British Columbia, Representative for Children and Youth, Mary Ellen Turpel-Lafond, (2014), indicates not only a lack of

follow through on previous recommendations for changes necessary in BC's approach to child welfare, but also highlights the need for change to policy, procedure and standards in order to address the serious gaps in service that children and youth at risk desperately rely on from the Ministry of Children and Family Development. The report speaks to "the need to change practice by shifting the culture or focus of an organization or service" Turpel-Lafond, 2014, p. 16).

Concerned about the number of Indigenous children being removed from their homes and mistreated in the care of provincial and federal government placements, First Nations groups began to advocate for the authority to govern their own child welfare services on reserve (Sinha & Koslowski, 2013). These organizations continued to grow in numbers but the provincial and federal governments would continue to place "greater constraints on First Nations child welfare agencies, requiring them to comply with provincial standards and introducing strict controls on funding" (Auditor General of Canada (2008) as cited in Sinha & Koslowski, 2013, p. 4) yet the scope of responsibilities held by these agencies continued to grow. Today "Canada has a decentralized child welfare system in which over 300 provincial and territorial child welfare agencies operate under the jurisdictions of 13 Canadian provinces and territories (Trocmé et al., (2010) as cited in (Sinha & Koslowski, 2013, p. 4). These jurisdictions maintain various different service delivery models in their approach to child protection work.

### **Research Questions**

As I consider the direction of this thesis and the research questions that intend to guide me, I am drawn to the words of Kovach (2009) who said, "start where you are, it will take you where you need to go" (p. 10). Where 'I am' is not only born of a longstanding

frustration with the systems that govern the safety and well-being of children today but is also of genuine curiosity around how change occurs and why a change such as this is so needed in child protection. I struggled with overcoming the challenges and barriers that exist in order to successfully shift the institutionalized thinking about how ‘we’<sup>2</sup> keep children safe. Finally, knowing that racism is systemically engrained within this institution, what will be the impacts to the Indigenous communities who so desperately seek authority over their own child protection systems? Using the auto-ethnography as a methodological approach to researching these questions allowed me to include my voice as one of many in a system that has developed a shared set of values, beliefs and assumptions (Creswell, 2007). Furthermore, utilizing this “mixed method... allowed for story and self-in-relation interpretations” (Kovach, 2009, p. 132), which will lend a much richer understanding of the ‘person’ in relation to the group. I turn then, to the following questions to direct my research:

Primary Question:

- How could a change be successfully implemented on a large scale within child protection organizations throughout Canada today?

Secondary Questions:

- What is the significance of using the *Signs of Safety* model in Child Protection work?
- What are the barriers and challenges to a successful implementation?

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<sup>2</sup> This is highlighted because I do not truly believe it is the job of the social worker to keep children safe. This is the responsibility of the parents, the family and community but for far too long ‘we’ have maintained this impossible responsibility.

- What would a strength-based, solution-focused model provide within the Indigenous context?

### **Rationale**

As a social worker that has participated in the British Columbian child protection assessment model, I was always very skeptical of its effectiveness. What I found was that the work was characterized by mistrust, suspicion and conflict and, as a result, there was little or no success with families. I worked within the Indigenous communities of British Columbia for over 9 years hoping for and working toward some change in the context of the work we do in child protection. Initially, what I encountered was an environment in which I (as the worker), was expected to solve the many problems people were encountering when brought to the attention of the child protection ‘authorities.’ The truth is, I didn’t know anything about their problems but somehow I was the ‘expert’ given the task of creating miracles that just never occurred. It became very disheartening not only to see the perpetual nature of families in crisis but also to feel as though I was somehow contributing to that. What I saw was an environment of hopelessness; families and workers alike were left with little sense of hope leading to a ‘quitter’s mentality’ for both. Was change even possible?

Additionally, I found myself watching Indigenous organizations battle the inequities that exist within the child protection structures, both in relation to funding and to workload crisis. It is for this reason I feel we simply cannot undergo any discussion about child protection without first understanding the effects on Indigenous communities because quite simply, there is a dis-proportionately high representation of Indigenous children in care (Pulkingham & Ternowetsky, 2001; Walmsley, 2005; Sinha &

Koslowski, 2013). Alberta Human Services (2014) published statistics for the 2012/2013 year wherein it was documented that there were 7,027 Indigenous children who received services from the department of child protection due to neglect or abuse; of those 7,027 children, 5,769 resulted in children entering foster care. The statistics for non-Indigenous children receiving services was 5,005 with only 2,723 of those children entering foster care. And to take a broader look at this picture, Woods and Kirkey (2013) report that nearly half the children (under 14 years of age) in foster care across Canada are Indigenous, and that “Overall, four percent of Indigenous children were in care, compared to a scant 0.3 percent of non-Indigenous children” (p. 1).

The displacement of Indigenous children is a historical issue that has gone ill addressed in Canadian society for decades. In so many ways, social workers have become just another arm of colonialism and vehicles with which to repeat the past; developing and employing systems designed with the white mainstream culture in mind. Walmsley (2005) quotes a service recipient saying, “...The power is in the hands of the judges and the social workers and everybody else but the family and the children involved in the situation. There’s that assumption that all First Nations people can’t care for their children” (p. 95). Gray, Coates, and Yellow Bird (2008) furthermore claim that “despite holding significant roles in providing social services to people from different cultures and societies, social work has been slow to accept non-Western and Indigenous world views, local knowledge and traditional forms of helping and healing. As a consequence social work education and practice... has struggled to develop and deliver services in an effective, acceptable and culturally appropriate manner” (p.1).

In an article produced by UNICEF (2009) entitled “Indigenous Children’s Health: Leaving no Child Behind,” it is estimated that “one in four children in First Nations communities lives in poverty, a rate more than double that of Canadian children on average. Much of this is the result of decades of policies that dislocated children from families and perpetuated disparity, generation after generation” (p. iv). For decades the child protection system has perpetuated the paternalism of the residential schools, removing children from their homes and placing them in ‘white’ mainstream homes and communities where they are introduced to new ways of being, new religions, and languages; cultures that are not their own (Pulkingham & Ternowetsky, 2001; Walmsley, 2005). Risk assessment in British Columbia has long been based on ‘white’ mainstream values about how people should live and historically, children have been without a voice in these systems, yet it is they who suffer the greatest harm; it is my hope that this particular research project will shed light on child protection assessment based practices throughout Canada making way for a more respectful approach leading to fewer children in care, and more empowering and successful outcomes for children and families everywhere.

### **Definitions**

“Indigenous”: I use this term when referring to people of First Nation, Metis or Inuit

decent as defined in the Constitution Act (1982) Section 35(2)<sup>3</sup>. There is no most appropriate term when referring to people as “the other” however, it is a term that has become accepted within the communities of those that I have worked with and so I use it with respect throughout the discourse of this thesis.

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<sup>3</sup> The term Indian is used in the Constitution Act (1982); however, “First Nation” has come into popular use as a term of respect for the position of Indigenous people as the original inhabitants of Canada but it has no consistent legal definition and its application is becoming uncertain because it is increasingly defined in various statutes

*“Appreciative Inquiry”*: Appreciative Inquiry (AI) is a change management approach that focuses on identifying what is working well, analyzing why it is working well and then doing more of it. The basic tenet of AI is that an organization will grow in whichever direction that people in the organization focus their attention.

*“Child in Care”*: As defined in British Columbia’s Child, Family and Community Services Act (1996) a child in care refers to a child who is in the custody, care or guardianship of a director or a director of adoption. While the age that constitutes the definition of the ‘child’ varies from province to province the child in care definition remains the same.

*“Child Protection”*: “the process of protecting individual children identified as either suffering, or likely to suffer, significant harm as a result of abuse or neglect. It involves measures and structures designed to prevent and respond to abuse and neglect” (Royal College of Paediatrics and Child Health, 2014).

*“Child Welfare”*: Social work that centers on the welfare of children. Not always associated with child protection. It is used interchangeably throughout this document if not specifically related to the protection of children.

*“Director”*: a person designated by the minister under section 91 of the Child, Family & Community Service Act.

*“Frontline”*: Frontline workers are those in the field of social work who work directly with families for the safety and well being of children. They often take the brunt of family frustrations as well as taking the fall for any mistakes leading to child injury or death.

*“Ministry”*: I use this term in reference to the provincial bureaucracy that oversees the



safety of children through the appointment of various “Directors”<sup>4</sup>.

“*Risk Assessment*”: As defined in the British Columbia Risk Assessment Model, this term is described as an evaluation of the “likelihood that a parent will harm a child in the near future” (p. 12). The product of risk assessment is “an educated prediction” (p.12). Munro, E. (2008) agrees that risk assessment is a prediction of what could happen and states that it requires “computing and combining probabilities” (p.58).<sup>5</sup>

“*Safety*”: The condition of being protected from or unlikely to experience danger, risk or injury. Safety can be provided in families – it is the things mothers, fathers or other caregivers do to ensure children are protected from injury or harm. These are the ‘signs of safety’ we look for in the assessment of risk.

### **Organization of the Thesis**

This thesis is an auto-ethnography that will take readers on a journey with me as I weave my way through my experiences as a frontline social worker/supervisor in a fully delegated Indigenous organization and later as a trainer and consultant aiding both Indigenous and non-Indigenous organizations in their implementation of the practice shift that is occurring across the globe today. It will include a review of the literature available relating to child protection models with an analysis of their inherent flaws, weaknesses, strengths and challenges as well as how practitioners cope with the demands and stresses of working in an environment of fear.

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<sup>4</sup> Section 91(1) of the Child, Family, and Community Service Act (1996) states that “subject to the regulations, the minister may designate one or more persons as directors” to oversee and carry out provisions of the Act.

<sup>5</sup> Munro, E. (2008) makes it very clear that the complexities involved in computing likelihood of risk is seriously flawed and can result in fundamental mistakes with devastating outcomes. This concern will be explored in Chapter 2 of this thesis.

The research itself is intended to reveal common themes that extend across my experiences and reflections in environments where organizations have been attempting to implement the Signs of Safety framework into their practice. It is hoped to provide readers with an understanding of what is required to make a practice shift of this magnitude not only possible, but also successful. Essentially, this is a collective of my personal recollections and understandings of the successes and challenges I experienced as most common among the child protection offices I worked with.

Chapter 2 will include a review of the relevant literature on the subject of risk assessment in child protection practice. This will expose readers to various models of practice used in the past and present, including the latest solution-focused model, Signs of Safety, as well as to highlight the complexities associated with human decision-making. The review will address and include information related to the primary and secondary research questions: “How could a change be successfully implemented on a large scale within child protection organizations throughout Canada today? What is the significance of using the *Signs of Safety* model in Child Protection work? What are the barriers and challenges to a successful implementation? What would a strength-based, solution-focused model provide within the Indigenous context?”

Chapter 3 outlines the method and methodology used to organize this research as well as an overview of the auto-ethnographical narrative used to report the experiences, themes, and outcomes of the study. It will describe the process used to collect, maintain, and analyze the data from the research itself.

Chapter 4 contains the materials collected from the researcher’s reflections and field notes over a three-year period of time as well as thoughts and recollections from the years

prior during the time in which the researcher was involved as a frontline worker in an implementing agency. The intent of this chapter is to deepen the understanding around the challenges and barriers I experienced while adjusting to change within the workplace.

Chapter 5 will present the final analysis of the findings contained within the materials researched. It represents five consistent themes required for successful implementation: Supervisor and Manager support for front-line staff; policy and legislative change to support the theoretical shift in practice; structural change to address the workload crisis (i.e. Generalist caseloads, shifting resources to the front end of services and lower caseloads); collaboration and education for community partners; and, finally, patience and continued training for staff learning to re-think their understanding of child protection work.

Chapter 6 provides the summary of outcomes, including the barriers and benefits to undergoing a change in the child protection field as well as the steps necessary to begin the journey of a lasting, historical and worthwhile change.

## Chapter 2

### **The Purpose of the Study**

The intent of this research is not only to emancipate workers from the constraints of the systems approach to child protection that has had devastating impacts on families for decades, but it is also to inform, enlighten and even educate readers on the complexities and intricacies of risk assessment. We as humans are complex organisms; as social workers we work with other complex organisms, all of which have the capacity to charm, manipulate, and deceive. Similarly, we have the tendency to respond to each experience or encounter with emotion; if we experience remorseful, cooperative parents we respond compassionately with care and concern, likewise if we experience resistant, angry parents we respond with judgment and heavy handedness. “Emotional factors within families and professional networks... can dislodge workers from objectivity” (Reder, Duncan, & Gray, 1999, p. 2). Whether one ‘did it’ or ‘didn’t do it’ we have already formed a judgment based on an emotional response; we are after all, human. Now place those same workers in an environment inherent with crisis and subsequent anxiety and fear, it’s a recipe for disaster. Under these conditions and pressured by timelines, workers will most often make their decision first, do the thinking later and look for reasons to then justify the decision they’ve made, emphasizing the information that fits best with the former decision (Munro, 2008).

Risk assessment relies heavily on the ability to make decisions but to lend further complexity to an already complex task at hand, workers are required to make a decision based on something that hasn’t yet occurred; the future likelihood of harm. It is as though workers are expected to carry with them a crystal ball that would allow them to

weigh the probability of harm based on the current crisis of the family then add to that the need to understand the parents' ability to provide a state of well being for their children in the future. "Unfortunately, humans are not good at dealing with probabilities intuitively. People's instinctive understanding of how probabilities should behave is wildly wrong, resulting in persistent and fundamental mistakes" (Munro, 2008, p. 58). Consequentially the decisions we make in the workplace have significant, and often negative, impacts on the lives of the children and families we work with: I recall as a frontline worker, my first experience with a sexual abuse case.

This case was laden with denial, deception, fear and frustration. I had no way of working with this family, I simply didn't possess the tools to deal with denial and to be honest I didn't have the first inkling of an understanding around the intricacies of such complex cases. As a result I fumbled my way through day after day and believe it or not, year after year with little to no relationship with the parents, in fact more than anything, I maintained a stance of judgment, resentment and pure frustration at the behaviors of the family. The assessment framework that I had been using under the British Columbia Risk Assessment model didn't improve the situation, nor did it provide safety for the child at home. There was so little clarity for me during this time and although I didn't know it then, I later realized that I had been looking at the situation with a sort of tunnel vision, not seeing the other forms of abuse and neglect that were present within the remaining family unit. This lack of clarity and inability to provide safety for this child led to emotional and psychological harm being done to the extent of hospitalization. Looking back I know that I could have done things differently had I been able to employ the tools and philosophy within the Signs of Safety framework. It's cases like this one

that lead me to think about the harm that systems do to children and families across the globe.

In considering tools associated with risk assessment, at first glance, it would appear that some form of checklists would aid workers in becoming more consistent in their ability to predict harm or injury. However, as Reder, Duncan, and Gray (1999) admit, a list can help organize workers' thoughts but they can also cause them to be "lulled into a false sense of security, believing that generalizations automatically apply to specific cases and are reliably predictive" (p. 124). In other words, they come to rely on the checklist alone creating a methodical and unintentional practice wherein the wider context goes unconsidered and thinking becomes obscure. In this way workers are not thinking critically about the wider context of the family such as strengths, safety, danger and harm, instead they are simply demonstrating to the 'Director' that they have covered off the checklist and made conclusions based on the formula provided to the best of their ability. It becomes then, a work focused on what's best for the worker rather than what's best for the child. Relying the work of Munro (2011), Turpel-Lafond (2014) recognizes this issue in her report stating "Implementation of recommendations focused on standardizing practice can result in an overburdening of front-line staff with "check-box" procedures that get in the way of genuine connections and the use of professional judgment with children, youth and families" (p. 11).

In utilizing an approach like Signs of Safety, workers are forced to think critically about the safety of children considering all possible categories of assessment; harm, danger, complicating factors, existing strength, existing safety, future safety and next immediate steps (Turnell & Edwards, 1999). In attempts to understand families where

abuse has occurred workers will quite typically focus attention on the presenting risk factors, getting caught up in a long list of what's going wrong. As Thomas observes, essentially what we are doing is focusing 100% of our attention on 5% of the family (the problem area), negating the other potential "95% of the behavior that may fall within broad definitions of ordinary competency and social acceptability..." (as cited in Turnell & Edwards, 1999, p. 36). This then converts whole people into problems, reducing the potential of hope, the possibility of respect and finally the capacity of workers to think their way into and through cases (Turnell & Edwards, 1999). Navigating the difficult terrain of child protection and assessment work is difficult enough, but add to that the intent to change it, flip it upside down and rebuild the very foundation of child protection practice itself from the very first phone call or knock at the door to the systems, legislation and policy that dictates it. You can imagine the challenge and complexity of it all. This discourse is an attempt to provide the reader with the strategies necessary to ensure success in a change of such magnitude.

### **A Review of the Literature**

*The 1991 National Commission on Children (cited in Turnell & Edwards, 1999) concluded that "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" (p. 12).*

Signs of Safety is a strength-based, solution-focused practice that allows workers the ability to empower families to take responsibility of their child's safety while at the same time building relationships with clients that would give the worker a much clearer understanding of the family, their supports and ultimately, the child's safety. The framework provides a method of assessment that considers both risk or worry, and

strength or those things that the family is doing to keep their children safe. In this way, the worker is provided a much more holistic view of family functioning, capacity and whether or not this creates safety or risk. The practice itself, lends clarity to the very unique situations of each and every family taking the complexity out of the work thereby reducing the fear workers feel when confronted with difficult cases.

The Signs of Safety practice framework requires assessment and judgment, not unlike the formerly used child protection assessment, however the difference is that the tools of practice allow workers to think critically, with focused direction and in collaboration with other professionals as well as with family and community supports. It is goal focused and based on creating small, possible change in families rather than jumping from A to B in one giant leap (Turnell & Edwards, 1999). It is based on the understanding that all families have strength, while former systems have based their practice on a deficit or risk focused assessment considering only what is going wrong with the family. Within such a framework the picture becomes very black and white: Turnell and Essex (2008) draw on the work of Luger, asking the question,

Who is going to be brave enough to make the decision that a child can go home and on what basis are they making it? It's far easier to find evidence to support the child not returning than to find evidence that a child should return home, and that's if there is the will to work towards rehabilitation. (p. 112)

I can't even begin to imagine how many children were needlessly removed from their families, their communities and their cultures as a result of assessment methods based entirely on the deficit of the family.

There is an accumulation of literature associated with various risk assessment models imposed in an attempt to understand potential risk to children across the globe. This literature review will utilize the four research questions to maintain the focus of this



study: What is the significance of using a solution-focused, strength-based practice in Child Protection work? What are the barriers and challenges to a successful implementation? How could such a change be successfully implemented on a large scale within child protection organizations throughout Canada today? What would a strength-based, solution-focused model provide within the Indigenous context?

### **What is the significance of using a solution-focused, strength-based practice in Child Protection work?**

The British Columbia risk assessment model was a tool used by all social workers across the Province up until April 2012, as a tool and guideline for working with all families who are brought to the attention of the child protection authorities. Grunberg (as cited in Child Protection Consultation Services, 1996) explains that the tool was developed in 1996 “when a representative group from the Ministry of Social Services identified developing a standardized risk assessment as the province’s number one priority in child protection” (p. 3). The origins of the BC risk assessment model came from that of New York State’s child protection model developed in 1991; it was chosen because it was found to be “well-researched, credible, valid and field-usable” (Child Protection Consultation Services, 1996, p. 10). At no time does the model suggest that it involved or even considered the families undergoing assessment; they do not appear to have been a part of the process of finding or adapting the model and yet they are the most affected by it. Furthermore, there is no discussion about the involvement of Indigenous communities during the development phase of this document; a document that would guide the efforts of every social worker across British Columbia for the years to come.

To address this issue and in attempts to align the practice with Indigenous worldviews, the Aboriginal Operational Practice Standards (AOPSI) was developed, then revised and

modified by executive directors of Aboriginal Child and Family Service agencies, the Department of Indian Affairs and Northern Development Canada (now Aboriginal Affairs and Northern Development Canada), and the BC Ministry for Children and Family Development throughout that province (Gayou, 2005). While the document was intended to guide the audit process for Aboriginal agencies, it essentially set up a standard of operations that were very difficult to achieve and resultantly few agencies were able to meet the criteria to become fully delegated. In Turpel-Lafond's report (as cited in Stueck 2013), outlining government spending on Indigenous initiatives aimed at helping First Nation communities achieve authority over child welfare she says that the "projects lacked clear goals and measurable outcomes" (para. 7). Furthermore, according to Van Bibber, Hubberstey, Hume & Rutman, (2009), the AOPSI while developed under the guise of Indigenous approaches to child protection, is evidently still being delivered under the existing legislation leaving the persistent gap between Aboriginal culture and child welfare laws and ideology.

"Although the existing AOPSI practice standards emphasize the importance of family and community within Aboriginal cultures and have been updated from time to time on an incremental basis, they do not embody practice founded on an Indigenous worldview. Thus, while the current standards may represent a novel application and adaptation of MCFD's standards they cannot be considered reflective of core Aboriginal beliefs, values and cultural traditions" (Van Bibber, Hubberstey, Hume & Rutman, 2009, p. 1).

In his review of literature regarding the benefits and downfalls of individual versus group decision making in child protection work, Crea (2010) proposes that assessments undertaken by individual case workers based on a "check list of strictly defined factors... cannot possibly capture the unique circumstances of each family. Given the complexity and depth of issues often experienced by families involved in child protection, a wider

*perspective* and more *sources* of information are needed than can be assessed using actuarial assessments alone to drive a decision-making processes that balances risk and protective factors...” (p. 4). Crea validates the need for both actuarial and clinical assessment but states very clearly that risk assessments are limited in function; they may lead the worker to a better prediction of future abuse but at the neglect of including current family function and treatment options. He goes on to quote Gambrill and Shlonsky, stating “risk assessments do not typically include consideration of protective factors that buffer the effect of risk factors experienced by families in child welfare” (p. 4). In other words we are only looking at one side of the story – the negative one.

Reder, Duncan, and Gray (1993) walk readers through thirty-five cases of child death inquiries where a lack of collaboration and communication among professionals became a fatal error for these children. They identify the need for child protection workers to develop a more sophisticated level of analysis in their use of assessment and determination of final intervention given the extremely complex relationship that exists between family and professional and the subsequent failure to see beyond what we’ve come to believe about a given situation. The research also highlights the risky business associated with child abuse assessment while navigating the complex terrain of parental capacity, domestic violence, disguised compliance and ‘closure’ as well as the subtle but fatal warnings given by parents in distress and finally the outcomes of an exertion of authority on families in significant hardship (Reder, Duncan, & Gray). All of which speak to the need for workers to adopt a method of critical thinking, a framework that would allow them to understand the inherent risk in families who come to the attention of child protection authorities.

There are a number of various approaches that can be utilized in the field of child protection to determine risk to children and promote safety within the family home. Crea (2010) explores a number of case management options for decision making, structured decision-making (SDM), multi-disciplinary team (MDT), team decision-making (TDM) and family group conferencing (FGC), but goes on to describe the pitfalls of human decision-making, which he claims, is primarily based on heuristics. There are a number of problems associated with this method of information gathering and conclusion forming, but most significantly is that workers have a tendency to “assess risk based on a small amount of evidence, ignor[ing] significant information known to other workers, and favor[ing] evidence based on whether it was the first or last information received, or whether it aroused emotion” (p. 7) leading to significant bias in the making of the final decision. Other authors have warned of the risks associated with the human emotional response to cases of child abuse and the subsequent devastating outcomes (Munro, 2008; Reder, Duncan, & Gray, 1993; Turnell & Edwards, 1999). McRoy, Crampton and Jackson (as cited in Crea, 2010) sternly warn that “biases in child welfare decision making may lead to disparate child outcomes experienced by children from racial minorities. And, while group decision making can, to some degree, counteract this, it also has its downfalls as workers tend to withhold information from the entire group for various reasons” (p.8).

Structured decision-making is a practice model that many jurisdictions have turned to for improvement in the assessment process and a more favoured approach to work with children and families. The evidence-based model includes a variety of assessment tools intended to improve the consistency of decision-making and is based on “clearly defined

service standards, mechanisms for timely reassessments, methods for measuring workload and ensuring accountability and quality controls” (NCCD, 2015, para. 1). There are numerous assessments within the model to be used at various phases of the work: intake, safety, risk, family strengths and needs, risk and reunification (NCCD 2015). And, while the model achieves very specific assessments across the spectrum of services, it does not address the day-to-day practice of workers in the field. Furthermore there have been some inefficiencies related to applying the assessment tools in use with Indigenous families who have a tendency to score as higher risk than should be (Loman & Siegel (2004). There are many child protection organizations throughout the U.S. that use a combination of Signs of Safety and Structured Decision Making finding it a successful approach to assessing risk and safety with families in crisis. Overall, there appears to be a global recognition that previous child protection models have not worked to provide safety or develop the much-needed relationship with families that will improve outcomes for children; the push for change is strongly evident across the globe.

There is a plethora of literature concluding that the very best climate in which good decisions can be made is in a climate of relationship; relationship between community and agency, family and worker, and between worker and supervisor (Crea, 2010; Munro, 2008; Reder, Duncan, & Gray, 1993; Turnell & Edwards, 1999; Turnell & Essex, 2008). These authors also insist that a decision-making framework must draw on the support and involvement of family, friends, and community as this is where many of the protective factors can be found. In the end, a balance of risk and safety must be considered along with family involvement in the decision-making process. Richardson (2009) also speaks to the need for family involvement in the creation of safety; in her work with ‘Islands of

Safety,' she refers to the process of meeting with family as "safety counselling," with the resulting safety plan being the focus and end goal as they work to "restructure relational styles around non-violence, and promote safety in families" (p. 10). Turnell and Edwards (1999) and Turnell and Essex (2008) would suggest that the safety plan is not necessarily the end goal but rather, it is the journey we go with families, it is the 'real' work we do to help families develop the safety necessary to keep their children home (and avoid future reports to child protective services). So, while actuarial assessment tools can be useful guides, they should not be relied upon for decision-making alone as they ignore the potential strengths of the family thereby skewing the process of determining future abuse and neglect.

In *Structural Social Work: Ideology, Theory, and Practice* (1997), Mullaly clearly defends the need for change in the conventional models of social work especially given the increasing social problems we are witnessing in the world today. He argues that both historical and current methods of practice have done nothing to shift the current condition of the welfare state and in fact, only continue to contribute to oppressive ideologies and thought structures. Mullaly examines the social, political and economic beliefs behind the ideology of social work within the context of various political paradigms in order to align the reader with the structural social work theory he poses as necessary for an effective management of practice. Howe (as cited in Mullaly, 1997) says, "theoretical ignorance is not a professional virtue but an excuse for sloppy and dishonest practice" (p. 100). Although social work is typically viewed as a practice based profession, theory is or should be an absolutely essential aspect of the day-to-day work done in order to ensure there is consistency in description, explanation, prediction and control or management of

future events (Mullaly, 1997). According to Howe (as cited in Mullaly, 1997), “If drift and purposelessness are to be avoided, practice needs to be set within a clear framework of explanation, the nature of which leads to a well articulated practice” (p. 100).

Munro (2008) argues that “...trained, experienced professionals cannot be replaced with bureaucrats [or] sets of forms, but they can be trained to develop their intuitive reasoning skills, understand their limitations, and use more analytic skills to test and augment them” (p. 1). Nevertheless, she explains, the dominant belief of this highly organized, bureaucratic child protection system is that the practice skills of workers can be improved with a more formalized and prescriptive approach adding a contained set of guidelines, checklists and procedures to the daily task of the risk assessment process. What bureaucrats may or may not know is that frontline workers recognize that these so-called tools don’t necessarily promote the best practice with families and as a result will use them minimally and only to fulfill their duties and expectations knowing that they are quite simply “a device for protecting management from outside criticism rather than for protecting children from abuse” (p. 2). Munro also discusses the need for both intuitive and analytical skills to be exercised in the work done as social workers and in particular to improve our ability to think our way through cases while also acknowledging potential bias. We need to remain cognizant of the reality that the removal of a child from the family of origin may increase immediate safety but at the same time, impede overall development. It is imperative that practitioners understand that, aside from the most extreme cases, the birth family is the best place for nurturing the development and well being of the child.

In *Signs of Safety: A Solution and Safety Oriented Approach to Child Protection Casework* (1999), Turnell and Edwards insist that the child protection field “repeatedly acts out the logic of paternalism, with professionals taking upon themselves sole responsibility for analyzing the problem of child mistreatment and generating solutions. Families are left out of this process...” (p. 18). This form of practice has not worked in the past and still does not work today. One of the basic principles used in the Signs of Safety approach is ‘brief therapy’ which concedes that when what you are doing is not working, don’t try harder try different. Turnell and Edwards also draw on the work of Thomas in stating that the greatest practice issues lie in the crevasse that exists between theory and practice, leaving “service recipients at the bottom of the trench” (p. 18). In order to address this practice problem, it is essential that we, ‘the professional’ develop cooperative relationships with the parents. This is certainly one way of doing it ‘different.’

Turnell and Edwards (1999) also maintain that within the framework of the solution focused practice the professional still carries a certain degree of statutory power which needs to be recognised, however, this power or authority can and should be very skilfully used with families in crisis. To assume that the professional always knows best is paternalism in its most traditional sense, what is needed instead is an understanding that the ‘professional’ is here to go on a journey with families; to ensure safety for children while respecting the human dignity of parent and family. It requires thoughtful questioning, keen listening and critical thinking skills to assess the safety of children – not a list of ticky boxes. Relationships must be established with families and in order to do this the helping professional must relinquish some of the control they hold over



families in crisis situations. At times, it requires the worker to put aside preconceived notions or assumptions about families and just listen openly; as Munro (as cited in Turnell, 2012) puts it, “the single most important factor in minimising risk to children is to admit that we might be wrong” (p. 10).

Turnell and Essex (2008) explore the complex work that is required in cases of denied child abuse: From preparation to follow up, the authors discuss the need to organize practice around future safety rather than past denial. They walk the reader through several cases where they have applied the “resolutions” approach, building safety for children in the face of parental denial. Many workers get caught up in cases of denial engaging in a bitter battle of the pursuit of truth, leading inevitably to the removal of children and a dead end to safety within the family. “The resolutions process bypasses the denial problem by inviting the family to show they can take the allegations seriously by demonstrating safety commensurate to the allegations” (Turnell & Essex, 2008, p. 43). Somewhere in the space between theory and practice exists the un-idealized place of ‘real’ protection work; the place where partnerships are constructed with a view to ‘family’ safety, it is the place where change occurs. Turnell and Essex (2008) use a method of “words and pictures” to engage families in a process of exploring, preparing and providing their own story to their children while engaging in the journey of safety. This is the safety organized practice of a solution-focused, strength-based philosophy based in the good work of relationship building.

Scerra (2011) is one of the few writers that have offered any form of critique of the solution-focused methods of practice in child protection work. In her discussion paper she admits there are limited critiques of the model but says that the one most prevalent is

that strength-based perspectives are “at odds with deficit or problem focused approaches” (p. 7), Scerra does however, go on to say that the Signs of Safety model addresses this by considering both the problems and the solutions in work with families. Scerra draws on the research of Gray (as cited in Scerra, 2011), who notes that the continued focus on family responsibility does not “adequately recognize the structural inequalities in society that can impinge on personal and social development” (p. 8). Such a focus, contends Gray, draws attention away from government responsibility and places it back on family and society without addressing the existing inequalities. Scerra concludes that there is a lack of empirical evidence to support the success of the strength-based perspectives in practice however notes that within her research it was found to be successful in work with adult substance abusers, high-risk youth, grandparents raising grand children, parents at risk of abusing young children, children with behavioural disorders, cases of domestic violence and was also seen to have led to improved health, child development and family functioning with Indigenous families.

### **What are the barriers and challenges to a successful implementation?**

“...Signs of Safety is fitting a complex social system into a complex social system”  
(Munro as cited in Turnell & Murphy, 2014, p. 50).

While the literature available around barriers to change in the child protection field are somewhat limited, there are several examples provided in the research related to Signs of Safety. Some of the most obvious barriers or challenges to implementing change in the approach to child protection would relate to the systems within the systems: Bureaucratic expectations related to liability of the ‘state’ often thwarts the alignment necessary between the approach itself and the policy, learning and leadership of any given

jurisdiction (Turnell & Murphy, 2014). Child Protection has not only existed for decades but has evolved over time as policy, legislation and standards are increasingly injected into practice based on what isn't working. There is an inherent ideology based on the values, beliefs and goals of individual organizations but also the field as a whole; child protection has historically been "characterised by organizational requirements becoming the central focus in the mistaken belief that compliance with detailed procedures will create safety" (Turnell & Murphy, 2014, p. 50).

In attempting to manage outcomes using a prescribed set of procedures and various organizational requirements, the actual work with clients is lost and we have reduced the workers ability to determine true safety. The work then becomes about following the 'rules,' filling in the paperwork, and ensuring we are not personally liable for the work we have done. Essentially it becomes about what's best for the worker or the state rather than what's best for the child or family. In their research with frontline staff, Skrypek, Otteson, and Owen (2010) found one of the challenges most mentioned was indeed related to "integrating Signs of Safety approaches into existing child protection protocols and practices..." (p. 2). In addition to this complexity is the inherent stress that accompanies the work we do and the resulting need to 'get it right.' We work with some of the most vulnerable people in society, this has the tendency to heighten the anxiety and fear of workers expected to make well-informed decisions about safety. Having tools, checklists and procedural manuals gives us a false sense of security that there is, in fact, a way in which to 'get it right.'

Munro, Turnell, and Murphy (2014) report that the outcome of the Munro review of 2011 "concluded that the system had become locked into a defensive compliance culture,

underpinned by unnecessary and overly bureaucratic procedures resulting in workers spending less time working directly with children and families and more time—up to 80%—feeding the system. Professional expertise had become eroded and social workers found their role becoming progressively less clear” (p. 1). Furthermore, one of the common complaints of solution-focused work is that it may neglect the inherent risk associated with abusing families if workers maintain a strong focus on strength and engagement with parents (Bunn, 2013). Within this argument, critics have cited the Peter Connelly Serious Case Review in which solution focused techniques were utilized leading to the death of the child in question (Bunn, 2013). Andrew Turnell (as cited in Bunn, 2013) addressed these contradictions in practice in a programme that aired in 2009, stating that “if you are talking about the future without reference to the past, that’s when it can get very dangerous in child protection work” (p. 66). Signs of Safety contains the critical element of tough conversations; we must be able to bring the harm that has occurred to the table in discussions with families and ensure it is considered in the determination of safety. Solution-focused work in itself does not address past harm. However unfortunate, children will die under any protection model because of the complexity of the work we do, it’s how we deal with those deaths that set us apart.

The cultural shift necessary for implementation then requires a commitment to maintain the course even in the face of tragedy, difficulty, and anxiety but it also requires an alignment of policy to the Signs of Safety practice approach (Turnell & Murphy, 2014). This can be very challenging given that “child protection organizations are amazingly reluctant to let go of complex policies and procedures” (Turnell & Murphy, 2014, p. 52). This will be discussed in greater detail in the next section. Additionally

however, Skrypek, Otteson, and Owen (2010) conducted a research study with staff who had begun an implementation in Minnesota, those who were still in the beginning stages of the implementation, reported fear or uncertainty about the level of support offered by their Ministry (the Department of Human Services) and the potential lack of long-term endorsement for continued training in the Signs of Safety model. These staff indicated “they needed a full and long-term endorsement from the state before they could fully engage in the program” (Skrypek, Otteson, & Owen, 2010, p. 2).

Another challenge Turnell and Murphy (2014) allude to is in relation to aligning information management systems with a new way of working. Workers often see the introduction of Signs of Safety into their work as something they need to do in addition to what they are already doing leading to increased anxiety about the workload. Shifting or changing the information management systems can be extremely costly but also complex and time consuming yet essential for organizational change to occur (Turnell & Murphy, 2014). There are also challenges associated with the work being front-end intensive: Systemic structures have not typically supported relationship building, family focused practice at the intake and assessment phases of the work. This is a shift that requires a significant reallocation of staff to the front-end of practice (Turnell & Murphy, 2014).

Also considered a barrier to implementation is working with invested community partners: Child protection work is not done in isolation, we work with various other professionals within the community including police, mental health professionals, medical professionals, judges, lawyers, educators and so on and so forth. “Each professional service has its own etiological and philosophical foundations, language and priorities” (Turnell & Murphy, 2014, p. 53). There can be an initial frustration created

among these professionals due to a lack of understanding about the Signs of Safety approach as well as an inability to comprehend the language of Signs of Safety. Finally, one last challenge relates to the learning strategies themselves: “The most frequent reoccurring error that organizations make in implementing new initiatives is to mistake training for implementation” (Turnell & Murphy, 2014, p. 54). This can lead not only to confusion among workers, but also to dangerous practice if continued learning is not pursued.

Other systemic challenges have been documented in relation to the ideology of child protection and the relative inability to institute change without mandated government authority. Trute and Hiebert-Murphy (2013) first explore the writer’s perspective as a parent with a child who has disabilities and trying to navigate a system designed to address the needs of the child but missing the mark widely when it comes to protecting the family context: “. . . Canadian child welfare services largely retain a “child rescue” stance with a paramount interest in the protection of the child (and with secondary attention given to respecting the integrity and permanence of the child’s family)” (p.6). And, while many children service agencies throughout Canada have adopted what they call a ‘family-centred practice,’ without the necessary government endorsement and mandated authority, they continue to fall short of their aim.

Trute and Hiebert-Murphy (2013) stress the importance of partnering with families in order to achieve the desired goals and outcomes for children and their families. This ‘partnering’ means allowing those parents who are willing and capable, to be the “senior partners” in the development of those service plans (Trute & Hiebert-Murphy, 2013). In fact, the writers contend that the more chronic and ‘un-curable’ the family condition, the

more pivotal the parents become in planning service priorities. They are, after all, the experts of their own families. And, it is within the context of the family-centred approach that parents are empowered to take back control of their situations and initiate the desired changes to ensure the safety and well being of their children. Trute and Hiebert-Murphy (2013) of course recognize that in situations where children are at risk of neglect or abuse, “offending parents have a restricted role in child and family service planning and processes of service delivery while the child is vulnerable” (p.24).

**How could such a change be successfully implemented on a large scale within child protection organizations throughout Canada today?**

*“The uncertainties and tensions, which current policy debates are attempting to address cannot be changed by remedial action aimed at redefining child protection as child welfare, child abuse as children in need or investigations as inquiries”*  
(Parton et al. as cited in Munro, 2008, p. 40).

Society has always held strong views about child protection, and continues to maintain a stance toward what professionals can and should do in cases of neglect and abuse. This has invariably had an effect on the policy and legislation that dictates practice in an anxious environment where uncertainty and error are unavoidable. In studying organizations such as air traffic control, where a high degree of reliability has been achieved, Roberts and Bea (as cited in Munro, 2008) note that key characteristics have been realized: “Giving a clear message that safety is the main priority; managerial factors, such as communicating the big picture to staff so that they understand the rationale for priorities; adaptive factors, such as becoming a learning organization; and having redundancy in the system to catch problems early” (p. 128). Particular emphasis is placed on creating an attitude of learning within organizations to which safety is a priority. Turnell and Murphy (2014) reiterate the need for a strong focus on learning,

saying, “learning needs to be multifaceted and continuous and become built into the fabric of everyday experience of staff” (p. 54). Training itself is only one way of learning, and at best provides only motivation for staff to begin the journey of change but as Turnell and Murphy admit, in itself, has little impact on the day-to-day work of staff. For implementation to be sustained there must be a continuous learning that occurs throughout the life of a practice shift. This would include basic training, core training for supervisors and managers as well as continued coaching on highly complex cases.

Fundamental and sustainable change requires not only support from the highest regions of the established system but also structural support: This means that not only does thinking about ‘what is’<sup>6</sup> have to change but also those structures intended to support that thinking must likewise change. In order to accomplish this task Turnell and Murphy (2014) have said that there are certain structural arrangements that must be in place: Planning and reviewing progress must occur regularly with key players being executive level workers; the practice model must become key to organizational policy; Signs of Safety must align with the detailed policies, procedures and information management systems that guide practice and accountability; and finally, a continued pursuit of understanding around the frontline worker’s experience are all key to successful implementation. Additionally, however, Turnell and Murphy (2014) say, a key requirement to success is in creating a “robust” front-end<sup>7</sup> in child protection practice and engaging critical community partners in the forward movement of a shifting practice.

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<sup>6</sup> This is the ideology of an organization, the beliefs, values and subsequent policies that guide the practice outcomes of individuals within it. It is essentially the epistemology or ontology of living, organized, human structures; why we do what we do in our daily practice.

<sup>7</sup> Front-end practice refers to the screening/intake and assessment work that directs the initial response of workers and determines the future life of a file. It is essentially the investigation phase of child abuse.



In an abstract related to managing successful change in the public sector, Fernandez and Rainey (2006) suggest that key to successful change management is found in the purposeful actions of managers, supervisors and other leaders within the organization. Managers do play a critical role in effecting change within organizations. Turnell and Murphy (2014) also speak to this providing specific details as to what that crucial role would be expected to look like in driving the change forward: “While the process of building a culture of appreciative inquiry around frontline practice must be embedded in regular individual and group supervision, it is vital that senior management replicate this process and practice, particularly when crisis occurs” (p. 46). Managers, Directors or Ministers expecting a change of this magnitude must insist that leaders on the ground pay particular attention to the practice and continue to enforce the shift through ongoing conversations with workers about what is going well. If leaders stop talking about it staff will stop using it.

Munro, Turnell, and Murphy (2014) reiterate that it is imperative that leaders engage with the day-to-day experience of staff, state a commitment to the practice framework, and focus on clarity. There must be evident, a parallel process and organization congruence with the practice framework that is demonstrated using the aforementioned questioning approach while promoting the principles and discipline across the organization. Leaders are also called to foster a “safe organization – building confidence that workers will be supported through anxiety, contention and crisis

- Anxiety is shared upwards and never carried alone

- If workers do their best within the organization's capacity, and they are frank and open but a tragedy occurs, they will be fully backed up by the organization through to the chief executive" (Munro, Turnell, & Murphy, 2014, p. 7).

To accomplish the arduous task of implementation on such a wide scale Munro, Turnell, and Murphy (2014) say the following reforms are necessary:

- Intake/First response – a simplified and single assessment and plan using the Signs of Safety framework
- Continuum of service across early help, family support, child protection and looked after children – using the common framework to allow for seamless transition and service provision.
- Family group conferences and child protection conferences – integrating to be consistent with Signs of Safety.
- Public Law Outline – introduction of pre-hearing Signs of Safety conferences.
- Further integration with other key services such as schools, health, police, youth services... (p. 8).

Wharf (1993) concludes his discourse related to child welfare in Canada taking a hopeful stance saying, "It is our conviction that child welfare services cannot remain in their current unsatisfactory state..." (p. 229). Broderick (as cited in Wharf, 1993) begs the question, "is it possible to move the public service from the era of control and compliance to an era of collaboration, cooperation and commitment?" (p. 228).

Broderick goes on to say, "The idea was that you have to create spaces where you plant this thing and let it grow. And you nourish it and you foster it and eventually you take over" (p. 228). This is, in its essence, what Signs of Safety seeks to do, create an

environment of collaboration and cooperation through nourishing and fostering the good in all that is.

### **What would a strength-based, solution-focused model provide within the Indigenous context?**

In MacLaurin, Trocmé, Fallon, Blackstock, Pitman, and McCormack's information sheet (2003), it is reported that child protection investigation patterns indicate "the overrepresentation of First Nations children is driven by neglect, compounded at each stage of the investigation cycle and associated with structural risk factors such as poverty, poor housing and substance abuse" (para. 1). The authors estimate that 57.30 out of 1000 Indigenous children involved in child protection investigations are substantiated while only 19.84 of non-Indigenous children investigated result in substantiation. However the reasons for substantiation vary: For Indigenous children, 56% of all removals or substantiated maltreatment was due to neglect, while for non-Indigenous children maltreatment was substantiated at 30% due to domestic violence and 27% due to physical abuse. Furthermore, 29% of all investigations involving Indigenous children resulted in a change in residence for the children whether into foster care or a kinship care provider, whereas only 11% of non-Indigenous child protection investigations resulted in a change of residence (MacLaurin et al., 2003). The total number of investigations conducted in non-Indigenous homes in this study was 88,214; the number of investigations conducted in Indigenous homes was 12,111 (MacLaurin et al., 2003). Is it just me, or is there something ominously wrong with these numbers? Looking at Statistics Canada (2008) numbers reported in Table 2 from Chapter 1 of this paper, it becomes evident that very little has changed in spite of the push for provincial reform to child protection in British Columbia. One thing becomes abundantly clear; something has got to change.

Walmsley (2005) explores the historical context of child protection as it relates to Indigenous populations saying that they are vastly effected in two very significant ways: Firstly, clients of child protection systems are “overwhelmingly drawn from the ranks of Canada’s poor” (p. 15) and secondly, child protection intervention “can be viewed as part of the colonization process” (p. 15). Essentially there is a serious overrepresentation of Indigenous children and families involved in the child protection system primarily due to poverty. This, argues Walmsley, is the outcome of the 1960’s social view that children who were facing poverty were in need of protection. The prevalence of this view resulted in a sharp increase in the number of Indigenous children entering care: In the 1950’s there were only twenty-nine Indigenous children in care in British Columbia, but by 1964 that number “had risen to 1,446” (p. 19). The vast majority of Indigenous children who entered care never returned home (Comeau & Santin, 1995).

What workers understand or believe to be situations of abuse have historically had an effect on outcomes for children and families. Baskin (2007) addresses this concern in her dissertation on Indigenous worldviews in the context of social work education. Baskin highlights the need for social work educators to become aware of their biases, stereotypes and cultural indifference through critical self-reflection; this needs to be true of social workers as well. Baskin states, “social workers must practice reflexivity, the critical examination of how their own culture and biases impact on the people they are trying to assist” (para. 29). Turnell and Edwards (1999) draw on the work of Nigel Parton, “arguing that the problem of child abuse, rather than being an objective reality, is a phenomenon that is constructed in the interaction between professionals who are heavily influenced by their beliefs and knowledges, on the one hand, and the family under

investigation, on the other” (p. 15). We must humble ourselves and seek to understand Indigenous values, knowledges and ways of being in the world to truly understand ways of helping. Signs of Safety seeks this type of understanding with each and every unique family and situation, beginning with the frame of reference of the client.

Baskin (2007) also speaks to the impact that social work has had on Indigenous families in the context of colonization; we as workers are recalled in the memories of countless individuals as people who came and took them from their homes in spite of their terror, their tears and confusion. We have become a lengthy part of the history of Indigenous people across Canada, which in turn has led to a paralysing, but understandable, lack of trust in the social worker who knocks at the door. Trust and relationship must be re-established using the “cultural competency” discussed by Weaver (as cited in Baskin, 2007, para. 27). This type of cultural competency is developed in workers over time as they deepen their depth of practice using the principles and practice of Signs of Safety. Agencies utilizing the Signs of Safety approach are seeing a much different outcome: Ktunaxa Kinbasket Child & Family Services adopted the model in 2008 “the most significant statistic seen is that...there is a substantial decrease in the number of children entering care” (Turnell & Murphy, 2014, p. 16). Additionally there was a decrease in the number of contested court matters and lower recidivism rates for those families utilizing the services. Scerra (2011) looks at evidence-based research conducted in a number of studies with Indigenous families and found that strength-based approaches enhanced “protective elements of good family functioning” while addressing “risk factors that were associated with negative family functioning” (p. 3). Drawing on the work of Walker and Shepherd, Scerra also notes that using strength-based work with

Indigenous families resulted in an improvement of “health, child development and family functioning. Their model of good practice has been recognised nationally for improving Indigenous child health and family wellbeing while reinforcing the inclusion of an Indigenous worldview into practice to achieve Indigenous solutions” (p. 3 – 4).

Turnell and Murphy (2014) inform readers that in both Olmstead and Carver Counties, Minnesota, the number of children being taken into care during the years they were implementing Signs of Safety, were cut in half, termination of parental rights dropped drastically as did the number of youth who remained in care. These outcomes are being experienced in jurisdictions across the globe including Sacramento, CA where the number of “African American children entering foster care... decreased by an impressive 53%” (Turnell & Murphy, 2014, p. 19), the Netherlands over 20% fewer children being taken into care, Copenhagen, Denmark again nearly 50% fewer children brought into care during the years implementing Signs of Safety (Turnell & Murphy, 2014). And finally, in just one year after beginning an implementation within the province of Alberta Canada, it is reported by Alberta Human Services (2014) that there has been an 11% decrease in the number of Indigenous children in care. Statistically speaking then, it is safe to say that utilizing a model such as Signs of Safety will result in fewer children being removed from their homes, their families and their communities no matter what the familial culture, background, or ethnicity may be. In my own interactions with over 40 Nations throughout Canada, I have been told again and again by both community leaders and workers alike “this model represents the most traditional way to problem solving; it is how our ancestors practiced conflict resolution and we used it because it worked.”

## **Implications for Indigenous Families**

It is an inarguable fact that there is a significant overrepresentation of impoverished parents involved in the child protection system leading to assessments of abuse, neglect and emotional harm (Walmsley, 2005) but in addition to that there is a substantial overrepresentation of Indigenous families who come to the attention of the child protection authorities (MacLaurin et al., 2003) which again, is likely due to the fact that in Canada, the poor are disproportionately Indigenous women (Walmsley, 2005). We have got to start asking ourselves ‘why?’ Does poverty lead to abuse and neglect or are we simply sitting in judgment based on white mainstream standards? What does risk to children really mean? And when is it safe ‘enough’ to leave children with their families? Child protection practice has got to be able to address how human beings make decisions or arrive at a place of judgment (Turnell, unpublished), how families cope with and provide safety at times of stress, and how children are affected by all of this. Essentially, the outcome of this research will provide a vehicle for change; a method of implementation, the indicators of success and the reasons and benefits for making such a shift. Ultimately it is hoped that this will lead to better outcomes for families; fewer children in care, greater awareness of risk and safety, less stigma associated with child protection involvement, and an overall improvement in the way families experience child protection services.

Comparably speaking, the practice of risk assessment and the resulting removal of children bear far too close a resemblance to the historically paternalistic residential school system (Baskin, 2007). Subsequently, one cannot study any facet of the child protection system without understanding how colonization is systemically embedded into the very fabric of the child protection work itself; we must acknowledge the inequities

that exist and how we as individual social workers contribute to that simply by performing the task of assessment. Assessment is defined as “the act of judging or assessing a person or situation or event” (Assessment, n.d.). But if all we were looking at was deficit in families, how could we possibly form a holistic understanding? We are making judgments based on such limited information about families and with such limited understanding of cultural difference that we are unable to see the strengths that exist within each and every family. It is undeniably time to reconsider the structure and process of assessment. In focusing this research on successful implementation of practice, it is hoped that I can conclude for the reader those necessary components for a transition from an ‘old’ way of thinking to a ‘new’ one.

### **Summary**

In reviewing the available literature, it becomes obvious there is a significant need for a change in the way we approach child protection work. Historically child protective systems have relied heavily on checklists to inform decisions and create safety for children. However, what the literature confirms is that checklists and ticky boxes don’t work to create safety because they simply cannot capture the unique circumstances of each individual family encountered by the system (Crea, 2010). As stated in the review, Mullaly (1997) insists, “historical and current methods of practice have done nothing to shift the current condition of the welfare state and in fact, only continue to contribute to oppressive ideologies and thought structures” (p. 23). The child protection system is inherent with these checklists that have been used by workers everywhere to inform planning and ultimately assess the safety of children and capacity of parents. There are no theoretical underpinnings in the use of checklists, in fact what they do is allow



workers to make decisions without any regard for, or reliance on, the essential critical thinking skills required in such complex work.

Munro (2008) confirms that checklists do not create safety or promote best practice, what's needed then is a model that would insist on the use of intuitive, analytical skills in order to improve our capacity to think our way through cases and minimize bias. Mullaly (1997) reinforces this insisting that theory is absolutely essential in the day to day work of child protection in order to ensure consistency and avoid "drift and purposelessness" (p. 100). Reder, Duncan, and Gray (1993) also take this stance in their discourse confirming that complex relationships require a more sophisticated level of analysis; a framework for critical thinking is unquestionably required in work with families in crisis. This type of thinking simply has not existed among the models of the past that have relied so heavily on checklists, but instead, according to Ferguson as well as Chapman and Field (as cited in Turnell & Murphy, 2014), what we get is a form of "conveyor-belt practice characterized by: responsiveness to efficiency drivers; getting cases through the system; meeting target; speedy casework resolution; and general compliance with policy and practice guidelines" (p. 46).

Child protection work has relied on risk assessment tools to inform us about the potential for future harm to children however, risk assessments themselves are limited in function and capacity because they don't include those "protective factors that buffer the effects of risk factors" (Crea, 2010, p. 4). These are those protective factors such as family strength as well as past and future safety. To date, child protection models in Canada have not been able to capture and apply the strength and safety of families in such a way as to determine its effectiveness in keeping children safe. Typically,

assessment models have been very deficit-based with workers seeking an understanding of the existent problems with the hope of somehow being able to fix those problems, when in fact what we need to be doing is searching for the strength and safety measures in the hopes of re-creating those elements in the lives of families in crisis (Turnell & Edwards, 1999). Instead, with an inherent focus on risk assessment tools, child protection has produced an environment of blame where the primary purpose is to determine who is at fault for the abuse (Reder, Duncan, & Gray, 1993; Turnell & Edwards, 1999). Blame creates an adversarial approach to child protection work wherein workers become defensive in their work with families and unable to think their way into and through the information surrounding a case. In such a climate children are more likely to be removed from their families with little hope for return.

Also inherent in the work we do is the danger of emotional responses and triggers: Because we are complex emotional human beings working with other complex emotional human beings, it is highly likely that we will respond to situations with emotion. This means that we will respond differently to families who are cooperative, remorseful and likeable than we would to those families who deny, who are uncooperative and unfriendly. Both Crea (2010) and Reder, Duncan, and Gray (1993) speak to the downfalls of emotional responses in protection work and the subsequent bias and obvious dangers associated with such responses; in many cases these lead to poor decisions, the inability to form relationships and worst case scenario, death to children. To date assessment models have been unable to equate for emotional responses in the work and as a result have left decision-making open to interpretation based on the family's ability to get the worker to 'like' them.

Turnell and Murphy (2014); Munro (2008); Reder, Duncan, and Gray (1993); Mullaly (1997); and Crea (2010) all conclude that there is an intense and consistent need for decisions to be made in a climate of relationship that would include family, friends and community because it is within these systems that we find the protective factors necessary to keep children safe. As a result family, community and friends should be involved in decision-making for family safety. In this climate, actuarial assessment tools become only guides for the work we do not to be relied upon alone for decision-making involving children at risk. Turnell and Edwards (1999) discuss the existing gap between theory and practice and say cooperative relationships with clients are the way to close that gap. It is critical thinking that is required in our work with families, not checklists, and this can only be generated through thorough, rigorous, solution-focused questions with families making them the experts of their own situations (Turnell & Edwards, 1999).

Barriers to an implementation such as the one being studied here seem to be more frequently found within the system itself: Bureaucratic expectations thwart alignment between the approach, the policy and the learning necessary for change (Turnell & Murphy, 2014). The ever-present emphasis on paperwork also has an effect on the ability of workers to adopt and maintain a course of learning, instead it becomes about what is best for the worker (or state) rather than what's best for the child and family and in such an environment workers become less clear about their perspective role with the family itself. Many workers fear that an approach that focuses on strength and safety will direct workers away from the potential risks and thereby put children in danger of being harmed. It is this fear-based practice that leads inevitably to the needless removal of children from their homes, families and communities. Skrypek, Otteson, and Owen

(2010) maintain that one of the greatest barriers or challenges to implementation is related to workers' "uncertainty about whether and to what degree the Minnesota Department of Human Services would continue to support Signs of Safety in the future... feeling they needed a full and long-term endorsement from the state before they could fully engage in the program" (p. 2). This fear creates a hesitancy in workers that prevents them from moving forward and adopting the Signs of Safety approach in their work.

Turnell and Murphy (2014) have noted several areas of concern related to the inability to successfully implement: Commitment to maintaining the change in the face of tragedy, letting go of complex policies and procedures, aligning information management systems with a new way of thinking, structural changes needed to address the front-end intensive work, community partner responses and finally the learning required to make such a shift possible in offices, regions or even provinces where hundreds or even thousands of social workers will be required to change their practice.

Successful implementation of these requirements, according to the literature review would require constant and clear communication; the creation of a learning organization through continuous training and in-house coaching (Reder, Duncan, & Gray, 1993; Turnell & Murphy, 2014); support from the top that would include alignment of policies, procedures and management systems; engagement with community partners; and the purposeful action of managers, supervisors and leaders. According to Turnell and Murphy (2014), the work of the management/leadership teams must be a priority and must ensure there is an intentional focus on the practice which can be accomplished through an appreciative inquiry of the good work of frontline staff; in this way the shift will be forced through continuous conversations while creating clarity of practice. These

leaders in organizations must be committed to the practice and should be able to parallel the model in supervision with their staff; asking the rigorous solution-focused questions will not only role model their commitment to the shift but will also create an environment of understanding around the safety of children. Anxiety for the work must be shared ‘up’ with workers feeling supported and knowing that in the face of tragedy they will be backed by their leadership (Turnell & Murphy, 2014). “When fatality happens, practitioners hold their breath, the underlying organizational culture is exposed and this is when agency leaders must demonstrate they can lead appreciatively and rigorously” (Turnell & Murphy, 2014, p. 46).

Based in the knowledge of family and community, Signs of Safety has the potential to create real and lasting change for Indigenous families and communities, it has the power and potential to return to communities what was taken; the capacity to provide safety, make decisions and govern the welfare of their children. This potential is created when we share knowledge and begin to value the beliefs of others, setting aside bias and white, mainstream values for the sake of partnering with people to ensure safety for children as a first and foremost priority (Baskin, 2007). The statistics provided by MacLaurin, Trocmé, Fallon, Blackstock, Pitman, and McCormack (2003) would indicate that Indigenous children enter care predominantly due to poverty, poor housing and substance abuse. This has always been a ‘gray’<sup>8</sup> area for workers attempting to determine future risk to children under these circumstances. What we know about Signs of Safety is that it redefines harm and danger, clarifying for the worker what is actually a safe standard of

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<sup>8</sup> In child protection we refer to gray areas as those situations that are not ‘black and white;’ it has often led to uncertainty about whether or not the neglect has harmed the child or would lead to future harm to the child. As a result these situations have often times been assessed based on the worker’s own values or feelings about what is an acceptable standard of care.

living for children. It also recognizes the harm that we (child protective services) have done to children by removing them from their families, their homes and their communities and thereby considers more starkly, what is in the best interest of children. Essentially, it removes the guesswork from the practice, insisting that workers think critically about each and every case as a unique situation and thereby removing the worker's bias about a given situation. It is respectful and mindful of the safety that already exists within family and community and considers this within the assessment framework to determine if there is enough safety for children to remain in their family unit.

## Chapter 3: Research Design and Methodology

### Introduction

After much consideration, struggle, frustration and what I can only describe as mental chaos, I finally came to rest with an auto-ethnographical approach to my research. Initially, as I examined the literature available on the various theoretical frameworks for research, I struggled to find a fit for this particular research design and one that spoke to my own epistemological and ontological knowing. However, throughout the duration of my own change experience I recall several points of epiphany that shifted the trajectory of not only my practice but also my outlook on people and on life itself and I wondered if perhaps the exploration of these through the auto-ethnography might be of benefit to others who are navigating this difficult terrain (Ellis, Adams, & Bochner, 2011). Furthermore, in reviewing Baskin's discourse (2007), I was compelled to consider how this method fit with my own epistemology in that our experience or 'memory' is "inclusive of spirit, blood memory, respect, interconnectedness, storytelling, feelings, experience and guidance" in this "it is perfectly acceptable and appropriate to believe that there is much that I am aware of, but that I cannot explain" (para. 6). Baskin goes on to describe the benefits of introspection on meaning making and concludes that knowledge is based on our experiences. Finally I find sense in the world of research.

As a former social worker I experienced working both with the BC Comprehensive Risk Assessment and the Signs of Safety model and have seen incredible outcomes as workers shift their practice, their thinking and their way of approaching families. I have worked with countless social workers, both Indigenous and non-Indigenous, and when I examined the research possibilities through my own way of knowing and understanding,

I knew that the best contribution I could make was through an auto-ethnographical study which allowed me to incorporate my personal journey into the research as one individual sharing the values, beliefs and understandings of the larger system. This I felt would lead to a much deeper, perhaps richer understanding of the whole.

But there was more; I grappled relentlessly over my ‘white’ involvement in that portion of the research that would inevitably focus on how child protection assessment and practice interrogates and marginalizes Indigenous families. It was because of this that I felt the need to incorporate the critical race theory as a part of my research. According to Creswell (2007), “critical theory perspectives are concerned with empowering human beings to transcend the constraints placed on them by race, class, and gender” (p. 27). The goal of the critical theorist is to explore social institutions and highlight “the historical problems of domination, alienation, and social struggles” (p. 27) thereby illuminating the possibilities for future change (Creswell, 2007). This definitely spoke to my motivation for doing this particular research study. Brown and Strega (2005) carried this even further for me in stating that, “the agenda of critical social science is to uncover myths, reveal hidden truths, and help people change the world for themselves” (p. 208). Of course there are limitations to utilizing critical race theory in research with the Indigenous experience in Canada, this will be discussed later in this chapter.

Having been given the right to maintain authority over their own child welfare and then having the Provincial government claw back those rights with an insistence that the Indigenous agencies continue to follow the very same frameworks, methods, assessments and practice as the ‘white man’s’ system, is nothing short of paternalism resulting in the



continued injustice toward Indigenous populations and silencing communities who are searching for something better for their children. It is for this reason that I advocate for the right of Indigenous agencies to choose the framework under which they wish to provide services to their communities and to choose a way that is traditional, respectful and mindful of the various cultures of Indigenous people across the globe. The desire for this research is that it will not only expose the government's paternalistic nature but also provide information that would empower agencies to take a stand and become the exclusive providers of their children's welfare.

## **Methodology**

### **Narrative Methods**

Kimpson, (as cited in Brown & Strega, 2005) writes, "Narratives create an opportunity for us to construct ourselves and our research in ways that may be of methodological and political interest to others..." (p. 73). Generated through self-reflective writing, the narrative is a tool for making visible the nature of knowledge opening up the possibility of different perspectives. According to Grosz (as cited in Brown & Strega, 2005), this leads us to "a multiplicity of positions in fields that up to now have been governed by a singular, exclusive, and privileged access to true representations and valid methods of knowing reality" (p. 75). I chose the narrative approach to the study because, like Creswell (2007) states, it is flexible and evolves as the research unfolds but it also utilizes themes, metaphors or even plots to unveil the work. Within the narrative there is both a speaker and an audience and it is between these two that "a sequence of events are communicated which create some kind of shared (even if perceived differently) space in which meaning emerges" (Graugaard, 2014, p. 1). Like Atkinson and Delamont (as cited in Graugaard, 2014) claim, narratives are "embedded in social encounters, they are part

and parcel of our everyday work; they are amongst the ways in which social organizations and institutions are constituted...” (p.2). The decision to use the narrative method was based on the desire to share what I have learned through my experiences, with those considering or undergoing change within their own child protection organizations.

The risk associated with using the narrative methodology develops from the collection phase of study and typically is a result of having narrow questions or from filtering out certain data; this puts the researcher in a position of speculation about the data denying subjects a voice in the process of reporting outcomes (Graugaard, 2014). In order to avoid speculation the researcher must respect the complexity of human relations beginning with the recognition that there are multiple realities among groups of people studied (Graugaard, 2014). This understanding allows me to engage in the study as a participant, sharing my own experience as a frontline worker and as a consultant/trainer. I am essentially observing my own past from the distance created by time, it is an observation of a time and space that allows me to be somewhat separate from the experience itself because of the time lapsed.

### **Auto-ethnography**

The framework or methodology of this study is based on a qualitative analysis, employing the critical race theory within an auto-ethnographical framework. “Auto-ethnography is an approach to research and writing that seeks to describe and systematically analyze personal experience in order to understand cultural experience” (Ellis, Adams, & Bochner, 2011, para.1). Atkinson and Hammersley (2007) make it clear that the ethnographical researcher does not create conditions for the research instead

people's actions are studied in everyday contexts. My actions, in this case, are studied in every day contexts. Delany, Didion, Goodall, and Herrmann, contend that the "author does not live through these experiences solely to make them part of a published document; rather, these experiences are assembled using hindsight" (as cited in Ellis, Adams, & Bochner, 2011, para. 5). Atkinson and Hammersley further state that data collection is unstructured and doesn't necessarily follow a fixed design and categories used for interpretation are generated out of the process of data analysis which "involves interpretation of the meanings, functions and consequences of human actions and institutional practices" (p. 2) and how these effect the broader context of the organizations or communities effected. Verbal descriptions, explanations and theories are typically the outcome of this methodology. This approach interested me and was among the reasons that I chose the narrative auto-ethnography; my design is based not only on an extensive review of the literature but also on my personal experiences and reflections as I look back over my years of involvement in the environment of change.

My personal experience with change began on the frontlines of social work as a supervisor leading the change initiative itself but later as a consultant and trainer working with organizations across Canada. As a consultant and trainer I wanted to pay particular attention to understanding the successes, challenges and future needs of environments undergoing the change process so that I could improve my own ability to provide the information and supports necessary for success. To accomplish this, I began to engage in a self-reflective practice, taking field notes of the change experience as well as videos of myself at work. As an independent consultant it is difficult to find ways to create learning experiences in order to enhance my own work. This is due to the isolation

experienced by many of us in the field, with only a handful of practitioners across Canada and only three of us in Western Canada; I found I could learn by focusing on my own practice, the good work I did as well as some of the challenges I experienced in order to create future goals for myself. It was this habit or practice I developed over the years that allowed me to bring forward years of collective experiences. This practice was something that was encouraged by my mentor Andrew Turnell, but it also aligned with the practice framework itself. I knew that best way to learn was by reflecting on my own behaviours when I was training and consulting but in doing this I was also able to understand the experiences of other workers who were navigating the change environment.

My methodology then, will utilize my personal experiences within the change environment pulling together the meanings, functions and consequences within the stories as they relate to the challenges, success and needs. It is my hope that in using my personal experience to illustrate various aspects of the organizational ethos within the change environment, I can familiarize readers with the change experience itself (Ellis, Adams, & Bochner, 2011). To accomplish this I will categorize and structure the information gathered from field notes while pulling in information collected from the literary review to systematically analyse the most common occurrence throughout the data. In this way I am able to analyse and combine my experience with data gathered from relevant literature allowing the data itself to pursue answers to the questions posed.

The combination of autobiography and ethnography means that this type of research method is both a process and a product (Ellis, Adams, & Bochner, 2011). “When writing an autobiography, an author retroactively and selectively writes about past experiences”

(Ellis, Adams, & Bochner, 2011, para. 3), while the unit of analysis in ethnographic research is very large and typically composed of one particular group being studied in order to describe a shared experience (Creswell, 2007). This is reinforced by (Ellis, Adams, & Bochner, 2011) saying “an autobiography should be aesthetic and evocative, engage readers, and use conventions of storytelling...” (para. 10) as well as “showing,” which allows writers to invoke emotion by bringing readers into the story with the use of a vivid writing experience (Ellis, Adams, & Bochner, 2011). The purpose of this research then, is to use my experiences through storytelling and ‘showing’ to uncover an understanding of change and discover the realities and/or possibilities of successful change management within child protection organizations.

The rationale behind the methodology chosen for this study is based on my own knowing, my beliefs, values, understanding of and interaction with the world around me. The philosophical assumptions position me in a particular place within the research itself and as a result will have an effect on it. Those philosophical assumptions are based on my own ontology, epistemology and axiology; these are, respectively, my “stance toward the nature of reality” (Creswell, 2007, p. 16), how I know what I know, and the role that my values play within the research itself (Creswell, 2007); reflexivity (self-location) will be used to address these within the paper. The axiological assumption in qualitative research is that the researcher brings with her a set of values and biases that need to be made explicit within the research. To address this Creswell (2007) contends that the researcher must position themselves within the study admitting, “that the stories voiced represent an interpretation and presentation of the author as much as the subject of the

study” (p. 18). I have addressed this concern within the study as I make known to the reader my own biases in relation to the subject matter.

As stated earlier in this chapter, I maintained field notes that were based on my own understanding of the change experience in organizations that were undergoing change. These recordings were made while I was out in the field not only to better understand the experience of change but also to improve my ability to provide useful support, advice and guidance in the future. My intent was to capture my experiences in a way that would ensure information would not be altered, lost or misperceived so I recorded these experiences in a format that was both familiar to me and one that allowed me to segment my thoughts into the areas that most concerned me (Appendix A); what I didn't know then was that it also ensured consistency of data gathering. These field notes are then evocatively re-storied in Chapter four in order to bring the reader into the ‘telling’ of the change experience so that they might experience the experience themselves (Ellis, Adams, & Bochner, 2011).

An objective study is quite impossible to achieve when the researcher is the object of study however it is possible to ‘bracket,’ or at least acknowledge, any preconceived assumptions or values held by the researcher. Brown and Strega (2005) assert that “the task for the researcher is to notice, acknowledge, and be reflexive about what her biases and values are, and hold these separate from the data in order to correctly interpret the material being gathered” (p. 207). Essentially the researcher needs to be as transparent as possible throughout the duration of the study. Thus an understanding and subsequent statement of my own values and philosophical assumptions is necessary to acknowledge before beginning the research itself; this will be explored later in this chapter.

### **Critical Race Theory**

I chose to base my methodology in critical race theory because it recognizes that racism is engrained in the very fabric of society; whether we acknowledge it or not, it is systemically inherent in the social institutions that govern society and subsequently within the dominant culture (UCLA, 2014). Utilizing this particular theoretical foundation for study, however, was not an easy decision for me: I held a great deal of fear and hesitation around conducting any kind of research that would include the study of Indigenous experience. That fear or hesitancy is based on my own ‘whiteness’ or lack of the ‘true’ Indigenous experience. Although I have spent my career working in Indigenous community, I have never lived the experience of the Indigenous people and cannot speak in any way to the epistemology of those I’ve worked with. I was concerned with ensuring that the outcomes did not impose a particular reality upon those Indigenous groups I worked with but was also mindful of the need to include my experiences in these communities because of the impact that child protection has had on the families and communities of Indigenous peoples across Canada. It was a challenge that I wrestled with for three years and one that kept me from completing this work sooner. If I look deep within myself I might recognize that the fear of doing this research is actually a fear of disrespecting those who I have sought to ally with; that I might somehow get it wrong or misrepresent the voices of those who so critically need a voice. Essentially I did not want to ‘use’ my experiences within the Indigenous contexts to benefit myself, or others, in a way that might be construed as disrespectful. In any event it has not been an easy decision, and as such these limitations will be further discussed later in this chapter.

Critical race theory seeks to examine the existing power structures while identifying how these perpetuate the marginalization of the group or culture studied (UCLA, 2014).

According to Fay (as cited in Creswell, 2007), its commitment is to social justice and the elimination of all forms of oppression and is dedicated to “empowering human beings to transcend the constraints placed on them by race, class, and gender” (p. 27). In this thesis I wanted to pay particular attention to the overrepresentation of Indigenous children in care due to the systemic racism and resulting oppression. However, critical race theory cannot be utilized without some discussion of its limitations and how it relates to Canada’s Indigenous populations. “Originally developed to address the civil rights issues of African-American people...it was oriented toward an articulation of race issues along a ‘black-white’ binary” (McKinley & Brayboy, 2006, p. 429) leaving other ethnic groups and considerations out of the conversation. And, while the basic tenet of critical race theory maintains that *racism* is endemic in social institutions, McKinley and Brayboy (2006) take the argument for Indigenous populations further saying that *colonization* is endemic in social institutions and as such have termed their work using ‘Tribal critical race theory’ or ‘Tribalcrit.’

McKinley and Brayboy (2006) make explicit the need for social change within those institutions where Eurocentric knowledge and power continue to dominate, saying researchers “must work to expose structural inequalities and assimilatory processes and work toward debunking and deconstructing them [while] creat[ing] structures that will address the real, immediate and future needs of tribal peoples and communities” (p. 440). McKinley and Brayboy (2006) conclude that while critical race theory was initiated in consideration of the ‘black-white’ racial struggle in the U.S., viewing it through an Indigenous lens is possible utilizing the nine basic tenets of ‘Tribalcrit’ which allows for the broader discussion of how colonization continues to thrive in our institutions with



Eurocentric thought well entrenched in the theory and practice that governs those institutions. Utilizing this theory for research then, allows the researcher to view patterns of domination and colonization through the lens of Indigenous “traditions, ideas, thoughts and epistemologies” (McKinley & Brayboy, 2006, p. 441) on which the theory is based.

In the view of Fay as well as Morrow and Brown (as cited in Creswell, 2007), critical researchers look at “social institutions and their transformations through interpreting the meanings of social life; the historical problems of domination, alienation, and social struggles; and a critique of society and the envisioning of new possibilities” (p. 27). The goal is to understand and change the social institution under study while empowering underprivileged groups through critical analysis and exploration of what constitutes the underlying ideology of domination. Critical race theory then, is to present stories of racism and how they are embedded in society in an attempt to “build cases against racially biased officials or discriminatory practices” (Creswell, 2007, p. 28). Child protection is an institution that has systematically sought to maintain power and control over the welfare of children with little to no regard for race or culture; it is a system constructed and administered in the upper echelons of a bureaucratic, bourgeois Canada. Through utilizing the critical race lens this study will seek to uncover the foundational flaws within child protection while exposing the need and the potential for change.

herising, F. (as cited in Brown & Strega, 2005) discusses the complexities involved in critical research using her discourse on “politics of location” (p. 133). The job of the researcher, according to herising, is to decenter and dislocate “our assumptions, values, and knowledges” in order to establish “the groundwork for articulating the processes and relationships of our research and research subjects” (p. 134). The author lends rich

insight into such research, saying further, “examining our own politics of location in relations to the subjects of our research can shift the terms of our inquiry. This examination is an invitation for us to become more accountable to our inquiries, to the processes of our research, and ultimately to the voices of the margins” (p. 134). This is very important to me as the researcher because of my own fear around doing research relating in any way, to Indigenous community

### **Summary**

In summary, the auto-ethnography grounded in the critical race theory allows me to utilize my personal experiences within the change environment to create a thick description in order to “help facilitate [an] understanding of a culture for insiders and outsiders... created by (inductively) discerning patterns of cultural experience – repeated feelings, stories and happenings – as evidenced by field notes...” (Ellis, Adams, & Bochner, 2011, para.13). Recording outcomes in narrative fashion allows me greater opportunity for reflectivity while also highlighting the potential for a multiplicity of positions within the research. It enables me further, to utilize the available literature and seek themes and inconsistencies in and across the data while also, very sensitively and respectfully, pulling in my experiences within the Indigenous context. In this way I feel the study will be of benefit and of interest to any child protection organization in Canada.

### **Research Design**

The narrative approach to study allowed me to become involved in the research itself as a participant seeking to unravel my stories in order to better understand how change can be successfully implemented in child protection organizations today. I chose the auto-ethnography as a method for conducting the research with a critical race lens in

order to better understand the change experience in one of the most paternalistic institutions in Canadian history but I also wanted to understand how change might effect Indigenous organizations to ensure there are adequate resources available to meet the unique needs of this very complex environment.

Narrative research will be used because I feel it “is best for capturing the detailed stories or life experiences of a single life...” (Creswell, 2007, p. 55). It simply allows for a more detailed description of the experiences being studied. Essentially what I hope to achieve through conducting an auto-ethnographical study supported by the critical race theory, is that successful change is not only possible but also necessary.

### **Data Gathering and Analysis**

This research involved an extensive study of the available literature on various models of practice with inclusion of my own experiences as a practitioner both from the frontline of direct practice as well as a consultant/trainer aiding workers to adapt their practice and shift their thinking about the way we work with people in crisis.

The research includes a description of the child protection change experience as reflected in my field notes throughout mainstream and Indigenous organizations; a redefinition of risk and safety; a challenge to the ideology and methodology of the dominant paradigms and their effects on Indigenous family; an in-depth discussion about the human ability to make decisions and the consequences of the resulting assessments; a description of the indicators of successful practice and implementation; and a concluding strategy for organizational change.

During the past six years I have spent a great deal of time reflecting on my own practice, the changes it has incurred and the hoped for outcomes I will achieve based on

that change. This self-reflection was something I learned to do as part of my own practice in order to ensure continued growth and increased understanding; it was also something that improved the longer I utilized the Signs of Safety model. Baskin (2007) confirms the need for this saying “in order to find meanings in the world around us, we must continuously explore our inner selves” (para. 7). My mentor, Dr. Andrew Turnell, once told me that if I want to be the best I could be then I needed to videotape all of the work I did as a trainer and spend the time translating those materials to seek and find my greatest source of strength and then do more of that. He wanted every conversation documented to ensure clarity of understanding but also to grow the best practitioners possible. It was through this that I began to record all of my experiences and conversations whether by video, picture or written materials. And, it was in the review of these materials that I began to see the unraveling of shared experience.

In addition to self-enhancement, my desire as a trainer and consultant was also to continuously improve the experience of participants; I was driven to record my experiences in the field to evoke a deep understanding and appreciation for the work effort needed to shift the philosophy of an entire organization but also to improve the experiences of other workers (Appendix A). Within the context of this study it is hoped that I might be able to pass the accumulated knowledge on to others in order to generate both empathy and support from the people who would likely never truly know what it was like to knock on the door of a family in crisis, and who would never truly experience what it was like to be at the precipice of this difficult learning journey. Essentially, it is intended to help readers ‘experience the experience’ through the reflections of my

journey and to recapture the essence of a successful change management approach in child protection.

The information accumulated over my years of working within the environment of change was re-storied in ‘Chapter Four’ to provide continuity and ease to the reader. However, the original data or field notes were initially recorded and/or placed in analysis charts or tables (Appendix A) in order to reorganize my thoughts and reflections of the experiences and provide an ability to view the collected data as a framework of categories and themes (Creswell, 2007). I separated the gathered information from my notes into subgroups that would help me to see and understand any distinct differences between my experiences in mainstream offices, and those in Indigenous agencies, which is where my change journey began.

I began my analysis by going through and sorting those things from the first category, “things that were going well,” from each of my experiences within the different groups (Indigenous, non-Indigenous, supervisors) and worked through each category subsequently; I then worked to color code any themes that were emerging from the data, going through it over and over again until all of the data was coded (Kirby & McKenna, 1989). Still at this point the themes were too broad so I went back over the information with the themes that had been constructed and began to see that many could be contained within one common theme; I then began to group those pieces together under headings, which became the primary categories of similarity (Kirby & McKenna, 1989). What I noticed at this point however was that the initial subgroups, Indigenous and non-Indigenous contained slightly different themes and as such I would have to report these findings in the distinct subgroups. By now I was beginning to make sense of the data

with commonalities unfolding and finally, I felt that I was ready to begin my analysis of the information and begin sorting the findings within each group to create a narrative that would weave its way through all of the accumulated information.

In following the qualitative research design of Creswell (2007) I used multiple sources of data to “validate the accuracy” of the findings then worked to “triangulate” (p. 46) those data sources by consulting the literature and finally I coded, grouped and re-grouped the findings as I sought to find commonality within the recollections of the various change environments. Kirby and McKenna (1989) refer to this as cross-referencing and use it as a means of searching for trends, themes or patterns of similarity throughout the data that could be the beginning of categories. This way of managing, organizing and finally analyzing the data made most sense to me, Kirby and McKenna also speak to this method saying,

the general analytic design consists of examining how data items and groupings of data items generate specific and general patterns. This is done primarily by going through the constant comparison of data items with other data items until sections that “go together with” or “seem to help describe something” can be identified and located together in a category file. (p. 130)

In order to truly understand the indicators of successful implementation I needed to first understand the challenges and barriers to implementation based on a multitude of experiences within the change environment with comparative value being sought in previous research and literature. Analysis of the data meant “moving data from category to category (constant comparative), looking for what is common (properties) and what is uncommon (satellites) within categories and between categories” (Kirby & McKenna, 1989, p. 146). Once I sifted through the data, charting and narrowing into themes and categories, arranging and rearranging until sensible patterns emerged (Kirby & McKenna,

1989), I was better able to attain a more collective and focused view of the change process. It was from here that I was able to begin to categorize the successes, challenges, barriers, fears and essential needs within organizations. Once I reached this point, I was able to produce an outcome containing the strategies required for organizational implementation and finally to conclude with a narrative outline of those strategies for change. The conclusions then, were drawn by analyzing, coding and categorizing the accumulated data (my field notes) in order to make sense of my experiences in the field; and then using Creswell's (2007) method of triangulating other sources (literature) in order to validate the unfolding conclusions.

### **Ethical and Political Considerations**

Conducting a study in my own "backyard" has been described by Glesne and Peshkin (as cited in Creswell, 2007) as "dangerous knowledge that is political and risky" (p. 122). This caution is most important when the information being generated from the outcome of research is important to the very organization being studied. To address this issue Creswell (2007) recommends, "multiple strategies of validation be used to ensure the account is accurate and insightful" (p. 123). Such validation in study can be achieved through proposed techniques such as "prolonged engagement in the field and the triangulation of data sources..." (Creswell, 2007, pp. 203-204). The researcher doesn't do this however, in order to make the experiences part of a published document, they are rather "experiences assembled using hindsight" (Ellis, C., Adams, & Bochner, 2011, para. 5). Furthermore, rich description is necessary to ensure transferability between the researcher and the reader (Creswell, 2007; Ellis, Adams, & Bochner, 2011). To address this I have relied on the outcomes of similar studies along with the literature resulting

from years of research coming out of the implementation in Western Australia, not to mention my ‘prolonged engagement’ in the field itself.

The information I accumulated over the years was the result of my experiences in organizations that were involved in an implementation within the child protection field. Over these years I maintained field notes documenting my reflections of the change experience so that I could better understand the challenges and implications for future success in organizations as a whole. That information has been stored on a pass-coded computer and now within this thesis. The information is the collective notes of my experiences and critical reflections upon those experiences. At the same time, this study focuses on the systemic racism inherent in the very structures of child protection practice in order to better understand the racial underpinnings of a system characterized by paternalism and mistrust. This research is not intended to address the personal sphere of individuals; it is rather, a study of the broader context of change in organizations where individuals perform roles. And, as Spicker, P. (2007) states, when pondering the ethical considerations of this type of research “the rules which apply in these circumstances cannot be the same as those that apply to people individually...” (p. 2). This work then, is simply a reflection of my own experiences within the climate of change in a field that has long needed wide-ranging reform.

I realize that I have taken some risks in conducting research in this fashion but at the same time I know without a doubt that change in the field of child protection is not only inevitable, but also absolutely essential and research is needed in order to help us better understand what it will take to get there. And, while this research may disturb the status quo of those child protection systems that continue to utilize the more paternalistic



models in their approach with families, the research itself is not intended to, nor is it likely that, any of the organizations I worked in will be harmed in the process. Furthermore, there is no likelihood of children and families involved with child protection systems becoming harmed as a result of this discourse, in fact, they could only surely benefit should this sway any organization to shift their practice to a more meaningful, more hopeful approach.

## **Merits and Limitations**

### **Merits**

The merit to conducting an auto-ethnography through the critical race lens is that it allows ‘the researcher’ to self reflect on a multitude of experiences within a given organization including the axiological, ontological and epistemological nature of the group itself in order to produce an in-depth narrative that will deconstruct and reconstruct that organization in a way that will benefit those readers who may stumble upon this discourse in the years to come. As Denzin and Lincoln (as cited in Creswell, 2007) state, “qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world” (p. 6). Quite simply I wish to transform the world. Implications of this and any related research are far-reaching and have the potential to create a more positive, hopeful world where children will find safety at home in the loving arms of their parents and where social workers will once again return to doing ‘real’ social work, producing meaningful outcomes for people across the globe.

I recognize that I hold a certain degree of bias that needs to be stated and understood as a researcher involved in this study. And, though I have covered the reasons for this bias in the limitations section of this chapter, my bias itself is that through my lived

experience I have come to see that the child protection system has been damaging families through the use of intrusive intervention in child protection for decades. After being introduced to Signs of Safety I have come to see that there is a better way of working with people and that this model is the best child protection model available in the world today. Of course, this isn't just a model; it is a theory that requires a philosophical shift in thinking. I see this as a re-creation of the very foundation of the child protection system: It is true a change like this is not easy because it requires a complete shift in the way practitioners think about what safety is and what the threshold of risk is or should be. The rewards however, to a deconstruction and re-construction in child protection, are immeasurable.

### **Limitations**

As a practitioner who has utilized at least two of the methods of practice being explored within this research, I have to admit that I may hold some bias: After years of working with families under the British Columbia Risk Assessment model, I became very disillusioned by the complexity of the work, the level of anxiety in families and the resulting mistrust, suspicion and ultimately both the failure of systems to meet the needs of the children as well as the lack of successful change within the family unit. Child protection involvement was visibly cyclical and perpetual as I saw children in care grow up and have their own children become involved with child protective services. Was there any way to lower recidivism rates and create lasting change with families? It was disheartening as a worker to experience the hopelessness of the system from the side of the so-called 'expert.' What was I doing wrong?

In 2008 when I was introduced to the solution-focused, strength-based model of Signs of Safety, I began to recognize an almost immediate shift; not only were the families experiencing real and lasting change but the staff I supervised were experiencing more satisfaction in their jobs as well. Could it really be that Signs of Safety was having an effect on the work we did with families? There was less conflict, more cooperation, more buy-in with the safety plans and perhaps more importantly, greater family and community involvement. No longer was I expected to solve the problems that existed within family units, that became the task of the experts – the family itself. I was there to ensure there was safety but families were once again held accountable for the safety of their children, they became responsible and as this happened their reliance on child protection workers and services began to diminish; why? Because they were actually doing the work themselves, relying on their own strengths and family systems for support and change. McKenzie and Hudson (as cited in Walsmley, 2005) state, “Colonialism involves creating dependency among a nation or group...” (p. 15). In other words the child protection system as we have known it for decades is an (often) unnecessary intervention with the goal of colonization of one nation against another; “it is the process of subjugating First Nations peoples to the norms and values of the dominant Euro-Canadian culture” (Walsmley, 2005, p. 15) in an effort to solidify control over a group of people. Had we actually begun the work of decolonization?

These experiences have helped shape the values, beliefs and assumptions that I bring to the research itself; as such I recognize the need for transparency as a researcher. In other words, prior to beginning the research, I already believed Signs of Safety to be not only the best child protection practice model out there, but also that it was evidently

possible to implement it on a large scale. It will be essential that I address this bias by acknowledging the ontological, epistemological and axiological implications in the research and allow the outcomes to evolve out of the materials researched without directing it personally. As Creswell (2007) states, “different researchers embrace different realities...” (p. 16). Furthermore, I will need to be explicitly aware of my assumptions about the research and attempt to bracket them as much as possible to obtain a unique and unbiased perspective on the subject matter (Creswell, 2007).

Another limitation that may need to be addressed is motivation. I have to ask myself what my motivation for doing this particular study is. Is it to see people and organizations everywhere benefit from a hope-filled, respectful practice in child protection work? Is it to see Indigenous communities take a stand against the patriarchal systems inherent in Canadian society still today? Or, is it to further benefit my own practice, my business and my knowledge of the practices available today? I guess you could say for certain that it is all of the above however I genuinely want to see a change in child protection practices being ‘ad-ministered’ to Indigenous families today. I truly want to see the day come where service recipients no longer feel stigmatized by the need for help, where they can actually turn to social workers for the help they may desperately want and need. In order not to jeopardize the outcome and to ensure I maintained a respectful balance, keeping the interests of child protection agencies at the forefront of my research, I documented and thoughtfully considered my reflections throughout the duration of my study.

## Chapter 4: The Data

Stories are “complex, constitutive, meaningful phenomena that teach morals and ethics, introduce unique ways of thinking and feeling, and help people make sense of themselves and others” (Ellis, Adams, & Bochner, 2001, para 2). This widens the production of meaningful research grounded in personal experience. It is for this reason I begin at the beginning of my own story, my own experience with change in the environment of child protection work. In order to better understand my own biases, beliefs, values and interpretations of the change environment in child protection I was determined to write about them in sections as I experienced them within the different environments or ‘subgroups.’

### **My Story as a Frontline Worker in Child Protection**

Autobiographical narratives “create an opportunity for us to construct ourselves and our research in ways that may be of methodological and political interest to others struggling with alternate forms of representation in the lives of marginalized people” (Kimpson, 2005, p. 73). “The elements of focusing on a single individual, constructing a study out of stories and epiphanies of special events, situating them within a broader context, and evoking the presence of the author in the study all reflect the interpretive form of study...” (Creswell, 2007, p.88). One of the core elements of ethnographic study positions the researcher within the research itself by being both an observer and participant in the environment being studied (Creswell, 2007). It is for these reasons that I began my exploration with my story as it was from the beginning.

As a child raised in a small semi-rural community in British Columbia I recall the first time I ever saw a residential school: My father had driven me passed it on our way to the

airport and at the age of 6 I was fascinated by its towering brick walls, its castle-like features, all nestled in the valley of the Rocky Mountains next to a beautiful farmers field, it truly was stunning. I asked him what it was and his response I will never forget, “that’s where all the Indian<sup>9</sup> children go to school.” My eyes widened with shock, “why?” I couldn’t for the life of me understand why any children would go to school way out there. “That’s just the way it is,” he responded. Just the way it is? This day, this conversation disturbed me greatly but also raised a deep sense of curiosity. I wanted to know more but it would be years before I would ever truly understand. I wasn’t sure if it was this or something else that led me to a career working on reserve with Indigenous children and families but whatever it was I was truly honoured for being accepted and, at times, even valued by those I worked with.

I was raised as an average white kid on an average income street in an average town. There really was nothing exceptional about me, or my family; they were working class folks who struggled at times like most average people do. My mother was the fifteenth child born to her French/German parents and my father was an only child whose heritage was lost through adoption. What I know of him was that he was born in Saskatchewan and adopted out of Alberta when he was nearly a year old. We searched for his family but were unsuccessful. I began work as a frontline social worker shortly after graduating with my bachelor of social work. I worked with a fully delegated Indigenous Child Protection Agency on reserve. This agency was relatively new in its final stage of delegation<sup>10</sup> and was receiving all the files of the Indigenous families who currently were

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<sup>9</sup> I use “Indian” only because it was a term used by my father that day and typically used in general during the 1970’s. It is not the term I use and can be considered offensive by my Indigenous friends.

<sup>10</sup> The final stage of delegation grants the Agency the power to remove children from their families of origin.

receiving services from the Ministry; we were told nearly 50% of all files would make their way into our office. That number later reached more than 55% which meant that Indigenous families represented the majority of all families involved with child protective services in our area in spite of the fact that they represented a marginal percentage of our overall population. Were we ready for all these files? It was hard to say but they kept coming nonetheless.

Within the first two months of work as a child protection worker, I was advised to remove two infants from two different families. The first one was from a mother I had never met; the reason for removal was because her first child had been removed previously and had never returned to her care. I had not even touched the file when a meeting was set up for me to go and inform the mother that she would not take her unborn child home from the hospital once he was born. I did as I was instructed; the mother cried and said she knew this was going to happen. I recall feeling very sad for her but I don't recall anything about the removal itself. Over the months to come I was determined to understand why this came to be. I read her file and saw that her oldest child had been removed because the mother struggled so much with his behaviours that she was heard by a neighbour to be yelling at him and even threatened to kill him. Her file stated that after each visit with her child he would go back to the daycare and spit at the other children, swear, hit and kick so it was determined by those workers that she was being inappropriate at the visits and as a result they were suspended indefinitely. When I received the file she had not visited with her son in nearly a year. She was a lovely lady who may have struggled some with poverty but was working really hard to obtain stable employment. In total she gave birth to three children but would raise none. Years later,

as the guardian of her first child, I had taken him for an assessment with a paediatrician who diagnosed him with Tourette syndrome and ADHD. I knew then that this wasn't a mother who abused her child; she was a single mother who struggled to cope with parenting an undiagnosed, high needs child. Her two subsequent children were not high needs, she could have parented them effectively but would never be given a chance because our system – the child protection system – had failed her and countless others.

My second removal, in the same month, was another high needs infant who had been born prematurely to parents who were involved with various criminal activities. There was suspected drug involvement but in addition, the father ran with a group of men who liked to steal outdoor equipment (quads, ATVs, Skidoos), essentially anything that wasn't nailed down. He made a fairly good living with this but it just wasn't a great environment for raising a high needs infant. Additionally, the parents left hospital when they were told the child would need to be transported to a children's hospital, and no one heard from them again. Of course all of this makes sense that the child could not remain in their care but a very strange thing happened once I removed him: The mother began to show interest. She came to my office (from out of town) every day begging answer to the question, "what do I need to do to get my son back?" And every day I would tell her the same thing, "you need to change your lifestyle." See, I couldn't help this mother because I didn't have the answer to 'how' she could do that. So it continued this way and while our discussions continued so did the length of time her son remained in care. I had no idea how that mother could change her lifestyle, all I knew was she needed to change it. And, because I lacked direction so too did she; it became an endless cycle for her and as a result her child remained in care until he was more than a year old.



What I learned over these years was that the longer a child was in care, the longer a child would remain in care. As a worker I was burdened with legislation and standards that insisted I manage my timelines. This meant that I was paying more attention to my court date than I was to getting this child home: I had to ensure that I had court documents filed on time for my 3 month order which then turned to a 6 month order and by the time he was in care a year I was forced to either return or go permanent which would mean this mother could lose her son forever. I had no idea how to turn things around for her and the sad thing was neither did she. And, the longer her child remained safe in care the more fearful I became about returning him home. I was beginning to realize that it takes more courage to return a child home than to leave them in care and to me this was very dangerous thinking. This meant that whether or not a child could go home was not based on family strengths or safety, but rather it would be based on my own fears. Were all social workers feeling this way? I had no way of knowing because they weren't discussions we were willing to have.

My experiences with social work continued to worsen: My caseloads reached an unbearable 37. I was a generalist, which meant that I carried everything from child protection (Investigation) to Resources (foster parents). I was the only social worker I had ever known that carried a caseload so broad. It meant that one day I could be out investigating a report and another day I could be struggling to support a foster parent while also supporting the child in their home if problems arose between them. I was working in a state of crisis and chaos with absolutely no reprieve and was burning out fast. What I recognized about this time was that not only was I working in isolation, but I also could not focus long enough to make good decisions; they were most often made in

haste, anxiety and fear. I was receiving minimal supervision and the supervision I was receiving was directive and lacked a skill-building component that I so desperately needed during these years. I am not sure how I survived them to be honest; I know there were times I wanted to quit.

During these first years on the job I saw very little growth or success with families; the perpetual cycle continued: Children who were raised in care had children who were raised in care who had children who were raised in care. Cases would open and close and open again. It was disheartening. I felt despised as a social worker in spite of the enormous amount of energy I poured into my work. I spent so much time in my office filling out reports; summaries, court documents and contact notes that I had so little time to spare doing any quality work with the families. I felt I was failing them dismally. Something just wasn't right with the system – if I was working this hard why wasn't I seeing change? I began to think change was not possible, and if that was true, what was I doing in this field?

In 2008 I was introduced to a practice model called Signs of Safety. This practice gave me hope and motivated me to continue on in the work. I knew after just one week of training that I could never go back to practicing the way I had prior to that. This model had more to offer me as a worker but also the families that I worked with and I began to put it to practice right away. My first experience with it was with a family that we had been working with for nearly two years. Very little had changed for them in spite of the work we had been doing but then we received one more phone call from a concerned citizen saying that the family had hired two drug dealers to work at their family business and one of them was living in the home as well; this one had been seen

out in the community with the oldest child and the caller was concerned this man was grooming the child for pick ups and drop offs. In addition to this concern the mother had significant mental health concerns that caused her to have vicious fights with the father and the 11 year old child as well; they could be seen by customers and heard by neighbours all around swearing, yelling, name calling and hitting each other. There were also two younger children in the home ages 2 and 3. The father was a very aggressive man often threatening to hire a lawyer to have social workers fired; workers were very intimidated by him but I had requested that the worker in charge of the file discuss the possibility that we would be apprehending the children because nothing had changed and in fact, had worsened.

The worker arranged to meet with the family but during this meeting the father quickly became agitated and aggressive which of course made the worker nervous so she came to me requesting my assistance. I entered the room and could see he was ready for a fight so I decided then to try the Signs of Safety tools we had learned. I worked through the assessment tool with the family and what I found was that the father was becoming visibly less anxious; he was working through the problems with us and when it came time to look at safety for the kids he was able to recognize that the children were not safe in their home. I asked the question, “mom... dad what needs to happen to keep your children safe?” He replied, “they shouldn’t come home with us.” I was stunned. He had made one of the most difficult decisions a parent would have to make, essentially he removed his own children from his care that day to ensure their safety; and he did it without yelling, swearing or threatening. He called his sister and asked if she would care for the children while him and the mother sorted out their problems and she agreed. The

children never came into care, we never went to court and the mother and father had a new understanding of the impacts of their behaviours on the children and what needed to happen to make their home safe enough for the children to come home. From that point on I knew I could never turn back and there were countless examples and stories of how this model impacted my practice and the lives of those families I worked with but I must skip ahead to the struggles and outcomes I experienced with the implementation of this model.

I believed so heavily in the model that when the request came within the agency for one of us supervisors to take on the lead role, I begged for it. As it turned out I didn't have to beg because no one else in the agency wanted to take it on. I didn't care; I wanted to see this model implemented. I worked with my own team first ensuring that they learned and practiced the tools weekly; we had team meetings that would include exploration of the tools used on the frontline. There were other regions within the province that wanted to hear more about Signs of Safety so I began to travel to provide workshops as well as consultant work on complex cases; interest was growing, as were my skills. Back home there were struggles though: Workers in the agency came to see me as a threat to their way of practice perhaps, or a "brown-nose" maybe, and they ridiculed me regularly but I didn't care because the practice meant more to me than what people thought of me.

We were seeing extraordinary outcomes already within the first year: Fewer children coming into care, less return phone calls, clients reporting that they were feeling respected and heard in the process, there were fewer files getting passed the intake stage so caseloads were dropping, clients reporting increased relationship with their family

members, less conflict, greater relationship between staff and families, greater clarity for both worker and family and also a greater sense of team among the staff and with community partners. This was great news. What I didn't see then was that there were problems brewing.

Many workers did not feel confident in using the practice so chose not to which led to an inconsistent practice depth throughout the agency. Families would feel the effects of this when their files were transferred from one worker to another. This also led to negativity throughout the teams, not only about the practice itself but also toward those workers who were using it. This became very toxic and some workers would even try to hide the work they were doing in order to avoid scrutiny from their colleagues, and the other supervisor in the office. Additionally, there were structural issues that didn't support the Signs of Safety model: The computer system mandated by the Province was in many ways a contradiction to the work we were doing, as was the legislation that guided our daily practice. The computer system generated a child protection response in cases that fell under section 13 of the Child, Family & Community Services Act and once open, the legislation kicked in dictating how much time we could spend on an assessment – typically about 30 days. The Signs of Safety model however, recognized that risk assessment must continue throughout the life of a file; from beginning to end, 30 days would not adequately determine the safety of a child because families are not static, they evolve, they change, they grow and as such assessment must continue. The legislation did not allow for such theories in practice. What this did was create more work, duplication of work and overload on workers who were already overloaded.

Additional struggles were associated with the depth of the practice itself: Staff struggled to comprehend how complex this change truly was. I also struggled; in fact I had no idea of the depth of skill that I would acquire over the years to come. For many staff what this meant was that they felt they were using the model adequately when in fact they had not nearly achieved the skill required to even understand what it was they didn't know yet. This didn't create any danger for children; it did however, create some inefficiencies with time management which further frustrated staff, and created an unwillingness to further their skill development thinking, "we are already doing this." Finally, one of the most important challenges workers faced was with their own managers and directors: staff quickly outgrew Managers and directors with little opportunity to practice the model; they too had little understanding of the tools and practice. There simply was no parallel process and staff conflict or issues were approached with a deficit-based thinking. In the end, this was viewed as a lack of support. Many of the organizations that I worked with as a consultant suffered from this same lack of support from the executive leaders and as a result failed in their attempts to implement. And, coupled with a lack of support from the province failure was inevitable.

There were a number of things I felt were needed throughout these years to support a successful implementation:

- *Provincial support* – we needed to know that we would be backed provincially should anything happen to a child. But we also needed the financial support to continue to provide training to the staff.
- *Management/Supervisor support* – I needed to see my own leaders using the principles in discussions throughout the office, not just when discussing cases.

There needed to be a parallel process and I needed to know that my leaders were confident in their use of the questions.

- *Consistency* – There needed to be consistency among the teams, every supervisor, and every worker respecting the practice and using it to the best of their abilities. And safety, there needed to be less teasing, less putting down of the staff that were using so we could feel safe as we began to learn this new way of doing and thinking.
- *Supervision Model* – I recognized during my last year at the agency and even more so during my years as a consultant and trainer that supervision was absolutely essential in this field. Once I began to use Signs of Safety practice principles and tools in supervision I began to get a clearer understanding of the safety of children, the skill of my workers and their future needs. But I also noticed that using the practice in supervision was creating a greater sense of team as well as happier, more satisfied staff and less conflict among them.
- *Changes to the computer system* – when I left we were operating 3 separate computer systems (the old Ministry system (MIS), the new Ministry system (ICM) and one developed by an Indigenous agency (BP). Very unproductive. Workers spent more time at the computer ensuring the documentation was complete than they did with families.
- *Legislative change* –legislation needs to address the theory of practice using Signs of Safety, which would relate to things such as timelines. The legislation appears to see assessment as static while we know that workers will assess families from the opening of a file to the closing and that during this time families can and do

change. There is also a push to permanency for children within the legislation that means parents will lose their rights after a year but we know that sometimes parents take longer than this to make the necessary changes.

During my early training and consulting years, I worked primarily with Indigenous agencies in British Columbia. When I look back at those organizations I recognize that there were challenges that didn't seem to exist in the mainstream offices: They fought to keep up with the administrative requirements of operating a child protection office and there were significant capacity issues due to funding shortages, overloaded caseloads, vacancies and junior staff which in turn led to a constant state of crisis, making a change of practice near hopeless. I recall working with one particular organization that was in such a state of crisis that their first reaction to any calls of concern was removal. The acting team leader was a junior social worker with a caseload of 47; she was overwhelmed and burning out fast. She called me into her office one day and with tears in her eyes she said, "Heidi someone is going to die here and I don't want to be held responsible." There was such a heightened sense of fear within this particular organization for numerous unmentionable reasons, the least of which being the adoption of the Signs of Safety practice. Many Indigenous child protection organizations have simply been set up for failure with a consistent lack of government and community supports, lack of funding, overloaded workers, complexities associated with geography, politics, culture, community, and top it all off with the inherent problems with housing, poverty and substance abuse. Mainstream offices experience only a fraction of these complexities. This issue requires (and deserves) insistent, focused research.



## Data Tables

The following data tables represent data that was accumulated over the past 6 years of my work both as a frontline supervisor and as a trainer/consultant. They have been organized into sections: Table 1 represents my own experience with change while working as a frontline supervisor in an Indigenous child protection organization; tables 2 – 4 are my field notes and experiences within the Indigenous context of change while working as a trainer and consultant; and, tables 5 – 10 are an accumulation of my field notes and experiences within the mainstream (non-Indigenous) environment of change as a trainer and consultant.

### Table 3 – Summary of my experiences of change in an Indigenous organization

Table 3

| <b>SUMMARY OF MY EXPERIENCES OF CHANGE IN AN INDIGENOUS ORGANIZATION</b>  |
|---|
| <b>What I found to be working well in the implementation of the practice?</b>   |
| <p>Reduced anxiety for both family members and workers<br/>           Fewer children coming into care, less return phone calls, lower recidivism rates, clients reporting that they were feeling respected and heard in the process, there were fewer files getting passed the intake stage so caseloads were dropping, clients reporting increased relationship with their family members, less conflict, greater relationship between staff and families, greater clarity for both worker and client and also a greater sense of team among the staff and with community partners</p>   |
| <b>What I found were some of the biggest challenges or struggles we faced as frontline workers trying to shift our practice and implement Signs of Safety?</b>  |
| <p>Lack of confidence<br/>           Inconsistency of practice skill among workers leading to practice gaps for families<br/>           Negativity among workers leading to fear of using the tools<br/>           Computer system contradictions creating redundancy and complexity in documentation<br/>           Legislative discrepancies leading to frustration in the work and a workload increase<br/>           Inability to grasp the depth of practice needing to be achieved leading to a naïve understanding of the tools, inefficient time management and an unwillingness to further the skill development so desperately needed<br/>           Manager/Director inefficiencies due to lack of knowledge around use of the tools leading to inappropriate or nonexistent supervision and the inability to create a parallel process with staff creating the sense of a lack of support from those directing our practice</p> |

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| <b>What were some of my worst fears around implementing a practice shift of this magnitude?</b>  |
| My worst fear was that this practice just would not stick with workers' negativity and frustration and as a result I would be forced to return to the Ministry practice, which just would not satisfy me, and I would be forced to leave the profession. |
| <b>What I felt we needed to ensure this implementation is successful?</b>  |
| Support from the Province<br>Management/Supervisor support<br>Consistency and safety<br>Changes to the computer system<br>Legislative change   |

#### Tables 4 - 6 Notes and experiences of change in Indigenous organizations

Table 4

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| <b>What have I seen that would indicate successful outcomes in environments of change?</b>  |
| Lower recidivism rates –fewer families returning to services within the agency.<br>More meaningful plans with families – planning has become more meaningful with more specific behavioural requirements and fewer service requests that had no meaning with regard to safety.<br>Mapping process <sup>11</sup> is making the work more clear<br>Facilitating complex map with families.  |
| <b>What are some of the biggest challenges or struggles encountered in practice while implementing Signs of Safety?</b>   |
| Families with no support networks or networks that turn out to be unsupportive.<br>Families don't follow through on plans.<br>Support people won't come to meetings.<br>Intergenerational cycle of Child Protection. Multiple calls, multiple intakes on same family – trying to break that cycle.<br>Everyone at different stages of the learning and different levels of confidence creating inconsistency for families.<br>Different levels of understanding among leadership causing confusion with variance in direction being given.<br>Infrastructure is set up for the prior practice: Signs of Safety (SoS) requires more work but staff are still managing the same number of files.<br>Teams with higher caseloads don't have the opportunity to do SoS because it takes more time.<br>Courts have not embraced SoS (hosp. Agencies, school) giving negative feedback. |

<sup>11</sup> The 'map' is the assessment framework workers use to determine if there is enough safety within the family unit to keep children at home (similar to Appendix A). It is typically done on a whiteboard with family and their supports present and is facilitated using solution-focused questions.

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| <p>Court orders getting in the way of inclusive work with families when couples/families can't be in the same room.</p> <p>Signs of Safety appears to be a front-end tool so children who are in care permanently aren't receiving the good work.</p> <p>Families who are marginal and working struggle to come to meetings.</p> <p>There is a struggle to let go of complicating factors (due to fear/control).</p> <p>Identifying harm is challenging – lack of consistency around how and when to formulate.</p> <p>Hard to be both the penholder and questioner during mappings with family</p> <p>Danger statements – lack of clarity of how to develop and present to child – fear of tough conversations.</p> <p>Simplifying the everyday language is challenging under the Signs of Safety model.</p> <p>Sometimes there is no harm so it's hard to develop a danger.</p> <p>Not sure how to engage youth in mapping.</p> <p>Time required for families to get supports to the table – sometimes it takes weeks, causes anxiety.</p> |
| <p><b>What are the biggest fears of implementing a practice shift of this magnitude?</b></p>   |
| <p>Worried that staff would burn out or continue to stumble without the practice needed and as a result they would not be able to support or work with families in a good way and would subsequently fall back to the 'old way' – bullying families and not learning the Signs of Safety practice.</p> <p>Concern that because staff are all new to Signs of Safety and at different levels of understanding, they will put children at risk of injury or death. And if a child does die in care this model will be abandoned for yet another new approach.</p>  |
| <p><b>What is needed to ensure this implementation is successful?</b></p>  |
| <p>System/management support available when something does go wrong (i.e. Child dies).</p> <p>Training for community partners (schools, courts, police, etc.)</p> <p>Legislation changes to support the shift to Signs of Safety</p> <p>Justice needs to shift their thinking.</p> <p>Facilitate maps – practice in teams.</p> <p>Caseloads need to go down without placing greater expectations on staff.</p> <p>Get rid of the administrative part of the job.</p> <p>Regularly reviewing the map.</p> <p>Feedback on process for families</p> <p>Ways of getting family members to the table.</p> <p>Knowing when to map – at what stage of the work with families should it occur.</p> <p>Put work back on family – keep maps short.</p> <p>Use the map in consultation and supervision</p>  |

**Table 5**

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| <p><b>What have I seen that would indicate successful outcomes in environments of change?</b></p>  |
| <p>There appears to be more satisfaction in the job using the Signs of Safety tools</p> <p>Signs of Safety is more strength-based and as a result less intrusive</p> |

Families are happier with workers  
 Building relationships with families that develop trust  
 Keeping more children at home  
 Families are not as militant with workers and when they aren't fighting with their worker they are actually focusing on the children  
 Signs of Safety is creating a quality of practice with caseworkers

**What are some of the biggest challenges or struggles encountered in practice while implementing the Signs of Safety model?**

The tools cannot be used effectively because management is inflexible and uncertain about using both Ministry and Signs of Safety tools and ways of working  
 The practice is beginning to be imposed on workers – systematizing the work  
 The map is being over-used  
 Management is not being held accountable to support staff during the shift  
 Concerns not being addressed  
 Micro-managing creating an environment of mistrust  
 Confusion about how SoS fits with planning for children who will be in care permanently. In these departments there is no talk about Signs of Safety  
 Heavy SoS at the front end of practice but very little being used in other departments such as foster care, adoptions and long term guardianship  
 Supervisors are not using a parallel process in supervision with staff  
 Guardianship workers won't use Signs of Safety because they aren't even sure where to start  
 Fatigue setting in because so much energy is spent on the Signs of Safety practice  
 Staff forced to use tools they don't understand  
 SoS is becoming a very prescriptive, top-down approach  
 There is a lack of consistency between supervisors and management  
 Disconnect between the Ministry guidelines/legislation and Signs of Safety: It's difficult for staff to meet timelines under this new model but management continues to place expectations on them related to the legislated timelines thereby confusing roles and expectations.  
 Consultations are unmanageable  
 Lack of Supervisory support at family meetings resulting in requests to redo the maps and subsequently resulting in a change of direction for family later  
 Lack of trust between management and staff – everybody is questioning everybody else  
 Management is not comfortable with SoS so put additional pressure on workers to 'get it right'  
 Not enough time to work on a learning plan  
 Management micro-managing staff and treating workers like children  
 There are different priorities between caseworkers and management – this could effect outcomes for children – Management is too far separated to know  
 Community partners don't understand the mapping  
 Support workers sabotage the process because they lack understanding  
 Too much training in other areas – need to focus on one (SoS)  
 There is conflicting information about community partner's use of and involvement in SoS  
 Partners don't know anything about Child Protection creates confusion about roles in risk

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| <p>assessment</p> <p>Caseloads are not sustainable – there is way too much work and something will have to give – people will be taking sick leave etc.</p>   |
| <p><b>What are the biggest fears of implementing a practice shift of this magnitude?</b></p>  |
| <p>Worried they would all quit and find other jobs or will do all this work to adopt the Signs of Safety practice and it won't stick in the end.</p> <p>Concern that children will die and no one will back the workers – being left to hang holding all responsibility/accountability</p> <p>Worried there is so much confusion about who does what that something will get missed and it will come back on the workers as their mistake or responsibility</p> <p>Concern about the burnout of staff due to poor working conditions</p>  |
| <p><b>What is needed to ensure this implementation is successful?</b></p>   |
| <p>Have a seasoned social worker come out on the front-line during investigation to see what it takes to do it right</p> <p>Need to know what the expectations are (i.e. Are family meetings needed with every case or not?)</p> <p>Need a supervisor at every mapping so that the decisions can be made right there</p> <p>Leadership needs to talk to staff about retention</p> <p>Staff want to be able to do their jobs well – whether that means lower caseloads or more flexibility with overtime hours. Allow accumulation of hours. Most families are not available during the day.</p> <p>Need for recognition and trust from leadership</p> <p>There needs to be communication up and down the chain to ensure transparency</p> <p>Create a safe environment so staff can share their experiences (good and bad) without retribution or fear of reprisal.</p> <p>Allow flexibility so staff can work with clients in the most effective way possible.</p> |

**Table 6**

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| <p><b>What have I seen that would indicate successful outcomes in environments of change?</b></p>   |
| <p>Clear process for investigation</p> <p>Good communication between teams</p> <p>Staff confident in leadership</p> <p>Supervisor confident in legislation, policy, court, families, and experience.</p> <p>Safe environment, knowledge of accountability</p> <p>Fewer children coming into care.</p> <p>Signs of Safety successful at the front end</p> <p>More information gathered from mapping and more supports found.</p> <p>Safety plan working to send children home.</p> |
| <p><b>What are some of the biggest challenges or struggles encountered in practice while implementing the Signs of Safety model?</b></p>  |

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| <p>Family not showing up for meetings putting workers behind in their work creating anxiety. Lack of communication with client who don't see it as important. Process is being held up before being able to move forward.</p> <p>Lack of knowledge around intakes (because intake rotates) resulting in lack of documentation</p> <p>Not enough information to map with.</p> <p>Staff not following SOS intake process.</p> <p>Waiting for supervisor to attend map holding up process</p> <p>Issues of transportation for families.</p> <p>Issues with daycare.</p> <p>Lack of confidence, due to being new</p> <p>Struggle with time – there isn't enough time to train new staff</p> <p>There's no solid process in place – it's there but doesn't get followed and then it falls back on the team.</p> <p>Lack of communication and teamwork</p> <p>Staff getting defensive when they are held accountable, being blamed.</p> <p>Supervisor abrupt creating a negative impact – no safety for open communication.</p> <p>Work is not getting done – creates resentment.</p> <p>Teams are separate, distinct – lack of information sharing. Poor communication leading to greater risk to children</p> <p>Not showing commitment. Work not evident</p> <p>Families tell workers what they want to hear but don't follow through.</p> <p>There are pieces of investigation that require safety info that isn't being gathered in the map.</p> |
| <p><b>What are the biggest fears of implementing a practice shift of this magnitude?</b></p>  |
| <p>Concern that if lack of communication continues and no consistent process is developed, then information will be lost and decisions will lead to more harm for children and families. Creating stress and burn out and breakdown.</p>  |
| <p><b>What is needed to ensure this implementation is successful?</b></p>   |
| <p>Need to grow competency and trust with respect and good communication. Clear demonstration of knowledge and use of SOS with families and during case assessment/management. Clear processes in place for staff to follow.</p>  |

**Tables 6 - 12 Notes and experiences of change in mainstream organizations:**

**Table 7**

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| <p><b>What have I seen that would indicate successful outcomes in environments of change?</b></p>                         |
| <p>Safe discussions</p> <p>Consistency of understanding around danger</p> <p>Creates hope for people using strengths.</p> |

Visual approach works for families.  
 Permits families to have their own voice – goals/plans/outcomes. Workers no longer directing plans.  
 Flushing out complicating factors.  
 Positive feedback.  
 Scaling helps see the situation from client's view.  
 Organized – keeps people on track.  
 Better able to explain process at the front end. Callers calling to consult not report.  
 Giving good questions to community partners.  
 Empowering schools –building relationships  
 Good focal point for families – also good conversation piece  
 3 houses<sup>12</sup> so impactful

**What are some of the biggest challenges or struggles encountered in practice while implementing the Signs of Safety model?**

Cultural barriers.  
 Need to be prepared. Some maps don't go so well because of denial and so won't give the worker the necessary information. Parents unable to acknowledge concerns.  
 Time consuming.  
 Facilitating writing at same time and capturing people's words.  
 Documentation – getting it to paper.  
 Working with families who are so overwhelmed, they can't see strength.  
 Families in crisis unable to engage in process.  
 Attention span of teens  
 Paperwork doesn't match the computer system. Everybody is doing it different. Some using harm/danger, others not. Some using scaling/others not. Could lose information – Community already has fears about workers using SoS, this just confirms it. They are worried we won't handle the supports.  
 Community keeps calling in order to get the attention of child protective services.  
 System issues i.e. Legislation.  
 More work due to community expectations (SOS and old thinking)

**What are the biggest fears of implementing a practice shift of this magnitude?**

Workers might work themselves out of a job.  
 There will be children lost in the system at intake.  
 Workers aren't opening cases and as a result families aren't getting help (i.e. Addictions)

**What is needed to ensure this implementation is successful?**

Workers need to be supported to continue to grow and learn the practice. Meet regularly to talk about SOS successes, challenges and cases. All workers across departments should be involved in the learning process.

<sup>12</sup> 3 Houses is the assessment tool we use to interview children in crisis. It is similar to the 3-column form used with adults. Utilizing the house of good things, house of worries and house of dreams, the worker facilitates a discussion using solution-focused questions while allowing the child to draw inside the houses.

Need more workers at the front end.  
 Trust in the outcomes  
 Safe to talk about the fears, the workload.  
 Validation – recognizing the good work and effort.  
 Consistency on the front end to build trust with community Partners (i.e. How to respond to referrals)  
 Education for community Partners.  
 Good communication and language.  
 Practice.  
 Recognition of different roles  
 Everybody on the same page – positive about the work.  
 Clear understanding about how to use SOS within framework  
 More resources at the front end

**Table 8**

| <b>What have I seen that would indicate successful outcomes in environments of change?</b>  |
|---|
| <p>The map lays things out. Speaks clear language focus on strengths.<br/>           3 houses with children. They seem to really enjoy it. Focus on children point.<br/>           Using as consults in complicated intakes. Lays it out visually. Separates complicating factors.<br/>           Supports the thinking<br/>           Harm/danger statements – simplifies worries and separates complicating factors.<br/>           Map spells things out clearly.<br/>           Helpful in gray cases.<br/>           Clarity for workers throughout the beginning to closure of file if used by everyone in all departments<br/>           Good outcomes – lower caseloads</p>   |
| <b>What are some of the biggest challenges or struggles encountered in practice while implementing the Signs of Safety model?</b>   |
| <p>Difficult at intake when caller has their own agenda and not willing to work through questions.<br/>           Taking time to do SOS – hard to find time?<br/>           Using the map is time consuming.<br/>           Doesn't fit within timelines (policy/legislation).<br/>           Support services finding it difficult due to limited resources.<br/>           Struggling with the basics – separating harm danger complicating factors and writing danger statements in simple language.<br/>           Difficult at intake when caller doesn't have info (i.e. Strengths, etc.)<br/>           Simplifying language in danger statements.<br/>           Getting families to the table.<br/>           Hard to trust in the model/assessment.</p> |



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| Community partners still pushing child protection to do the work.<br>Inconsistent among workers   |
| <b>What are the biggest fears of implementing a practice shift of this magnitude?</b>   |
| Worried if workers don't implement properly they will resort back to working without family involvement.<br>Worried the SOS process will slow workers down and the work won't get done and it will put children at risk and workers get in trouble.<br>Concerns that workers will miss stuff or do it wrong putting children at risk.   |
| <b>What is needed to ensure this implementation is successful?</b>  |
| Workers need to use the tools/practice in consistent ways. Patience needs to be given to staff so they can take their time to learn the tools and shift their practice gradually without being rushed. Start simple (i.e. Just a danger statement – not whole maps)<br>Support from supervisors, managers, and directors<br>More time at intake.<br>Harm, danger and complicating factors used at intake.<br>Need ideas for getting families to table<br>Practice.<br>Example questions for intake (relationship, exception, etc.)<br>Communication around what SOS should look like at intake. Messaging around investigation process.<br>What to do around high-risk pregnancies for first time mothers.<br>Practice with danger statements.<br>More strategic implementation from higher ups about how it should look at front end for consistency and direction.<br>Not working in isolation but having opportunities to meet with other offices and create the time to do that.<br>Reducing the redundancy |

Table 9

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| <b>What have I seen that would indicate successful outcomes in environments of change?</b>   |
| Building relationships with families through respect, transparency, and honesty – as a result families are more engaged and willing to open up. Process is more hopeful and gives families more in control<br>Families feel heard, there is more buy in, and safety plans are more realistic and hold them accountable<br>Balance of power between Worker and Family<br>Empowers families<br>It's less intrusive; more collaborative<br>Focus on Strengths helps to get past the issues/concerns |

Solutions are more creative; workers thinking outside the box  
 Brings clarity of direction, focus, and concerns for worker and families.  
 Workers are slowing down to really look at the work we do with families, resulting in less open files  
 3 Houses etc. adds another component to the Face-to-Face and gives children/youth a voice. It works really well with children, getting them to open up and share their anxieties  
 The analysis is well thought out and clearly written  
 SoS uses a language the family can relate to  
 Involves more people/support for family, all of whom know the concerns. The worker then has a network within the family to call.  
 Practicing mapping within teams helping to determine complicating factors vs. harm  
 Using during supervision helping to identify issues and find solutions  
 Supervisors know it's going to take time to learn and are being patient with staff  
 Gives workers ways to move past the "I didn't do it" conversations

**What are some of the biggest challenges or struggles encountered in practice while implementing the Signs of Safety model?**

Taking more time to use with families and so much time is being put into implementation (training, practicing), so timelines are not being met. If caseload demands do not shift, staff cannot do SOS well.  
 Not enough opportunity to practice  
 Administrative tasks and existing tools do not align with the framework, and leads to duplication of work  
 Supervisors putting extra pressure on staff  
 Only using SOS on new files so other departments/workers are not getting practice  
 Struggling to use with children who are in care permanently who have no family  
 Dumping problems on families without support  
 When we look at 'What's Not Working' first, families shut down  
 Facilitating a serious map with a family  
 People have a different interpretation of process. Is there a wrong way?  
 People who have been through the system lack trust and won't buy in. Doesn't work when there is denial  
 Because it is an extreme shift in practice rolling out at different levels and quickly, something might get missed  
 No communication with Supervisors – they don't understand, so workers lack confidence  
 It fails to understand human behaviour  
 Doesn't work with families who have no support, or when they do bring in "supports" they are not supportive and/or don't come to meetings  
 Intergenerational cycle of child protection concerns with multiple calls on the same family – tough to break that cycle  
 Different direction from different supervisors creates confusion and hinders the work  
 Hospital, schools, and other community partners do not understand SOS and are giving negative feedback  
 No Contact Orders make bringing everyone together to plan difficult  
 Marginal families who are working have trouble coming to meetings  
 Struggling with letting go of the complicating factors and being clear.

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| <p>Hard to be both the pen holder and the questioner<br/>         Struggle with creating danger statements and presenting to a child – fear of tough conversations<br/>         If there is no harm it's difficult to come up with danger statements<br/>         Difficult to engage youth in the mapping process.<br/>         Sometimes it takes weeks for families to get support people to the table, which causes anxiety.</p>   |
| <p><b>What are the biggest fears of implementing a practice shift of this magnitude?</b></p>   |
| <p>Worried a new government will come in and do away with the Signs of Safety model<br/>         Worried workers will get lost in the process and it will fall apart<br/>         There is fear a child might die because they are left in a situation that they would not have before, then the pendulum will shift back to more intrusive<br/>         Concern that the process and forms will become so prescriptive that the client focus will be lost</p>   |
| <p><b>What is needed to ensure this implementation is successful?</b></p>  |
| <p>Larger system support for training and consistency<br/>         Upper Management needs to support the change in structure necessary (less files, computer system allows, documentation requirements to align, etc.), and they need to know there is support from higher up if a child dies<br/>         Supervisors must be fully trained and practicing with staff<br/>         Implementation to be more organized and consistent<br/>         Community support partners need roles and expectations to be more clear, simplified<br/>         Need for top-down commitment to this for a length of time – it can't be thrown out with a management change<br/>         Start trying the tools, find how it works, adapt the tools to work with unique family situations to show how the framework is flexible and adaptable<br/>         Fewer files/assessments to allow for the extra time needed<br/>         More opportunities to practice<br/>         Co-workers available to help map<br/>         It's not going to happen overnight<br/>         More information on how to revisit/review a map<br/>         Training available to Community Partners (Police, schools, court)<br/>         A tool to get feedback from families regarding the process<br/>         Legislation needs to change to support SOS<br/>         More practice in teams</p> |

**Table 10**

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| <p><b>What have I seen that would indicate successful outcomes in environments of change?</b></p>                               |
| <p>Genogram helpful<br/>         Identifying existing strengths and safety – clients seeing that they are doing some things</p> |

right.

Starting with what's working lowers the client's defenses – they're not so angry.

Less authoritative – clients get to find their strength – safety.

Calm part (health) viewed presentation and really liked it.

Finding reasons to keep families together rather than looking for reasons to take children out. Families opening up more. More appreciable. Shifts the tension.

Brings everybody together – brings out everyone's ideas and brings people together – each person is important.

Sending children home that wouldn't otherwise go home.

Family feeling respected. Able to develop a plan and come to agreement.

Map points out strengths to family.

### **What are some of the biggest challenges or struggles encountered in practice while implementing the Signs of Safety model?**

3 houses difficult with children with brain damage.

People struggle on questions about strength. Philosophy of humility and don't see recognizing strength as humility.

Language difficult if English is not first language. Need to really break it down.

Scaling difficult to families works better to break it down very simply. Can be too broad.

Hardest thing about implementing is the fear of getting it wrong and so avoiding doing it altogether.

Families not being honest and not following through.

Staff don't have consistent thoughts about next steps with family.

Struggling to cope with demands due to staff turn over. SOS is front and intensive and there is a lack of staff and time for staff to do the SOS work.

Not doing safety plans – just creating a list of services for families to do – mappings are too simple – not enough info.

Not doing safety plans – just creating a list of services for families to do.

Mappings are too simple – not enough info.

Lack clarity around who does danger statements.

Time frame allowed for assessment not enough to do SOS.

Community complaining that child protection is not doing their job.

### **What are the biggest fears of implementing a practice shift of this magnitude?**

The case could still go south even if workers have done the mapping and children could be harmed as a result.

The community will think nothing is getting done and increase pressure on workers.

Workers scared they will be blamed for not doing their job if something happens to a child.

Because workers are keeping children out of care, some people will view it as soft.

Safety network people might say they are taking responsibility for safety but if something happens, workers will still be blamed.

Worried this will reflect badly on agency – SOS must continue and every staff member must use and believe in it.

### **What is needed to ensure this implementation is successful?**

Workers need to have confidence in the SOS work and in their skills. Using the tools more, it will become natural and there will be less concern about blame.  
 More buy in from family and community.  
 More collaboration between service providers.  
 More resources available for clients.  
 Community education in order to better understand the work and the vision for families  
 Patience – this is a process.  
 Need clarification – does there need to be a map even though there is established safety?  
 Safety planning practice/training  
 Danger Statements Safety Goals practice  
 Stop making decisions in fear – this creates blame and micro managing.  
 Do more SOS with families.  
 Words and pictures/Safety planning.

Table 11

| <b>What have I seen that would indicate successful outcomes in environments of change?</b>   |
|--|
| <p>3 houses – even with youth – clear picture of needs. Helps them see what supports they have. Also really helpful to show parents.<br/>           Getting down to why workers are involved. Greater understanding.<br/>           Able to link staff involvement to the act<br/>           Family maps working really well on all types of files – family coming up with own danger statements and next steps.<br/>           Shared in a respectful way.<br/>           Families understand it better.<br/>           Mapping at assessment and Case Management.</p>  |
| <b>What are some of the biggest challenges or struggles encountered in practice while implementing the Signs of Safety model?</b>  |
| <p>3 houses not natural for workers yet – children shutting down.<br/>           Timelines – doing, implementing, training and managing cases at same time.<br/>           Family forgets about the good work 2 weeks later.<br/>           Myth that SOS wasn't done right if children apprehended.<br/>           Time it takes and making it work for everyone and getting people to show up.<br/>           Increased caseloads mean less time available to do work.<br/>           Duplication – transferring map on board to comp.<br/>           Cultural/religious barriers.<br/>           Reliability of safety network.</p> |
| <b>What are the biggest fears of implementing a practice shift of this magnitude?</b>  |
| <p>Time involved will make it difficult to do the work and the rest of the caseload demands will not get done and workers will crash and burn or the children needs will not be met and placement will breakdown.<br/>           Worried that a child might die and workers might be blamed or not supported. There is</p>   |

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| <p>pressure from the top to get it right and not put children at risk.<br/> Worried that staff will spend 3 years doing this and then just drop it.<br/> Worried that the managers will continue to question workers.<br/> Worried offices will use the map prescriptively (i.e. Doing it with the team but not with families just to get it on the file).</p>  |
| <p><b>What is needed to ensure this implementation is successful?</b></p>   |
| <p>Need lower caseloads to make room for the work.<br/> Change to the timelines.<br/> Less anxiety about using the tools and doing the work.<br/> Support from the top – less questioning while staff begin the transition.<br/> Community education to better understand SOS<br/> Community awareness campaign providing overview of all the good work staff do. PR in media about child protection work and approach.<br/> Continued commitment from director – need to know this will continue this no matter what.<br/> Improve inconsistency<br/> Scale willingness, capacity and confidence.<br/> More practice, opportunities, team meetings with people who know tools.<br/> Review of map.<br/> Compatible computer systems.<br/> Smart boards and videoconferences.<br/> Flexibility to do what works instead of everyone doing it exactly the same.<br/> Messaging that it won't always result in children staying at home no matter how hard staff tries.<br/> Words and pictures.<br/> Willingness, openness and opportunity to talk about good and bad.</p> |

Table 12

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| <p><b>What have I seen that would indicate successful outcomes in environments of change?</b></p>  |
| <p><b>What are some of the biggest challenges or struggles encountered in practice while implementing the Signs of Safety model?</b></p>   |
| <p>Community partners – i.e. Probation. Still deficit based. They think staff is overlooking risk.<br/> Families can get overwhelmed.<br/> Scaling question is subjective.<br/> Families in so many complicating factors hard to figure out what harm was.<br/> Some workers still hesitant or resistant – would be nice to decrease the gap.<br/> Getting too rigid in the jargon and becoming prescriptive then staff lose the ability to make it their own.</p> |

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|--|
| Time frame duplication.<br>Lawyers dissecting SOS in court.  |
| <b>What are the biggest fears of implementing a practice shift of this magnitude?</b>  |
| Worried that because of the length of time required to do the paperwork staff will resort back to doing the work in the office without family involvement. Dysfunction between the work and the educational component to the work. Worried workers and SOS won't withstand in court if really questioned or dissected by lawyers/judge. Won't hold validity/how credible is it   |
| <b>What is needed to ensure this implementation is successful?</b>   |
| Need to have the support from the organization to know staff are ok to give this a go.<br>Get community partners to mapping table.<br>Need a worker in house who is available to consult when needed.<br>Organizational commitment ongoing so that the practice doesn't change.<br>Conscious decision by management to push ahead using appreciative inquiry etc.<br>Workers need to decide 'today is the day'.<br>Get the lawyers on board as a start – they could be great advocates at court.<br>Using SOS and language in team meetings. |

## Summary

In many ways the information that was gathered to produce this discourse has surprised me: I truly expected that the themes would be distinctly different throughout the jurisdictions I worked with. However, in taking a look back over the years of accumulated data I can see that there are in fact very few differences among the subgroups (Indigenous and non-Indigenous), nonetheless, each group lends a very distinct and important understanding to the broader picture surrounding a change implementation in the workplace of child protection so each has been reported separately in the concluding narrative in Chapters five and six. I am excited to see what emerges from all of this.

## Chapter 5: The Findings

Before highlighting the themes that emerged among the groups and subsequent data gathered, I wanted to restate the original research questions to maintain focus and clarity as I weave my way through the materials:

- What is the significance of using the *Signs of Safety* model in Child Protection work?
- What are the barriers and challenges to a successful implementation?
- How could such a change be successfully implemented on a large scale within child protection organizations throughout Canada today?
- What would a strength-based, solution-focused model provide within the Indigenous context?

As stated in the previous chapter, there were similar themes that emerged within each of the subgroups but they will be separated here in order to provide clarity for each of the distinct groups in the following summary of findings. This chapter will focus on the two subgroups and the themes found under each of the categories used for data gathering and finally a conclusion will be drawn to provide the reader with an understanding of the consistent themes indicating what is required for a successful implementation of this magnitude. This chapter will further utilize the critical race lens to examine the existing power structures and identify how they perpetuate the marginalization of Indigenous organizations who suffer through some of the most complex cases in communities heavily ridden with alcoholism, substance abuse, violence, suicide, poverty and various other complexities associated with residential school trauma. The following is the charted themes that emerged in the study:



Table 13

| <p style="text-align: center;">→</p> <p style="text-align: center;"><b>Subgroups</b></p> <p style="text-align: center;">↓</p> <p style="text-align: center;"><b>Categories</b></p> | <i>Indigenous Emerging Themes:</i>   | <i>Non-Indigenous Emerging Themes:</i>   | <i>My Story Emerging Themes:</i>   |
|--|--|--|--|
| <i>Category 1:</i><br>“What’s working?”  | Outcomes (fewer children in care, lower recidivism rates etc.)<br>Clarity<br>Relationship<br>Supervision   | Outcomes (fewer children in care, lower recidivism rates etc.)<br>Clarity<br>Relationship<br>Supervision<br>Reduced fear/anxiety                               | Outcomes (fewer children in care, lower recidivism rates etc.)<br>clarity<br>Less Conflict<br>Improved Relationship<br>Greater sense of team |
| <i>Category 2:</i><br>“What are the challenges?”   | Community Partners<br>Time/workload<br>Systemic Capacity<br>Family Barriers<br>Supervision   | Community Partners<br>Time/workload<br>Systemic Capacity<br>Family Barriers<br>Supervision   | Systemic Capacity<br>Supervision - lack of Manager/Director support due to lack of knowledge of model  |
| <i>Category 3:</i><br>“What are the worst fears?”  | Risk to children<br>Liability of workers<br>Return to paternalistic approach<br>Burnout  | Risk to children<br>Liability of workers<br>Return to paternalistic approach<br>Community views  | Return to paternalistic approach   |
| <i>Category 4:</i><br>“What is needed for success?”  | Support from Supervisors and Managers<br>Structural changes<br>Policy changes<br>Education for community partners<br>Practice, patience and training for staff | Support from Supervisors and Managers<br>Structural changes<br>Policy changes<br>Education for community partners<br>Practice, patience and training for staff | Support from the Province<br>Management/Supervisor support<br>Consistency and safety<br>Changes to the computer system<br>Legislative change |

Based on the analysis of data and grouping of themes under each subgroup I found that there are, in the end, five consistent themes required for successful implementation: supervisor and manager support for front-line staff; policy and legislative change (with the exception of the leadership group) to support the theoretical shift; structural change to address the workload shifts (i.e. generalist caseloads, shifting resources to the front end of services and lower caseloads); collaboration and education for community partners; and, finally, patience and training for staff learning to re-think their understanding of child protection work.

The first theme, *support from supervisors and managers* emerged in both of the subgroups, as an essential ‘need’ for successful implementation. This theme also emerged quite heavily in the challenges associated with a practice shift of this scale. Nearly all offices struggled with an inconsistency of messaging among supervisors leading to confusion and inconsistent practice, which subsequently affects the families and children receiving services. It was also consistently noted that there was a lot of pressure from supervisors and managers to use the practice in spite of the existing lack of confidence among workers in the tools themselves; this in itself, created a sense that the practice was being imposed creating a certain degree of discouragement and subsequent resistance to using the model. This theme begins to highlight the challenges associated with the changing practice in the environment of child protection work.

The second theme that emerged was *policy and legislative changes to support the theoretical shift*. In nearly every office I have ever worked there have been countless debates about the need to address the shift in our legislation itself; just like the structure of our child protection ‘business,’ legislation has been constructed on the foundation of

something that doesn't work for workers and families alike. This legislation dictates how workers treat calls that come into the office and, very specifically, lays out the length of time workers have to complete their investigation, determine the safety of children and remove or not remove. It was and still is evident that this timeline was ineffective within the Signs of Safety practice framework, which is not only putting strain on workers but also creating confusion around best practice with families. There is a strong desire for policies to better reflect the ability to work with clients in the most effective way possible.

The third theme that emerged was *structural change to address the workload shifts*. The Signs of Safety practice is front-end intensive work and as such requires more time and more resources at the intake and investigation/assessment stages of practice. This was experienced within the environment of change with the need for lower caseloads and flexibility at the front end to allow time to do the good work with families. This theme does, however, also recognize the need for changes in administrative requirements of workers who experience a significant amount of redundancy in the documentation required as well as the way in which the electronic systems are set up. These systems hold all information on families related to any child protection intakes, assessments, and outcomes and, in many jurisdictions, subsequent referrals and work done with families.

The fourth theme that emerged from the data was *collaboration and education for community partners*. This may seem insignificant to an outsider but I can assure you, this is one of the most significant challenges faced by workers throughout the jurisdictions implementing Signs of Safety, or any, new practice. Community partners have been comfortable with the way child protection provides services for decades; to begin a

change as drastic as this, is at best, precarious. Those partners who child protection services have partnered with for years in one particular fashion are now questioning the ability of workers to provide appropriate safety to children. Both of the subgroups display concern over the lack of understanding that community partners have and the subsequent chaos they create in attempting to sabotage the work that is being done with families. This has been, at first, very damaging to the relationships that previously existed between courts, schools, hospitals and child protection services causing a significant degree of pressure for staff.

The fifth and final theme that emerged as a need to successful implementation is *patience and training for staff learning to re-think their understanding of child protection work*. With one of the greatest challenges being capacity issues related to the re-learning and re-thinking of practice, workers require supervisors and managers to be patient during the learning journey. Allowing workers time to absorb the principles, the practice, the theory and tools and being mindful of the fact that staff's greatest fear is liability should a child die is essential to the change journey; staff really do want to get it right. In all offices, in both of the subgroups, there was a strong need for more training opportunities, more learning and patience as staff fumble their way through this new terrain that is so very foreign in the beginning. It was also clear that there was still a lack of clarity about the basics of the Signs of Safety practice; what is needed is time and practice in order to build confidence while deepening the understanding of the philosophy and theory behind it. This isn't easy.

## **Theme one: Support from Supervisors and Managers**

### **Significance:**

“While the process of building a culture of appreciative inquiry around frontline practice must be embedded in regular individual and group supervision, it is vital that senior management replicate this process and practice, particularly when crisis occurs” (Turnell & Murphy, 2014, p. 46). This theme is key to any successful implementation but it is also key to building happy, satisfied staff who are able to think critically. It was clear that supervision in mainstream offices was improved using the Signs of Safety tools to identify family issues and find solutions without getting caught up in cases of denial. My experience was similar in that it allowed me to become clear and focused on child safety while also promoting a greater sense of team and staff satisfaction. Supervision is not something people in this field invest a lot of time into thinking about. Across the board, throughout every office I have ever worked with, supervision with staff has been consult-based with very little consideration or time given to clinical supervision and staff development. In fact, I’ve heard supervisors say things like “I’m not their counselor, I’m not going to listen to their personal issues.” This is the mindset that leaves workers feeling unsatisfied in their jobs and feeling dehumanized by their experiences. Child protection is a crisis driven field and the frontline staff bear the brunt of it, good supervision is essential to not only understanding the safety of children, but also to conflict resolution, critical thinking, confident/skilled workers and reduced turnover of staff. The outcome is the best possible service provision for children and families.

### **Challenges and Barriers:**

The lack of supportive supervision became very evident throughout the analysis of emerging themes; the Indigenous offices had managers that created confusion, were

inflexible, imposed practice on staff, and were micromanaging but not using the practice themselves. Leaders were not being held accountable for supporting workers in the shift of practice and it was evident in the field notes that there was a growing discontent because managers and supervisors were too far removed from the practice to understand what workers were really going through. This is consistent with my own experiences where the managers lacked confidence and were unable to provide a parallel process in supervision, which in fact, led (in part) to my own resignation. It is very possible that this is partly due to the dual accountability experienced by workers on reserve who, as Reid (2005) reports are “accountable to the provincial and federal governments as well as to First Nations community members” (p. 4). Mainstream (non-Indigenous) offices had similar challenges with supervisors creating confusion because of a lack of consistent direction, they continued to pressure staff and create a lack of confidence in workers because they themselves didn’t understand the practice. There was additional concern in some Indigenous offices around a lack of trust between workers and their supervisors/managers due to a lack of clarity around roles and boundaries and the leaders’ inability to comprehend the practice because of the few opportunities they have to test the tools.

**Successful Implementation:**

A successful implementation requires effective, manager led supervision. This is confirmed in the literature by Fernandez & Rainey (2006), who suggest that key to successful change management is found in the purposeful actions of managers, supervisors and other leaders within the organization, and Turnell and Murphy (2014), who contend that leaders and managers must pay attention to key aspects of the Signs of

Safety practice and the experience of frontline staff. Key subthemes found throughout my experiences related to supervision needs are as follows:

- *Trust* – this was noted as the need for supervisors to create a safe environment where staff can openly share the concerns and fears about implementation without reprimand or reprisal. There would be recognition and trust from leaders that staff are doing the best they can.
- *Consistency* – this was noted as the need for a consistent practice throughout all departments implementing Signs of Safety in order to create better outcomes for children and families. The supervisor/management teams should ensure that messaging and communication around the practice shift is consistently given to staff to reduce worker anxiety; staff should also be encouraged to continue to use the tools while highlighting the good work that is practiced. In my experience I noted that the lack of consistency led to teasing or ‘putting down’ staff who use the tools and this became quite toxic leading to staff hiding their work. This was experienced in many of the offices I worked with including my own.
- *Commitment* – this particular subtheme is heavily evident throughout offices implementing Signs of Safety that are typically encumbered with fear. Throughout my field notes I consistently noted that a change of this magnitude seemed to create a fear or a sentiment that child protective services are suddenly leaving children at risk and that should a child die, staff will be held responsible. The truth of the matter is child protection has always left children at risk because it’s never truly understood danger and safety.

Nonetheless, staff require the messaging from their leaders that they will not be held liable for incidents that occur while they are learning the practice but also that the practice itself will not be forsaken when such an incident does occur. Workers need to know that their leaders (supervisors, managers, directors and in some cases even ministers) are committed to the change for better or for worse.

- *Emotional support/critical debriefing* – managers and supervisors need to follow up with workers and offer better emotional support or have some means of critical debriefing, because of the significant trauma related to working closely with children and families at risk. It is essential that supervisors and managers maintain consistent and ongoing discussions with staff around the challenges and successes associated with the work being practiced. Great teams grow when staff are supported through tough times and validated in good times.
- *Philosophy of learning* – all my experiences within the subgroups speak to the need for continuous learning to ensure successful implementation. This was also heavily needed in my own office in order to grow strong, skilled workers who would be confident in their use of the tools. A philosophy of learning requires that supervisors meet with staff as individuals and as a group to explore the good work. Turnell and Murphy (2014) insist that access to critical supervision through reflective practice is vital to achieving the practice depth necessary to work with families in crisis. Child protection must grow organizations and staff who can learn to appreciatively inquire about the good work being done with families in order to create, establish and solidify the ability of workers to think critically through the complex cases of neglect and



abuse. Training itself does not equate to implementation, in fact workers who attend training events retain very little of the information required to shift their practice. I have witnessed this when a year after training staff have come to me asking for review of the most basic information. Implementation success requires practice, supervision and ongoing training.

**The Indigenous Context:**

In my experiences with Indigenous organizations I have noticed a significant degree of fear and anxiety among workers and supervisors; many of these offices were in such a state of crisis due to the administrative demands of the work, that slowing the process down long enough to think critically only produced further anxiety. It is this type of crisis driven work that has the potential to create serious gaps in service quality, which will inevitably affect an organization's ability to lead and supervise staff as well. Reid (2005) reports that for many workers the stress is unmanageable and can lead to chronic health issues, job change, stress leave and forgetfulness; all of which of course will effect service outcomes for families and children. Reid also reports a serious lack of organizational supports to help workers deal with the vicarious trauma they experience on the job leading to more of the above noted issues.

In the BC Ministry of Children and Family Development: Supervision Model (2011) it states that there are two distinct types of supervision, *casework* and *clinical*. The model describes supervision as the overseeing of another person's work in an effort to ensure they are providing a quality of practice that adheres to the organization's standards. The supervisor can accomplish this by providing feedback and direction to build the worker's abilities and competencies. Clinical supervision on the other hand, is described as more

of a distinct professional practice whereby the supervisor supports and enhances the direct work of a practitioner to ensure quality service while promoting positive client development and well-being. This can be achieved through the establishment of intentioned and purposeful relationship building. This type of supervision takes time and time is something few child protection supervisors have.

Additionally however, I recognized that there was a significant degree of inequality existing in agencies administering services for the welfare of their children: Not only were Indigenous communities who held the full delegation of services, expected to promote and support community development above and beyond their duties as workers, but they were also expected to somehow unravel the years of trauma that led families to this point of our involvement. Indeed, the complexities of working in Indigenous community is much more demanding than that found in the mainstream and additionally many of these staff struggle to make decisions about their own community members, sometimes even family, when forced to do so under an imposed system that does not regard local knowledge, safety or culture. In her study, Reid (2005) speaks to the challenges faced by women working in delegated Indigenous child protection agencies on reserve saying that not only is it a significant challenge to work in your own community where you “are considered community members first and social workers second” (p. 5), but also there are cultural conflicts created from working under an “imposed foreign system” (p. 5). Workers in Indigenous organizations “remain in a colonial, racist and paternalistic relationship with the Canadian government and the child and family service laws, policies, practice and systems that impact their holistic health” (p. 4). A colonial Canada still exists in spite of any desire to put it behind, and the racism of our country is

still very much alive and evident in our policies, legislation and governing systems; this includes but is not limited to child protection.

My experiences in all of the Indigenous offices, even in the beginning phases of the practice shift, was that not only were there fewer children being brought into care, but the recidivism rates were also dropping; families who they would typically see again and again were in fact, not returning to services once their file was closed. These offices were also creating more meaningful safety plans for families as a result of the Signs of Safety practice tools, creating clarity for workers allowing them to better understand the harm, danger and safety of children. Workers in these offices were also using the model in very unique and creative ways to reflect the culture and situations of the families they worked with. The Signs of Safety model is quite fluid and flexible allowing for the language to reflect the culture, beliefs, tradition and language of the community itself. But it also allows for tools to be used with families in exceptional ways; and it was within the Indigenous organizations where the greatest degree of creativity was used. Pieces of the model were relied upon to help create books based on community legends; family meetings were used on a community-wide scale to address larger community issues such as alcoholism, drug trafficking and suicide; there was even a story drawn on buckskin to explain to a child why he could not live with his biological mother and father, the story included the history of colonization so that this child would know that his mother and father were not to blame for the current circumstances of his family and community.

Finally, in those communities utilizing the Signs of Safety approach it was evident that families receiving the Signs of Safety services were happier and more engaged in the process with the focus being on their children rather than on the fight with the Ministry.

Utilizing the Signs of Safety practice with families is not only less intrusive but also strength-based which minimizes the conflict between the ‘Ministry’ and the family itself. Workers appear to be more confident about the information being gathered at intake as a result of utilizing the Signs of Safety tools, which allowed for a much clearer understanding of families in crisis.

## **Theme two: Structural Change**

### **Significance:**

This theme although distinctly separate from the rest in the outcomes, actually ties into the first and third themes. There was a consistent need for workers to know they would be supported in their learning journey as they began to implement the Signs of Safety practice. What I experienced was that workers can become quite overwhelmed with not only the complexity of the work itself, but with the addition of having to learn a new ‘way’ of practicing, a new philosophy; this meant that additional time might be required to do the good work. This additional time would require lower caseloads and less administrative work while workers adjust to the change. “The center of the work – the actual practice – is lost when organizational arrangements and prescribed procedures are seen as the way to control child protection practice and outcomes” (Turnell & Murphy, 2014, p.). For the most successful outcomes, organizations looking to implement change simply must be able to look past pre-existing structures to find what truly works for families and the staff they work with.

### **Challenges and Barriers:**

Signs of Safety is front-end intensive work but in the environments experienced, the current systems are not set up to manage that much work in the early stages. And, although the legislation differs in each province, most only allow up to five days to

complete an initial assessment. Workers need more resources at the intake and investigation/assessment stages of practice in order to truly accomplish the work that the Signs of Safety model requires of them. Paperwork, documentation and duplication of work were subthemes that emerged throughout the data indicating that new workers would be unable to perform to the best of their abilities because existing caseloads and expectations around paperwork meant less opportunity to use and practice Signs of Safety.

**Successful Implementation:**

Interestingly enough, the ‘structural change’ theme did not show up in my own implementation journey which I can only assume is because we were generalist workers and were able to build relationship with family as well as maintain a great deal of flexibility within the agency to shift the structure to meet the demands of the work so any front-end overload became quite unnoticeable. Perhaps an adjustment such as this would be key to successful implementation; it certainly did work for us. My experiences suggest the possibility of other options such as more workers at the front-end of practice, more time allowance at the intake and investigation stage and flexibility for workers to do what works with families rather than having to adhere to such prescriptive, inflexible measures as ordained by the Ministry. Lower caseloads, more time and in-house mentors or practice leads are clearly needed for successful implementation of the Signs of Safety practice. Managers and supervisors would also benefit from in-house mentors and practice leads; there is also an increased need to identify ‘practice champions’ who will mentor the other staff throughout the journey of change. Structural change might also include shifting staff with lower caseloads to the front-end of service to relieve the

fatigued workers and moving files to a generalist caseworker as soon as they know its going to open. It is imperative that implementing organizations address the impact of workload on staff to assuage the subsequent stress on workers and the potential effect on outcomes to children and families.

**The Indigenous Context:**

In my experience throughout the duration of my career, I have seen that there is a significant degree of inequality existing in many Indigenous agencies administering services for the welfare of their children. Not only are Indigenous communities who hold a full delegation of services, expected to promote and support community development above and beyond their duties as workers, but they are also expected to somehow unravel the years of trauma that led families to this point of child protection involvement. Indeed, the complexities of the work in Indigenous communities is much more demanding than those found in the mainstream. In these organizations, as with others, the infrastructure is still set up for practice that utilizes legislation, policies and procedures that often contradict the Signs of Safety model. And, even though the Signs of Safety practice requires more work, staff continue to carry the same number of files, this is in addition to the complexity that already exists within Indigenous agencies.

One of the biggest concerns that I identified throughout the field notes was a fear that workers would burn out while struggling to implement the Signs of Safety practice, and would perhaps feel their work with families was ineffective and would subsequently fall back to using former methods of practice because they are familiar and thereby more comfortable. There was a sharp distinction in some Indigenous agencies between intake/investigation workers and caseworkers that appeared to create a lack of

communication and a non-existent sense of team that is much needed in the child protection field. This can lead to dangerous practice as highlighted by Reder, Duncan, and Gray (1993), who note that lack collaboration and communication among professionals became a fatal error for many children who died at the hands of their parents.

### **Theme three: Policy Change**

#### **Significance:**

Within the child protection field policies, legislation, standards and procedures have been constructed and implemented as a means of correcting issues that have arisen in practice but they are “often complex, prescriptive and time consuming...” which results in “suffocating many workers, stifling their creativity and keeping them at their desks” (Turnell & Murphy, 2014, p. 52). Turnell and Murphy (2014) acknowledge that policy needs to be ‘streamlined’ and often times even re-written in order to align with Signs of Safety. Legislation and timelines have a way of suffocating staff and preventing them from doing the good work required by the practice shift. It is essential then, for there to be some flexibility with regard to the assessment phase of the work as well as court proceedings, this will allow workers to regard families as unique while promoting relationship and cooperation leading to better outcomes for children, families and workers alike.

I noted in my experiences that the legislation that dictates the workers response to calls of concern, treats assessment as though it is static yet frontline workers know that family assessment occurs from the opening of a file to the closing of a file. Furthermore it is understandable that during this time families can and will change. Also, one of my own frustrations with the mainstream approach to child protection is the legislation’s

push to permanency for children; this would insist that all parents have exactly one year (if you're lucky) to make the necessary changes or parents will lose their parental rights and their children will be placed for adoption and potentially lost forever. This is something the Indigenous communities have seen throughout history. Sinclair (2007) cites the work of Fanshel, York, Timpson, and Fournier and Crey, saying, "Aboriginal children were apprehended in disproportionate numbers throughout Canada and adopted primarily into non-Aboriginal homes" (p. 66). Sinclair goes on to say that apprehensions were a deliberate act of genocide, a follow up to the 60's scoop after the demise of the residential school; and, according to Sinclair, "the white social worker, following on the heels of the missionary, priest and Indian agent, was convinced that the only hope for the salvation of the Indian people lay in the removal of their children" (p. 67). Carrière (2008) in her discourse on the adoption of Indigenous children adequately confirms that, "colonialism, residential schools and the child welfare system have been systemic assaults that imposed adversity [in the lives of Indigenous people]" (p. 72). It is evident that a shift in policy is not only necessary but also overdue; new policy around this and countless other areas related to child protection leading to better outcomes for children and families everywhere is desperately needed.

**Challenges and Barriers:**

*Child protection organizations are amazingly reluctant to let go of complex policies and procedures. Because the work is so complex, anxious and uncertain, almost invariably policies and procedures have attempted to capture all the diverse elements of the work and to prescribe actions accordingly. (Turnell & Murphy, 2014, p. 52)*

There is a certain false sense of security that comes with policy and legislation, somehow workers and organizations alike feel as though these policies create safety for children as unlikely as that may seem. It is, however that false sense of security that



prevents organizations from making the necessary changes to that policy in spite of the long overdue need for it. This is potentially one of the greatest challenges organizations will face in implementing Signs of Safety. It requires a rigorous and thorough restructuring. My experience confirmed that there is increased time needed to provide families with the service required under the Signs of Safety framework, at least in the beginning phases. Workers have a tendency to be working more evening hours in order to prevent negative consequences to families who work during the day; this is just one of many policy issues that need to be addressed in order to do the good work. In my experience there was also a fear that the framework would change to meet legislation rather than legislation changing to meet the framework.

**Successful Implementation:**

I recognized early on in my experience that workers undergoing the practice shift would need to see a reduction in the redundancy associated with the work, and a change to legislation to ensure it supports the Signs of Safety practice that staff are expected to utilize. Essentially, to be satisfied Signs of Safety was being successfully implemented, staff need to know that they will see lower caseloads making room for the perceived increase in work and that timelines will be addressed within policy.

**The Indigenous Context:**

Indigenous offices share similar concerns around policy and legislation leading to caseloads that are unsustainable; this needs to change and it needs to be reflected in policy to reduce staff fears around liability. Staff need to know there will be support for them if things go wrong but to be clear about utilizing the Signs of Safety practice they require a clear process in place so workers understand when to do what. There were

subthemes that emerged in relation to the fear and anxiety that workers throughout all offices shared: Risk to children, liability of workers and a return to paternalistic approach. These fears were evident throughout offices (Indigenous and non-Indigenous) with concern about becoming confused and potentially missing errors that would lead to fatalities leaving workers to blame. This lack of trust in the bureaucracy is real and creates an environment of fear and anxiety; good work simply cannot happen in such an environment. Implementing organizations must work to minimize the fear of workers by creating supportive policies and role modeling a healthy response to incidents of tragedy. Turnell and Murphy (2014) confirm this saying, “perhaps the most fundamental and testing role of leadership in a child welfare organization is fostering a safe organization – building staff confidence that workers will be supported through anxiety, contention and crisis” (p. 57).

My experiences in Indigenous offices is that there is a heightened sense of insecurity, anxiety and fear due to the complexity of the work, the capacity of the workers (related to the practice shift), the lack of funding and constant turnover of leadership; all of which is exasperated and perhaps even instigated by the higher rates of poverty, violence, suicide, and other traumatizing events experienced by workers on reserve. Characterized by mistrust and frustration, the government-Indigenous relationship continues in a state of despair due to the historical ideology and intent of the government to “civilize” and assimilate Indigenous people. This political agenda has led not only to the destruction of traditional family, social and political systems, causing generations of institutional abuse and trauma, but also subsequently to a high level of child protection involvement (Sinclair, 2007). This over-involvement of child protection in the lives of Indigenous

families means increased caseloads for workers on reserve but also heightens the complexity of the relationship between worker and family due to lack of trust, suspicion and uncertainty; this is a direct contradiction to the nature of the work practitioners are tasked to perform. This paradox bedevils the worker's ability to ensure safety for children and thereby increases the fear and anxiety of the worker, which in turn, decreases their ability to think critically about situations of abuse leading once more to higher rates of apprehension. These problems faced by workers in Indigenous community need to be acknowledged and addressed through equitable funding, improved and ongoing training, an equitable distribution of experienced workers in all departments and finally an upward sharing of anxiety.

#### **Theme four: Education for Community Partners**

##### **Significance:**

Child protection work is not done in isolation; there are a multitude of community partners involved including but not limited to police, courts, schools, hospitals and many others. These partners have been relying on our services to become intrusive with families when there are reported concerns. In all offices, regions and provinces I have ever worked I have noticed an unsettling response from these partners when workers begin to utilize a more respectful, less intrusive way of working. Many have become indignant, insistent, pushy, angry and in some instances even sabotaging work with families during meetings. This is primarily due to a lack of understanding, and where there is lack of understanding there is fear. What is needed to address this is a continuous education for community partners to create shared understanding and minimize the fear.

**Challenges and Barriers:**

In mainstream environments it was evident that the community had growing fears about the practice shift and are, in at least one of the offices, calling repeatedly to get the workers' attention. Community partners are pushing for child protection to do work that, in some cases, isn't even child protection related. This push from community partners is quite common; they are exhausted with the behaviors of children in the classroom or on the streets and rather than call the family they call child protection to deal with the family. Today staff are pushing back and community partners are feeling the pressure. In all environments there was an inherent lack of understanding within the community making the work more challenging for workers; workers have been questioned in court by judges and lawyers, who are sensing that child protective services may be overlooking risk, while other partners are gossiping in the community saying that child protection isn't doing anything to address concerns reported because they aren't seeing any action from the workers (by action they mean apprehensions). At the end of the day, many of the community partners are just as prescriptive and deficit-based as child protective services; it takes time for systems such as these to develop an understanding and begin to shift their own way of thinking, but it can be done. You will note after all, that this theme did not show up in my own experience table because our office had worked right from the start to educate our community partners (lawyers, teachers, school board, health professionals) recognizing that this was needed. They were quite confused and even a little frustrated at the changes being made so I had offered free training to them early on and many very quickly came to appreciate the practice even adopting it into their own positions in the schools and health care settings.

**Successful Implementation:**

An implementation of Signs of Safety requires a shift in our understanding about child safety and well-being; it requires reflexivity in practice and a thoughtful consideration of the authority workers hold in order to reduce the power dynamic and approach families with a degree of humility. Signs of Safety does in fact, require a philosophical shift in our everyday thinking about child protection ideology. Obviously such a shift would not be easy for workers but it can present an even greater challenge to our community partners who work alongside child protection in providing supports to families in need. For a successful implementation to occur, child protection systems will need to work to increase understanding throughout the collaborative working systems through ongoing discussions, involvement and education. It is essential that our partners come to know the language, the process, the context and theory for practice in order to ensure improved safety for children.

It was identified that there is a need to create consistency on the front end (intake) in order to build trust with community partners; practitioners need to know that they will encounter the same response from different workers maintaining a positive outlook on the work; there is also a need for role clarification with solid understanding and clarity around who does what in order to identify who's prompting and checking in at necessary checkpoints; training must be made available to community partners (i.e. Police, schools, court); it is important for staff to see more buy in from the community as well as a greater degree of collaboration between service providers. Essentially, the community needs to understand our work and what our vision for the organization and community is. And, finally it's time for our communities to hear about the good work done by practitioners in

child protection; some positive ‘PR’ in media about the work and the Signs of Safety approach would make a vast difference in the public’s perception of child protection.

**The Indigenous Context:**

The Indigenous agencies have similar needs for community partner training. My experience is that because the courts have not embraced Signs of Safety, they are actually causing problems for staff; and those other community partners such as schools and hospitals lack the understanding necessary to work collaboratively within the Signs of Safety practice framework as well. And, as stated earlier, the lack of support from partner agency staff has actually resulted in workers sabotaging the work with families while they are sitting at the table. Successful implementation would require that there is training available for all community partners and clarification around roles and expectations for everyone.

**Theme five: Practice, Patience and Training**

**Significance:**

As stated in chapter two of this discourse Turnell and Murphy (2014) insist that there is the need for a strong focus on learning and “needs to be multifaceted and continuous and become built into the fabric of everyday experience of staff” (p. 54). Training itself is only one way of learning, and at best provides only motivation for staff to begin the journey of change but as Turnell and Murphy (2014) admit, in itself, has little impact on the day-to-day work of staff. For implementation to be sustained there must be a continuous learning that occurs throughout the life of a practice shift. This would include basic training, core training for supervisors and managers as well as continued coaching on highly complex cases.

**Challenges and Barriers:**

Of course any change of practice requiring a shift in the very philosophy of an organization is going to cause some uneasiness, fear, hesitancy and not-to-mention capacity issues for workers. There were a large number of capacity concerns noted throughout the duration of my experiences with implementing organizations; too many to include here but I will include those subthemes that came out of the ‘capacity’ theme related to challenges and barriers:

- Facilitating and writing on the whiteboard at same time and while trying to capture the voice of families
- Involving and engaging youth
- Struggling with the basics – separating harm danger comp factors and writing danger statements in simple language.
- Hard to trust in the model/assessment.
- Inconsistent in different offices.
- Struggling to use Signs of Safety with permanent guardianship files and permanency planning because there is no family
- Facilitating a map with a family
- People have a different interpretation of process. Is there a wrong way?
- Families who have been through the system lack trust and won’t buy in. Doesn’t work when there is denial
- Intergenerational cycle of child protection concerns with multiple calls on the same family – tough to break that cycle
- People are still struggling with letting go of the complicating factors and being clear.

- Fear of tough conversations
- Not doing safety plans – just creating a list of services for families to do – mappings are too simple – not enough info.
- Families with so many complicating factors make it hard to figure out what the harm is.
- Staff still very directive, despite using the tools – they have not realized the philosophy behind it, nor the importance of relationship building.
- Some workers still hesitant or resistant.

Capacity concerns are most often related to initiation of a new response to crisis, assessment and essentially the theory behind our practice. However with ongoing practice, training and mentoring, staff very quickly come to understand the shift, I noticed that between years one and two, the practice depth of workers was significantly greater. This comes from creating that philosophy of learning that Turnell and Edwards (1999); Turnell and Essex (2008); Turnell and Murphy (2014); Munro (2008); and Munro, Turnell, and Murphy (2014) all speak of utilizing the appreciative inquiry that examines the good work that staff have done.

**Successful Implementation:**

What is needed to ensure the implementation is successful is training around Signs of Safety processes at intake and assessment/investigation stages, ongoing opportunities in-house to practice, how to get families to the table, ongoing training and practice opportunities for supervisors and managers and more use of the tools to ensure workers are practicing in consistent ways and growing their confidence in the work. Upper management must find ways to show they are able to be patient with staff as they go on



this learning journey recognizing it's not going to happen overnight; organizations must work to create a safe environment where workers can share their good work creating a willingness, openness and opportunity to talk about the good and the bad. Managers and supervisors need to be cognizant of the benefits to focusing on team building within their organizations using group supervision and modelling the solution focused questions in supervision with staff.

My own experiences with training confirms that training does not equate to implementation, there needs to be ongoing specific opportunities for purposeful practice within each and every organization implementing. This is best created through the use of appreciative inquiry, which has the added benefit of creating happier, more satisfied staff whose quest for knowledge is ever-increasing leading to the practice depth most desired in the field of child protection.

### **The Indigenous Context:**

Indigenous communities require ongoing training and practice opportunities as well as mentorship to be made available in-house. There is an evident need for improvement in good communication, a clear process that allows workers to more effectively do their individual jobs and a demonstrated knowledge of Signs of Safety. My experiences within Indigenous organizations indicate that due to the increased complexity and demands of the work in these areas, learning is slowed and capacity reduced. As a result, I recognize that there needs to be greater emphasis for training within these implementing organizations with continued patience and support as their learning journey may take longer and require a greater degree of funding and training opportunities. For many Indigenous organizations this funding is simply unavailable, many have utilized dollars

from operational funds or other departments of the organization; one particular organization I worked with actually forfeited their individual professional development dollars for the training. Today however, in some jurisdictions that are fully implementing, training dollars have been made equitably available to all child protection offices, regions and Delegated Aboriginal Agencies alike. They have even provided training for community partners and support workers. This type of forward thinking should be sought across all provinces in Canada.

## **Chapter 6: Navigating the Outcomes**

This thesis intends to provide readers with the actions and commitments necessary for those organizations that may be considering a theoretical and philosophical practice shift in the way they currently provide services to individuals in crisis. As seen through the notes and experiences of this writer, a change of this sort requires supervisor and manager support for front-line staff; policy and legislative change to support the theoretical shift; structural change to address the workload shifts; collaboration and education for community partners; and, finally, patience and training for staff learning to re-think their understanding of their work. As recorded throughout this discourse, change comes with considerable angst, and numerous challenges but it is also inherently rewarding for workers, families, children and even Ministries who recognize that finally, they are able to provide ‘real’ services to people with ‘real’ outcomes.

To truly understand what is meant when said implementing Signs of Safety is like “fitting a complex system into an already complex system,” the reader must first consider the historical nature of child protection. The foundation of child protection work has been well established over decades of experience and decades of wrongful response to situations that might be deemed failures. What I mean by that is that governments worldwide have responded to every child death with new regulations, changed policies, legislative shifts and staff expectations. This is the ideology of child protection work. In order to implement Signs of Safety those foundations need to be broken, policies need to shift, legislation needs to change and structures need to be restructured. This requires time and commitment: Signs of Safety is a five-year journey; it is not something that can be obtained in a two-day training. This may scare our leaders into maintaining the status

quo but what I know is that the existing structure of child protection has not worked; not for mainstream, Indigenous or immigrant families alike.

One of the greatest problems in the field of child protection is that it is work done in an environment of fear; society feels that it is up to social workers to ensure no harm comes to any child that ever becomes involved with a child protection system. The result of this fear is control; in order to protect those children control is exercised within the situations themselves in order to manipulate outcomes and subsequently the individuals involved. After all, the social worker's job depends on it, or so it seems at least. Now compound that fear on the fear and anxiety of the families who are working with child protective services: Imagine yourself as a mother who has just opened the door of your own home only to find a social worker standing there requesting access to your home, your children, your fridge, cupboards, bedrooms and your actions. Imagine the intrusion, the range of emotion, and the desire to run, hit, kick, scream and protect your children at all cost. Now imagine that this triggers a memory of a painful story your grandmother told you about the day the 'authorities' came and took her children away from her and placed them in residential school. The two events are so similar they could actually be the same. What if, social workers were able to relinquish some of that control? What if a degree of control was placed back into the hands of the families allowing them to talk, and to make decisions about the safety of their children? What if workers were able to offer hope instead of fear? Respect instead of threat? What if families and communities were once again responsible for making decisions about the safety of children instead of insisting it to be the task of the professional? What if... families were considered the experts? It is hoped that this research will not only answer the questions implied, but that

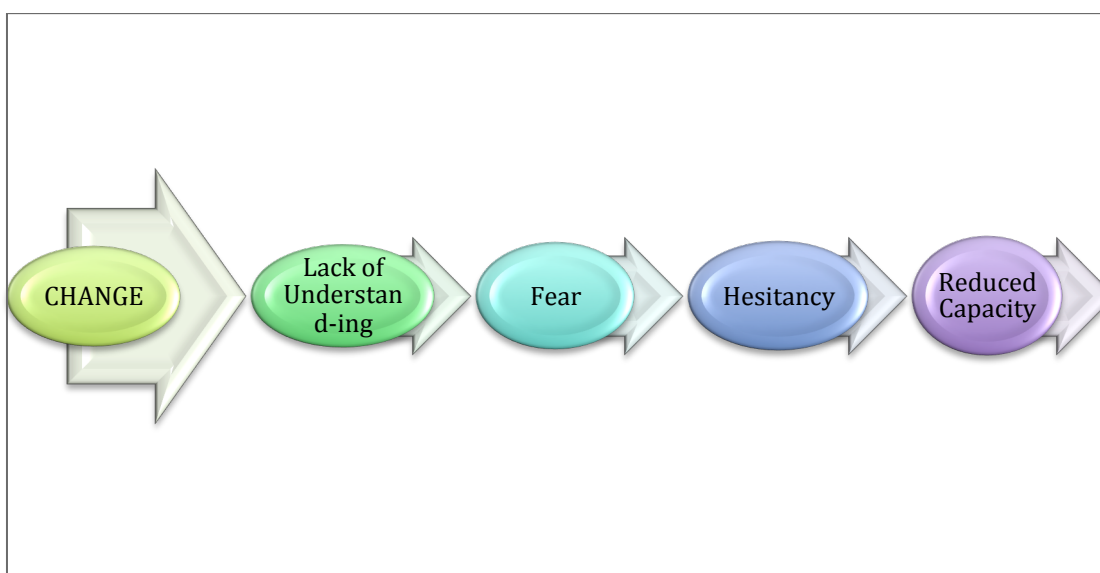
it will encourage organizations across the country to implement a practice that will lead to that sense of hope, respect and safety for children and families alike.

Using my experiences both as a social worker and as a consultant/trainer in the implementation of practice, this study purposed to take an in-depth look at the historical context of social work highlighting the need for systemic, organizational and legislative change while identifying a process for successful implementation of the Signs of Safety practice framework by first exposing the indicators of success. Utilizing an auto-ethnographical methodology grounded in the critical race theory I have provided my personal experiences; the successes, the challenges and the barriers to change along with a thematic-based outcome of the organizational needs required to make it happen.

While I don't purpose that all experiences of change within organizations have been or will be the same as what I myself experienced, what I can say is that what I learned throughout the creation of this thesis was that the experiences of most organizations undergoing change is the same as (or at least similar to) my own, but the response to the challenges and barriers differ depending on the level of safety and support within the organization. For instance, though my personal experience with organizational change on the frontline included frustrations around community partners who did not understand the Signs of Safety practice model, I did not become overly concerned with it and addressed the issue right away by providing free workshops open for anyone; this seemed to help our partners develop an empathy and understanding for the work we do.

Reflecting on my experiences within the change environment of child protection, I have come to discover that the vast majority of capacity issues that were presented in the 'Practice, Patience and Training: Challenges and Barriers' section in Chapter Five are

primarily due to a heightened sense of fear that occurs during the initial stages of any change encountered by workers. These fears were consistent among all groups as the theme: risk to children. And, as I experienced, this can be viewed as the result of an undeveloped sense of understanding about the theoretical shift being undertaken. In other words, a lack of understanding during the infancy stages of implementation leads to fear, which then leads to hesitancy (also known as resistance) in the use of the Signs of Safety tools and subsequently a reduced capacity in workers. This is reflected in the following chart:



**Figure 1**

To address this cycle and ensure successful implementation occurs it is essential, to provide *support from supervisors, management and ministry* alike. Staff need to know there will be safety for them as they step out and begin this journey. There needs to be ongoing opportunities for *practice, and training as well as patience* from all departments, horizontally and vertically, to ensure staff know there will be flexibility while they increase their understanding over time. Furthermore, *community partners need to be engaged* and encouraged to attend training at the early onset of the change cycle to

minimize the challenges associated with this theme. And, finally change must be paralleled in the organizational structures and engines that guide our work; the *policies, legislation, standards and computer systems must be altered* to fit the Signs of Safety theories, principles and practices of the Signs of Safety model.

And finally, as discussed in Chapter Three of this study, the critical race lens was used to look at the institutions of child protection and the historical problems of domination, alienation, and social struggle it creates within the Indigenous populations in order to envision new possibilities (Creswell, 2007). The desired outcome is to both understand and change the institution under study while empowering Indigenous communities to lead their organizations toward a change that will have crucial and beneficial results for families and children. Critical race theory also seeks to examine the existing power structures while identifying how these perpetuate the marginalization of the group studied (UCLA, 2014). In consideration of the Indigenous context, governments and bureaucracies responsible for decision-making must develop an empathy and understanding of the complexities that bedevil the work of the courageous workers in Indigenous organizations who often take on so much more than they can bear. Underfunded and overloaded, these organizations may require a heightened need for greater support, additional training and allowances for an extended change journey.

Also evident in the development of this thesis is that even in the infancy stages of change there are significant outcomes for workers and families alike. This was evidenced in the themes where all sub-groups including myself experienced improved outcomes with families including but not limited to fewer children in care (up to 50%), lower recidivism rates (suggesting success) and lower caseloads. For workers there was a

greater sense of clarity in the work with complex files of abuse and neglect, there were better relationships with families and a reduced sense of fear and anxiety for both workers and families. When used in supervision, the philosophical shift has the ability to generate enthusiasm about the work and the growth of skill and critical thinking. There is a consistent increase in staff satisfaction, commitment, confidence and capacity as well as a greater sense of team. All of these outcomes are consistent with my own experience as a frontline worker.

### **Conclusion**

Doing research of this kind has been both challenging and rewarding. As a practitioner of the change process working from a strength-based perspective and training workers how to encourage families to be the experts and then suddenly as a researcher I feel I am expected to present conclusions as though I am an expert when I don't in any way consider myself an expert. It is in fact a direct contradiction to the very nature of my work but needless to say I am here pulling together the information in the best way I know how. I have learned a great deal in doing this study, not only about the change environment but also in relation to 'research' itself. Sometimes considered a 'dirty' word, research can have significant effects on future studies as well as on those environments affected by the research itself; a study of any sort lends credence, holds value and as such carries weight which leaves me feeling a great deal of responsibility toward the information contained within this discourse. As such it is necessary for me to affirm that the knowledge presented here is not the end all be all, it isn't intended to state that in all cases where change is implemented, organizations *will* experience the same outcomes, struggles or needs. It is simply information available to the reader based on



my journey of change and implementation. In the end, every organization and every community, region or province implementing is just as unique as every family we encounter and as such the needs and solutions will be just as unique.

Based on the literature review and my lived experience within the child protection system itself, my findings are that the solution-focused, strength-based model is the most respectful and gentle approach to child protection work available. It challenges the current frameworks by the very nature of the practice: It is not about the tools we employ as practitioners, it's about the way we think. Signs of Safety requires a shift in thinking; from deficit-based to strength-based and it requires an attitude of humility, recognizing that all families have strength; the worker's task is to help families find that strength and re-create it. When families can re-create the good work they do, only then can change occur. It is this that will end the perpetuation of the need for child protective services and lower the intensified recidivism rates.

Furthermore, in viewing this study through the critical race lens, it becomes starkly evident that colonialism and inequality persist within the structures of Canadian society, and Indigenous children and families continue to pay the greatest price. Indigenous families must be given responsibility over their own children's safety and well-being; being held accountable for the welfare of their children will increase the responsibility held by families and communities, it will rekindle hope and lead to improved situations in both family and community but this must be undertaken with appropriate funding and programs in place respecting Indigenous worldviews, cultures and knowledges. There needs to be recognition of the inequitable share of resources within Indigenous

community along with the high rates of poverty, homelessness and unemployment to ensure that adequate services and funding are made available.

The over-involvement of child welfare in the lives of Aboriginal families means increased caseloads for workers on reserve but also heightens the complexity of the relationship between worker and family due to lack of trust, suspicion and uncertainty. Problems faced by workers in Indigenous community need to be acknowledged and addressed through equitable funding, improved and ongoing training as well as a balanced distribution of experienced workers in all departments and finally an upward sharing of anxiety. Blackstock (2008) in her editorial update of Jordan's Principle,<sup>13</sup> speaks to the disparity in Indigenous community, saying, "in a government policy that baffles common sense, the federal government will pay foster parents to look after First Nations children with special needs, but will not provide support for the child's own family to care for them at home, even when there is no abuse or neglect" (para. 3). This is the ideology of government and policy that needs to change in order to create a better future for Indigenous children. Tupel-Lafonde cited in Stueck (2013) concluded the "provincial government spent 66-million over the past dozen years without a single child receiving better services as a result" (para. 6). It is evident that change must be pursued within the provincial budgets with priority being given the wellbeing of children and Indigenous community.

Additionally, Policies, legislation, standards and procedures have been constructed and implemented as a means of correcting issues that have arisen in practice. They provide a false sense of security, and are complex, prescriptive and time consuming

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<sup>13</sup> The child-first principle adopted by the Canadian government to "ensure that federal and/or provincial funding disputes do not interfere with First Nations children accessing government services that are available to other Canadian children" (Blackstock, 2008, para. 1).

resulting in poor outcomes for children. If any changes are to be sought it should be in the area of policy. Child protective policy needs to be streamlined and often times even re-written to ensure it supports a way of practice that honours family while supporting and enhancing the capacity of the worker to provide the best services possible. Some necessary changes might include:

- Reduced caseloads
- More flexible work hours
- Flexible timelines (i.e. assessment/investigation, court, permanency etc.)
- More resources (workers) at the front end of practice

Through this paper, it is my greatest hope that I have been able to highlight the need for change in our approach to child protection, and at the very least, that I may have been able to ignite the desire in organizations to change the way they think about child protection. So to answer the initial research question, “how could a change be successfully implemented on a large scale within child protection organizations throughout Canada today?” The answer according to both years of documented experience and the literature alike: supervisor and manager support for front-line staff; policy and legislative change to support the theoretical shift; structural change to address the workload shifts; collaboration and education for community partners; patience and training for staff learning to re-think their understanding of the work and, finally, increased awareness of the systemic racism that negatively impacts child protection on reserve and equitable funding, resources and training made available to address and improve their ability to provide the best services possible.

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## Appendix A

### Example of Field Notes in 3 Column Format

#### THE CHANGE ENVIRONMENT

| Challenges and struggles with the change of practice?  | Working well?   | What's needed to ensure success?   |
|--|---|--|
| <p>Cultural barriers with immigrant families<br/>Need to be prepared. Some maps don't go so well because of denial and so won't give the worker the necessary information. Parents unable to acknowledge concerns.<br/>Time consuming.<br/>Facilitating writing at same time and capturing people's words.<br/>Documentation – getting it to paper.<br/>Working with families who are so overwhelmed, they can't see strength.<br/>Families in crisis unable to engage in process.<br/>Attention span of teens<br/>Paperwork doesn't match the computer system. Everybody is doing it different. Some using harm/danger, others not. Some using scaling/others not. Could lose information – Community already has fears about workers using SoS, this just confirms it. They are worried we won't handle the supports.<br/>Community keeps calling in order to get the attention of child protective services.<br/>System issues i.e. Legislation.<br/>More work due to community expectations (SOS and old thinking)</p> <p><b>Greatest Fears:</b></p> <p>Workers might work themselves out of a job.<br/>There will be kids lost in the system at intake.<br/>Workers aren't opening cases and as a result families aren't getting help (i.e. Addictions)</p> | <p>The practice creates safe discussions<br/>There is growing consistency of understanding around danger<br/>Creates hope for people using strengths.<br/>Visual approach works for families.<br/>Permits families to have their own voice – goals/plans/outcomes. Workers no longer directing plans.<br/>Flushing out complicating factors.<br/>Positive feedback.<br/>Scaling helps see the situation from client's view.<br/>Organized – keeps people on track.<br/>Better able to explain process at the front end.<br/>Callers calling to consult not report. Giving good questions to community partners.<br/>Empowering schools –building relationships<br/>Good focal point for families – also good conversation piece<br/>3 houses so impactful for parents</p> | <p>Workers need to be supported to continue to grow and learn the practice. Meet regularly to talk about SOS successes, challenges and cases. All workers across departments should be involved in the learning process.<br/>Need more workers at the front end.<br/>Trust in the outcomes<br/>Safe to talk about the fears, the workload.<br/>Validation – recognizing the good work and effort.<br/>Consistency on the front end to build trust with community Partners (i.e. How to respond to referrals)<br/>Education for community Partners.<br/>Good communication and language.<br/>Practice.<br/>Recognition of different roles<br/>Everybody on the same page – positive about the work.<br/>Clear understanding about how to use SOS within framework<br/>More resources at the front end</p> |

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