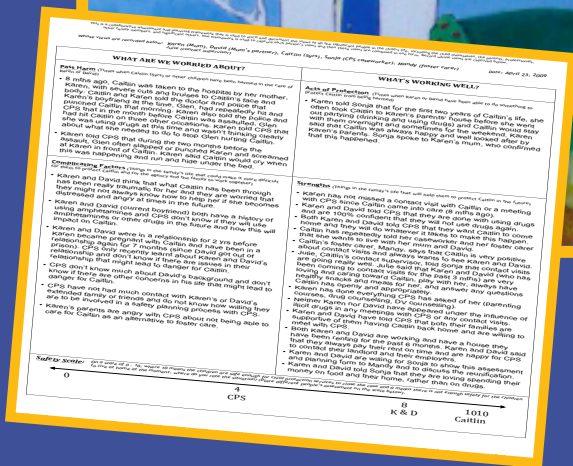
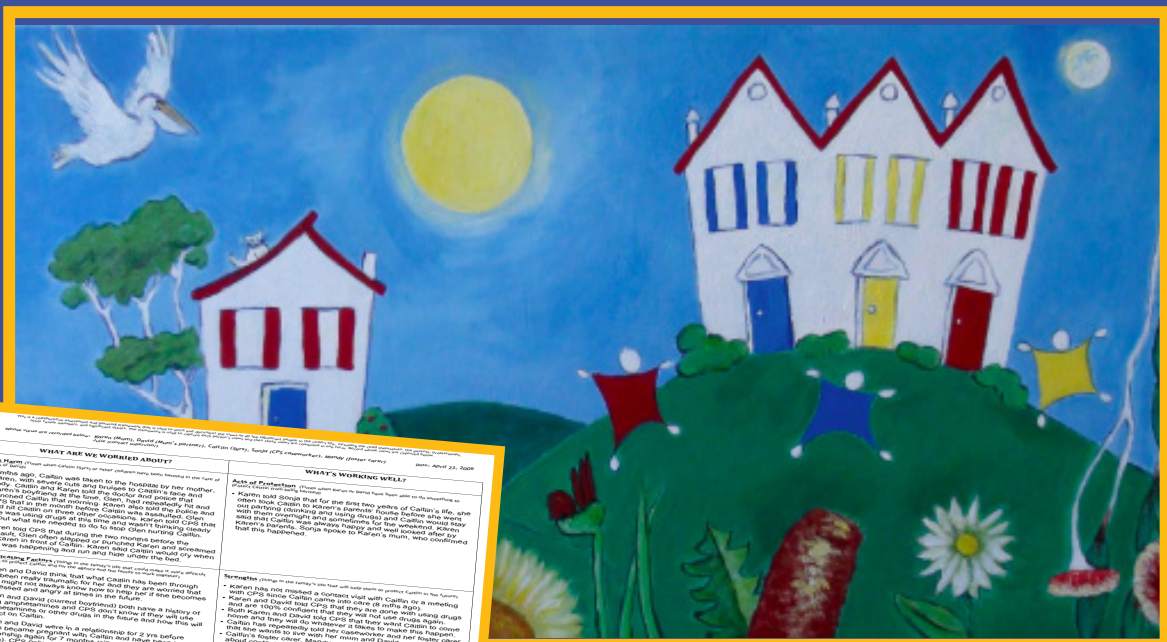


Partnering for Safety Collaborative Assessment and Planning (CAP) Framework

A detailed exploration of how to use the PFS Collaborative Assessment and Planning (CAP) framework to undertake comprehensive child protection risk assessment and planning in collaboration with families



by Sonja Parker



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Introduction to the Booklet

This booklet is designed to help child protection practitioners develop a deeper understanding of the Collaborative Assessment and Planning (CAP) Framework and the process of using the CAP framework, in collaboration with families, to undertake rigorous and comprehensive risk assessment and planning.

The first part of the booklet contains a detailed description of the CAP Framework and a step-by-step guide to the different parts of the framework, and the second part of the booklet contains a detailed exploration of the “how to” of using the framework, including the process of bringing the framework to families.

Overview of the CAP Framework

The CAP framework is a strengths-based, family and safety-centred practice framework that is used to elicit and analyse all the key information known about a child and family at any given time, into key domains relevant to the goal of enhancing ongoing safety, belonging and wellbeing for the children.

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

<p>WHAT ARE WE WORRIED ABOUT?</p> <p>HARM Times when a child has been, or was in danger of being, significantly harmed (physically, developmentally or emotionally) as a result of actions/inactions by the caregiver.</p> <p>COMPLICATING FACTORS Things that contribute to greater difficulty for the family and that could make it more difficult for the family to protect and care for the children and/or for the agency and the family to work together.</p>	<p>PURPOSE OF THE CONSULTATION <i>What are the worker, team, family and/or network looking for from this conversation?</i></p> <p>GENOGRAM/ECOMAP/ CIRCLES OF SAFETY and SUPPORT <i>Who is in the family and network? Who cares about the child/family? Who is willing to help?</i></p> <p>CULTURAL CONSIDERATIONS <i>How does the family identify themselves culturally? Which family members/community members/agencies need to be involved in the assessment and decision-making?</i></p> <p>CURRENT SDM SAFETY AND FRE LEVELS</p>	<p>WHAT IS GOING WELL?</p> <p>PROTECTION & BELONGING Actions, taken by the caregivers or network, that have protected the child from harm. Actions, by the caregivers or network, that have promoted enduring connections to family, community and culture.</p> <p>STRENGTHS & RESOURCES Positive factors, resources or capacities in a child or family's life that help or could help the family to enhance the children's safety, belonging and wellbeing.</p>
<p>SAFETY & WELLBEING SCALE On a scale of 0 –10, where 10 means the children are safe enough for Child Safety to close the case and 0 means there is not enough safety for the children to live at home at the moment, where do you rate the situation? (Place different people's assessment on the scale below).</p> <p style="text-align: center;"> </p>		
<p>WHAT NEEDS TO HAPPEN?</p>		
<p>WORRY STATEMENTS What are people worried will happen to the child if nothing changes? Consider if statements are needed to cover:</p> <ul style="list-style-type: none"> • Safety • Belonging • Wellbeing 	<p>GOAL STATEMENTS What needs to be demonstrated, over time, to address the worry statements and to ensure the child is safe, well and connected to family, community and culture?</p>	
<p>ACTION STEPS What needs to happen next, to work toward the goals? Who has agreed to do what, when? Recommended SDM guidance?</p>		

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

The CAP framework is used in partnership with children, families and their extended networks to first undertake a balanced and comprehensive assessment of what has happened and what is happening within a family in relation to the safety, belonging and wellbeing of the children, and to then work together to enhance the children's future safety, belonging and wellbeing.

The CAP framework is used from the first point of contact with a family right through until case closure and is also used in supervision and case consultations to bring clarity and focus to casework and case planning.

Four Domains of Inquiry

The collaborative assessment and planning framework is organised around four key questions:

- What has happened/is happening within the family that worries us? (Harm and Complicating Factors)
- What is going well within the family? (Protection and Belonging, and Strengths)
- Safety and Wellbeing Scale: On a scale of 0 to 10, how safe is it for the children in the care of the family at this point in time?
- What needs to happen for the children to be safe and well in the future? (Identifying future worries, collaborative goals and next steps to achieve these goals).

Including all four key questions or domains of inquiry ensures that this is a balanced assessment (focusing on the worries as well as what's going well), that the safety judgement is made explicit as part of the assessment and planning process, and that the focus is on moving forward from the assessment toward building future safety for the children.

These key questions are asked of all the significant people involved in the children's life - the parents, the extended family and family network, child protection workers, supervisors and managers, lawyers, magistrates, other professionals, and even the child him/herself - and the information gathered in response to these four domains of inquiry is then recorded within the collaborative assessment and planning framework. It is this process of eliciting and incorporating the views of all the significant people in the child's life that transforms the assessment and planning process into a collaborative process.

More Detailed Analysis of Information within the Framework

Within each of the domains of inquiry, the assessment and planning information is further analysed into a number of key elements. It is the sorting and analysis of the information into these elements that provides the depth and rigour within the assessment and planning process. Within the "What has happened/is happening in the family that worries us?" domain, the information is analysed in terms of harm and complicating factors. Positive factors (What's working well) are analysed in terms of actions of protection and belonging, and strengths. Working forward from this analysis, the planning process then involves identifying the future worries for the children (worry statements), the future goals to (goal statements), as well as the next steps in working toward these goal statements. All of these elements will be explained in much greater detail in the next section of this booklet.

Statements of Harm

The statements of harm, or harm statements, describe times when these children, or any children, have been harmed in the care of these parents. An understanding of harm is vital because research shows that the best predictor of future danger is the pattern of past harm.

Harm statements describe who reported the harm, the parents' actions or lack of actions that led to the harm and in what circumstances these actions occurred, and how this behaviour impacted on the children (the actual harm to the children).

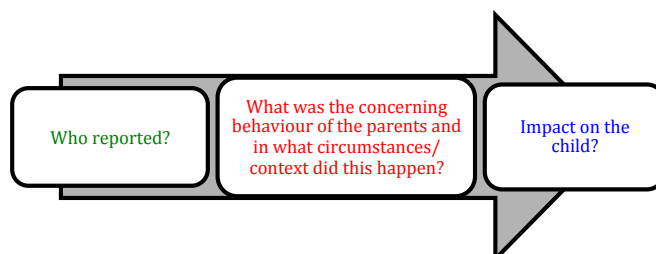
It is important to be specific about the behaviour of the parents that resulted in harm to the children (eg. hitting the child, hitting and yelling at the other parent in front of the children, leaving the child alone with someone who has harmed a child, etc), as it is this behaviour that we will be asking parents to change. It is also important to identify the circumstances in which this behaviour occurred (eg. a parent was feeling really angry and frustrated with the child, a parent was feeling really angry with their partner, was affected by drugs or alcohol, was feeling overwhelmed by life and not able to cope with caring for the child etc), as we will be asking the parents to build future safety and wellbeing for the children in the same or similar circumstances. The more specific this information is identified in the harm statements, the more clearly everyone will be able to plan for future safety, belonging and wellbeing.

It is quite common for there to be disagreement between professionals and family members about whether or not harm actually occurred to the children. While the assessment and planning process is a collaborative assessment process, it doesn't mean that everyone has to agree on what has occurred. The different views about what happened in the past can be captured within the harm statements (see examples below) so that time and energy can be used to focus on future safety, rather than on trying to get agreement about what happened in the past.

Writing Harm Statements

Harm statements have three components:

1. Who reported (or "It was reported that ..." if you are not able to identify the reporter).
2. A description of the behaviour of the parents that led to the harm and the particular circumstances or contexts in which this behaviour occurred.
3. A description of the harmful impact the parents' behaviour had on the child.



In writing the harm statements, it is important to be as specific as possible about what happened and to write the statements in straightforward, every day language that a child or young person would be able to understand.

Examples

- *The hospital social worker and the doctor at the hospital told CS that Tahlia (14 mths) was brought to the hospital two days ago by her maternal grandmother, who told the hospital staff that she went to visit her daughter, Tanya and Tanya's partner, David, that day and she found Tahlia alone in the house with the door unlocked. Tahlia was in her cot and crying loudly. Tanya and David told CS that this was the first time they had left Tahlia home alone, that they went only out for a short time together while Tahlia was sleeping and that they were both drug affected and so weren't thinking clearly about what could happen to Tahlia if they left her home on her own.*
- *The hospital social worker and the doctor at the hospital told CS that Tahlia's grandmother told the hospital staff that she thinks Tanya and David are using drugs and not feeding Tahlia properly and not looking after her properly. The doctor said that Tahlia is significantly underweight for her age (on the 3rd percentile) and appears to be a little developmentally delayed.*

In writing harm statements, a guiding principle that is used is to have one harm statement for each type or category of harm that has occurred. This means that you will have one harm statement to describe any physical abuse to children that has occurred in the care of the parents, one harm statement to describe any emotional or psychological harm, one harm statement for sexual abuse, one for neglect and one to describe any family violence that has occurred while the children were present. If there have been a number of incidents of the same type of harm, these incidents are summarised within one harm statement. This principle is designed to limit the number of harm statements (and therefore the number of worry statements and goal statements) to a number that is workable and achievable with the family.

Complicating Factors

Complicating factors identify those things that make the situation more complicated, both for family members and for professionals involved with the family. Complicating factors are issues that may have made it more difficult for the parents to keep their children safe and well in the past, or might make it more difficult for the parents to achieve future safety for the children, such as substance use, mental illness, poverty or isolation, but that have not (to the best of our knowledge) led to harm to the children (If these issues has led to harm to the children, this would be recorded under the harm). Complicating factors are also factors that make it difficult for the family and parents to work together, such as disputes between professionals and family, cultural misunderstandings, etc.

Examples

- *Tanya and David told CS that they have been using cannabis and amphetamines for about four years and use cannabis most days and amphetamines about 2 - 3 times a week. Tanya and David said that they have both tried to stop using drugs a couple of times but they have then started using again because the other person and/or their friends have still been using.*
- *CS have not had contact with either Tanya or David's families or friends and so don't know if any of them would be willing or able to be part of a safety network for Tahlia.*

In the analysis of information about the family, it is critical that we distinguish between the past harm to the children and the complicating factors. Making this distinction helps us to develop clear statements of future worries (what everyone is worried will happen to the children in the future if nothing changes in the family) and case planning can then focus on addressing the worry statements in the shortest possible time. If harm statements get confused with complicating factors, it makes identifying and addressing the future worries to the children much harder.

2. What's working well?

The 'What's working well?' column focuses on those things that have been happening in the family in the past and are happening currently that are positive and that contribute to the safety, belonging and wellbeing of the children. This information is analysed into two quadrants:

- Protection and Belonging
- Strengths

This information is critical as it provides ideas about what future safety, belonging and wellbeing for the children could look like (based on examples of actions of protection in the past) as well as identifying the resources and capacity (strengths) that the family can draw on to build future safety, belonging and wellbeing. Paying attention to strengths/actions of protection and belonging also builds relationship and creates hope and energy for talking about and addressing the difficult issues.

As for the first column, the information can either be sorted into the two quadrants as it is being elicited, or you can elicit everyone's views first and then discuss how the information can be categorised into the two quadrants.

Protection and Belonging

Actions of protection and belonging describe any times when the parents/caregivers have taken actions or made decisions that led to the children being safe and well in relation to the worries. These actions of protection and belonging are exceptions to the problems – times when the children might have been harmed in relation to the identified worries, but because of actions or decisions by the parents, were safe and well at these times.

While these actions of protection and belonging are not enough to constitute enduring safety, belonging and wellbeing for the children, paying attention to past or current actions of protection and belonging is vital as it recognises that the problems within the family may not be happening all of the time and identifies ways the family have found to provide safety, belonging and wellbeing for the children at times. In this way, actions of protection and belonging become the building blocks for enduring safety, belonging and wellbeing. Talking about protection and belonging also builds relationship and creates hope and energy for addressing the problems within the family.

Statements about actions of protection and belonging need to be specific and describe the actions/behaviours by parents (or other caregivers) that resulted in safety, belonging and wellbeing at that time for the children. In describing the parents' behaviour and the impact on the child, it is important to be specific, identifying details such as what happened, where did it happen, when did it happen, and how often it happened.

Examples

- *Tanya told Sonja that last month, when she knew that David's friends were coming over for a party and that people would be drinking and using drugs, she arranged for her friend (Kathy) to look after Tahlia for the weekend. Sonja spoke to Kathy on the phone, who confirmed that this had happened and gave Sonja the date and described what she did with Tahlia that weekend.*
- *Tanya and David told Sonja that they have gone out a few times together to parties and have organised a babysitter to look after Tahlia. Tanya and David said that they made sure that the babysitter was someone who Tahlia knew and felt comfortable with, like Tanya's friends Kathy and Dana, or their neighbour, Patti.*

Strengths

Statements about family strengths describe things that are happening in the family or resources/capacities of the family that make things better for the children or that might help the family to protect the children, particularly in relation to the worries. Statements need to be specific and describe those attributes or resources or capacities of the family that have contributed to the children's safety, belonging and wellbeing in the past and might contribute to their safety, belonging and wellbeing in the future.

Examples

- *Tanya says that she wants to stop using drugs and to be a better mum for Tahlia.*
- *Tanya and David told Sonja that they are willing to talk to both of their families to explain to them what has happened and to see if any of their family members are willing to be part of a safety network for Tahlia.*

3. The Safety and Wellbeing Scale

The safety and wellbeing scale in the CAP framework is used to move from the analysis of all the significant information within the framework to the most critical judgement that needs to be made in a child protection case, namely: How safe is the child? The safety and wellbeing scale uses a number to represent everyone's judgement about how much safety, belonging and wellbeing there is for the children right now if nothing was to change in the family.

Examples

- *On a scale of 0 – 10, where 0 means the situation for these children is so bad that it is not safe for them to be in the care of the parents at this time and 10 means that there is sufficient safety, belonging and wellbeing for the children to close the case, where would you rate the situation right now?*
- *On a scale of 0 – 10, where 0 means the recurrence of similar or worse abuse for these children is certain, and 10 means that there is sufficient safety, belonging and wellbeing for the children to close the case, where would you rate the situation right now?*

The safety and wellbeing scale question is designed to be used with all the significant people involved with a family and can be a powerful way to elicit everyone's views about how things are going in the family at this point in time. Different people's views are recorded on the scale by writing their number on the scale and name beneath.

An important thing to remember about using the safety and wellbeing scale is that it doesn't matter where someone places himself or herself on the scale. Wherever someone locates themselves on the scale, you can use questions to explore their views further by asking them to identify:

- The things that are going well in the family that have them scaling as high as they have (which can be recorded as either strengths or actions of protection and belonging).
- Things that they are worried about that have them scaling as low as they have (that can be recorded as either harm or complicating factors, or if they are phrased as worries about what might happen to the children in the future, then they can be recorded as worry statements).
- What they would need to see happening in the family to scale one point higher on the scale (which can be recorded as goal statements if they are at the level of goals, or as action steps in working toward the goals).

4. What needs to happen?

Once there has been a balanced and collaborative assessment of what has happened in the past and is currently happening in the family in relation to the safety, belonging and wellbeing of the children (using the top segment of the framework), it is then possible for everyone to work together to focus on the future safety, belonging and wellbeing of the children. The bottom segment of the framework is the planning component and identifies:

- Future Worries about the children (worry statements)
- Future Goals to address these worries (goal statements)
- Next steps (to achieve these goals).

Worry Statements

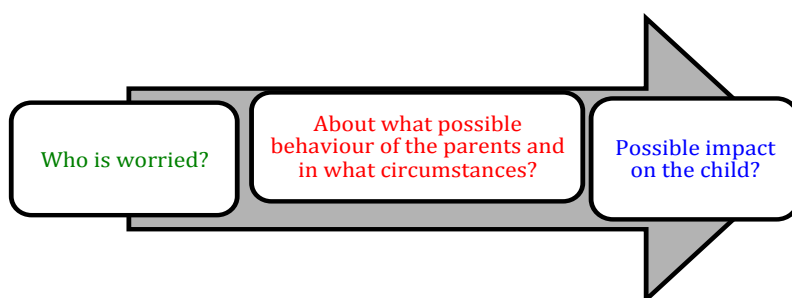
The worry statements describe what we are worried parents might do (or not do) in the future that could lead to the children being harmed. Working with all of the key stakeholders to identify the future worries about the children is critical in planning for future safety, belonging and wellbeing so that all casework and planning is then focused on addressing these worries. For the statutory agency, these worry statements identify the reason for our involvement and the concerns that must be addressed for the case to be closed.

The worry statements can be identified once there has been a balanced and collaborative assessment of what has happened in the past and what is currently happening in the family in relation to the safety, belonging and wellbeing of the children. In particular, it is the analysis of harm and complicating factors that helps everyone to identify the future worries that must be addressed. For each statement of harm, you are likely to have a worry statement (remember, the pattern of past harm is the best predictor of future harm). You may also have worry statements that correspond to the most serious complicating factors, if you think that a complicating factor could create future danger for the children (could lead to future harm or maltreatment to the children).

As discussed earlier in relation to harm statements, in writing the worry statements it is important to identify the possible behaviour of the parents that we are worried might happen in the future, as it is this behaviour that we will be asking parents to change. It is also important to identify the possible circumstances or context in which this behaviour is likely to occur, as we will be asking the parents and all the key people involved with the family to think about how to ensure safety, belonging and wellbeing for the children within these or similar circumstances in the future. The worry statements also identify our worries about how this behaviour could impact on the children. The more specifically all of this information is identified in the worry statements, the more clearly everyone will be able to plan for future safety, belonging and wellbeing.

Writing Worry Statements

The worry statements make explicit the relationship between our concerns about the parents' possible future behaviour and actions (what they might or might not do in relation to the children) and our concerns about how this might impact on the children in harmful ways in the future harm.



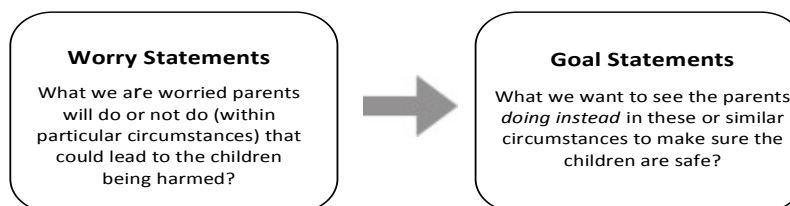
Worry statements therefore have three components:

1. Who is worried.
2. About what possible behaviour of parents (what parents might do or not do) and in what particular circumstances or contexts.
3. About what possible impact on the child (what we are worried may happen to the child).

Professionally created examples

- *Child Protection Services and the doctors at PMH are worried that Tanya and David will use drugs or be affected by drugs while they are looking after Tahlia and then not feed Tahlia often enough and well enough and not play with her and stimulate her enough and that Tahlia might become sick and not develop properly because she isn't getting the food and attention she needs to grow and be healthy.*
- *Child Protection Services are worried that Tanya and David will use drugs or be affected by drugs while they are looking after Tahlia and then do things like leave Tahlia at home on her own, and that Tahlia might be frightened, might hurt herself or be hurt by someone who comes into the house.*

With family and community members, these worry statements provide a structure for important but difficult conversations to occur. With skilful questioning, they also help family members and the agency begin to move toward joint understanding and agreement about the nature and purpose of our work together. In writing worry statements, it is useful if workers first write worry statements to identify their own views and then use a questioning approach with family members and other significant people to elicit their views. In this way, workers can move from professionally-created



worry statements to worry statements that are mutually-constructed with the family and the family's network (if they are involved at this stage).

Mutually constructed examples

- *Grandma, Tanya's sister, Julie, CS worker, Sonja, and Dr Levett at PMH are worried that Tanya and David will get caught up taking drugs and then won't feed Tahlia often enough and well enough and won't play with her and talk with her enough and that Tahlia might become sick and not develop properly because she isn't getting the food and stimulation she needs to grow and be healthy.*
- *Grandma, Julie, CS worker, Sonja, and Dr Levett at PMH are worried that Tanya and David will get caught up taking drugs and do things like leave Tahlia at home on her own, and that Tahlia might be frightened, hurt herself or be hurt by someone who comes into the house.*

While the worry statements are developed collaboratively with the family and perhaps the network, this doesn't mean that everyone has to agree on all of the worry statements. What is important is that everyone can understand each other's concerns and can recognise that addressing these concerns is the purpose of the child protection intervention. The process of working with families to create mutually-constructed worry statements is discussed in detail within the next section.

Goal Statements

Goal statements are clear, behavioural statements about WHAT the parents will be doing differently in their care of the children in the future to address the worry statements and to protect the children from the identified worries (the identified possible behaviour of the parents, within the identified worrying circumstances). The goal statements provide a vision for future safety, belonging and wellbeing for the children and provide the focus and direction for the creation of rigorous plans.

One of the most common pieces of feedback from families who are involved with child protection systems is that the professionals constantly “shift the goal posts” or fail to define the “goal posts” in the first place. The collaborative assessment and planning process is designed to directly address this issue so that workers are able to work with families to clearly define the goals and then with increased knowledge and confidence, maintain this focus in their work with the family.

Goal statements are constructed to directly address the worry statements. The worry statements need to have been identified before you can develop the goal statements and in some ways, the goal statements are the ‘mirror image’ of the worry statements. While worry statements identify the potentially dangerous circumstances and behaviours or actions of the parents that could lead to possible harm to the children in the future, goal statements identify the safe and protective behaviour of parents that we would want to see happening within these circumstances in the future to be confident that the children will be safe. If worry statements describe what we are worried the parents might do within particular circumstances or contexts (that could lead to harm to the children), goal statements describe what we want to see the parents doing instead within these circumstances to ensure the safety, belonging and wellbeing of the children.

Writing goal statements

As stated above, the goal statements describe the future actions or behaviours of the parents that will protect the children from the identified worries. Goal statements provide the broad description of these actions and behaviours. The details of how these behaviours will be achieved on a day-to-day and ongoing basis are then contained in the action plan.

As well as the future actions of protection, goal statements contain two other components:

- An initial umbrella statement that makes it explicit that the parents will need to work with a network and with the child protection agency to develop a plan that will contain the details of how the goal statements will be achieved.
- A time frame that identifies how long the goal statements would need to be demonstrated for (or how long the plan will need to be working effectively for), for everyone to be confident that the plan will continue working to achieve the goal statements.

To help in creating meaningful goal statements, I have developed the mnemonic **S.A.F.E.T.Y.**

Goal statements need to be:

- S** Specific and measureable, describing the actual behaviours and actions of parents needed to protect the children from each of the identified worries (each of the worry statements).
- A** Achievable. The family/network need to have, or be able to develop, the knowledge, skills, resources and willingness to achieve the goal statements.

- F** Family-owned. Ideally, the goal statements will be based on both the family and the agency's vision for future safety but at a minimum, on the family's ideas of what will satisfy the statutory agency.
- E** Endorsed by the statutory agency, who have agreed that the goal statements (once demonstrated over time) will provide the level of care and protection for the children required to close the case.
- T** Time frame. Goal statements need to be demonstrated over a specified period of time to build everyone's confidence that the children's safety, belonging and wellbeing will be maintained once the statutory agency withdraws/closes the case.
- Y** Young people and children have contributed to the goal statements or at a minimum, are able to understand the goal statements.

Suggested formula

While every goal statement is a little different, a general formula can look like this:



Professionally created example

Tanya and David will work with Child Safety and a network (of family, friends and professionals) to develop and put into place a plan for Tahlia that will show everyone that:

- *Tahlia is always looked after by an adult who is sober/not affected by drugs and who everyone agrees is a 'safe' adult.*
- *Tahlia is getting the food and the care she needs to stay at a healthy weight and to reach her developmental milestones.*

Child Safety will need to see the plan in place and working for a period of 6 months so that everyone is confident that the plan will keep working for Tahlia once Child Safety withdraw.

Just as with the worry statements, goal statements are developed collaboratively with all of the key stakeholders or at a minimum, with the family members, network members and other professionals who are involved at that point in the assessment and planning process. The process of developing mutually-constructed and collaborative goal statements starts with workers first writing goal statements to identify their own views and then using a questioning approach with family members and other significant people to elicit their views on the goal statements. In this way, workers can move from professionally-created goal statements to goal statements that are mutually-constructed with the family and the network (if they are involved at this stage). Ideas for working with families to elicit their goals are explored in more detail further in this booklet (pp. 34 - 39).

Mutually constructed example

Tanya and David agree to work with Child Safety, grandma, Tanya's sister Julie, the medical team at PMH and others who Tanya and David will ask to join their network to make and put into action a plan that will make sure that:

- *Tahlia will always be looked after by an adult who is able to keep her safe and who isn't affected by drugs or alcohol.*
- *Tahlia is given the food and the love and attention she needs to stay at a healthy weight and to reach her developmental milestones.*

Everyone wants to see the plan working well for a period of 6 months to feel confident that the plan will keep working to keep Tahlia safe once the child protection agency withdraw.

Working collaboratively to develop goal statements does not mean that everyone needs to agree on the goal statements. As discussed above in relation to the worry statements, family members, network members and even other professionals may not agree with the concerns held by the statutory agency and so may not agree that all of the goal statements are necessary. But at a minimum, everyone needs to be involved in the process of thinking through the care and protection for the children that the statutory agency would need to see in place to be prepared to close the case.

Next steps

The 'next steps' describe what everyone needs to do next in working toward the goal statements being achieved and toward building enough safety, belonging and wellbeing for the child protection agency to close the case. The next steps are identified collaboratively so that the family and the network are involved in the process of thinking through the steps required for the goal statements to be achieved and demonstrated.

These next steps are case planning steps and this part of the assessment and planning framework is continually updated as the case progresses and the actions steps are achieved and then new next steps are identified. Continuing to update the next steps within the framework will help everyone to stay focused on the goal statements and on ensuring that all of the work with the family stays focused on achieving enough enduring safety, belonging and wellbeing for the children.

Ideas for working with families and network members to involve them in identifying the next steps are explored in more detail further in this booklet.

Using the CAP Framework in Practice

The use of the collaborative assessment and planning framework with families is an ongoing and dynamic process. What this looks like in practice is that we:

- Use the framework to ‘map’ our initial assessment of what is happening in the family, based on the information we have received in a referral/report or that is contained in the case files.
- Continually gather new information from all the significant people in the children’s lives about what has happened in the past and what is happening now in the family, in terms of the safety, belonging and wellbeing of the children.
- Record and update that information within the assessment and planning framework on an ongoing basis so that the information can be presented to everyone (family and professionals).
- Constantly focus on planning for future safety, belonging and wellbeing for the children and ask everyone, based on our current understanding of what has happened to the children, to identify the future worries to the children and what the parents would need to do in their future care of the children (goal statements) for everyone to be confident that the children will be safe and well in the future. It is these goal statements that then provide the focus and direction for the development of a comprehensive and rigorous plan with the family.

This next section explores in more detail the ‘how to’ of using the framework, including ‘mapping’ the initial case information, using the framework to elicit the family’s views, and the process of bringing this information together as part of our ongoing assessment and planning with the family.

‘Mapping’ the initial case information

As a practitioner, when I receive information about a family (whether as a written or phone referral, or through reading the files for children in care), the first thing that I do is record the information in the assessment and planning framework. I don’t do it neatly or perfectly – I just start to ‘map’ the information into the framework as a way of organising the information, helping me to identify what we know and highlighting what we don’t know. ‘Mapping’ the case in this way also guides the questions that I ask at this early stage to elicit further relevant information.

While the assessment and planning framework was explained in the previous section in a linear manner, it is important to recognise that the process of ‘mapping’ is not a linear process. You can start ‘mapping’ the information within any of the elements of the framework and you can move about the framework as you are gathering and recording information, as long as all of the parts of the framework are covered and all of the relevant information is included. It is also worth noting however that while the ‘mapping’ process isn’t a linear process, some of the elements of the framework can only be comprehensively ‘mapped’ once a corresponding element has been ‘mapped’. For example, both the harm and significant complicating factors need to be clear before you can be confident that all of the worry statements have been identified. Similarly, the worry statements need to be clear before you can fully identify the goal statements and the next steps toward achieving these goal statements.

When you first begin ‘mapping’ cases using the assessment and planning framework, you may be concerned about the amount of time that it takes to work through the framework. This is a very common response when workers first start using the framework and is certainly something that I experienced in the beginning. What quickly becomes evident however, is that ‘mapping’ the case brings an enormous amount of clarity to our work with families and saves significant time in the process of working with families as all of our interactions and interventions become focused on working toward enough safety, belonging and wellbeing to close the case.

A really important clarification at this point is to recognise that 'mapping' the case at this early stage is just that: a 'map' of what has been initially reported to us about this family or for ongoing cases, a 'map' of what we know, or believe we know, about the family at this point in time.

Case Example

The following anonymised case example involves a new referral for a 4 week old baby. The example includes the written referral that was received from the hospital social worker and my initial use of the assessment and planning framework to 'map' the referral information.

Referral Information from Princess Margaret Children's Hospital social worker

Child: Isabella (4 weeks) DOB: 04.05.10

Mother: Kristy (25 yrs)

Father: Darren (29 yrs)

Isabella was brought by ambulance to the Princess Margaret Children's Hospital two days ago (03.06.10), following an episode of respiratory distress/cyanosis at home earlier that morning. Isabella was home with her mother, who called an ambulance after waking to find Isabella with signs of vomit around her mouth and appearing to be having difficulty breathing.

This referral is being made to child protection services due to Kristy's drug use during pregnancy, and concerns that Kristy may still be using drugs and therefore may not be able to provide safe care for Isabella. Darren spoke to a nurse for a number of hours on the first night of Isabella's admission and he said that he was concerned that Kristy may have used amphetamines over the weekend. Kristy's mother and sister visited the hospital that same evening and also told the nurse that they were concerned that Kristy was still using drugs. I met with Kristy and Darren yesterday and they denied that current drug use is an issue and Darren has denied that he made these comments to the nurse.

Background information

On 11.04.10, when 32 weeks pregnant, Kristy was admitted to King Edward Memorial Hospital (KEMH) with contractions and advised medical staff that she had used illicit drugs for various periods over a period of ten years, with her most recent use being the previous night. Kristy stated that she was using IV illicit subutex, and had been using subutex on an almost daily basis throughout her pregnancy. Kristy remained in KEMH for two weeks to detox and commenced on the methadone programme, which she continues to be on and which is managed by Dr Gordon from Wilcock Medical Centre.

Darren informed me that he had previously been a heavy amphetamine user but had used only occasionally during the past 7 years, with his most recent use approximately 4-5 months ago. Darren is currently working away at the mines (three weeks on, one week off) and is required to undergo regular and random drug testing for his work.

Isabella was born at 35 weeks at KEMH on 04.05.10 with Neonatal Abstinence Syndrome as a result of mum's use during pregnancy. Isabella was placed on morphine following birth, and remained an inpatient on the special care nursery until she was discharged 11 days later.

Upon discharge, Darren and Kristy were provided with a morphine-weaning programme to be administered at home until 24.05.10, with a follow-up appointment at KEMH scheduled for 25.05.10. The purpose of this follow-up appointment was to review whether Isabella still required morphine. Darren and Kristy did not bring Isabella to this appointment and as a result,

her withdrawal status was not reviewed. KEMH did not follow up with Darren and Kristy after the missed appointment. During her time at KEMH, Isabella was not feeding or sleeping well and upon discharge, had not returned to her birth weight. Her birth weight was 2.33kg, her discharge weight was 2.17kg and upon admission to PMH at 4 weeks of age, her weight was 2.4kg.

Kristy and Darren have told me they were concerned about Isabella after she was discharged from hospital as she wasn't feeding well, wasn't sleeping well and still wasn't gaining weight. Kristy and Darren said that Isabella was seen by the child health nurse on 19.05.10 and then again the following day due to concern about Isabella's low weight gain. Isabella had gained 0.3g by the following day, which satisfied the child health nurse's concern. Kristy and Darren said that they telephoned KEMH twice during that time to ask for help and then made an appointment to take Isabella to see a doctor.

I have spoken to KEMH maternity ward, who advised that Kristy contacted them on two occasions during the week commencing 25.05.10; once to discuss her concerns about Isabella being blue around her lips, and a second time to ask for a phone number for the child health nurse and for a referral to a paediatrician.

Darren returned to work on 31.05.10. Kristy told me that she contacted Wilcock Medical Centre to make an appointment for Isabella to be seen by a GP, and that the first available appointment was on 04.05.10. This appointment was not kept as Isabella was admitted to hospital. I confirmed with Wilcock Medical Centre that this appointment was scheduled.

Current Situation

Isabella continues to be an inpatient and is likely to remain in hospital until mid next week. Kristy and Darren are doing all the practical care of Isabella and are very loving and attentive and providing good care. Isabella is continuing to display signs of drug withdrawal and is losing weight, which may be because of drug withdrawal or may be caused by another medical condition. Further medical investigations are being conducted to determine if there is an underlying medical condition for her poor weight gain.

As part of my assessment with this family, I have met with Kristy and Darren on two occasions and have spoken to the staff at King Edward Maternity Hospital, the child health nurse and Wilcock Medical Centre. Their contact details are provided below. Darren and Kristy told me that they receive extensive support from Darren's family. His mother and father, Tom and Mary, live around the corner from Darren and Kristy, and his sister, Karen, lives across the road. His other sister, Tracey, lives a short distance away. Kristy also said that she has contact with her family, particularly her mother and sister, but that there is a lot of conflict between them. Darren's family are Aboriginal (Noongar) and Kristy's family are of Malaysian descent (Kristy was born in Malaysia and came to Australia with her parents and sister as a young child).

Kristy and Darren are aware of this referral to child protection services and are willing to meet with CS, prior to Isabella being discharged from hospital, to address the concerns in relation to this child. Kristy has told me that she is willing to do random drug urinalysis and also to move in with family members if that is required until she has demonstrated that she is not using drugs.

Mapping of initial professional views based on the referral

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father).
Whose views are included below: Sonja (CS caseworker)

Date: June 5, 2010 (Date referral received).

WHAT ARE WE WORRIED ABOUT?	PURPOSE OF THE CONSULTATION	WHAT IS GOING WELL?
<p>HARM</p> <ul style="list-style-type: none"> Princess Margaret Children's Hospital (PMH) social worker told CS that Kristy told her that she used illicit subutex most days during her pregnancy up until she was 32 weeks pregnant. Isabella was born early (36 weeks) at King Edward Memorial Hospital (KEMH) and she was born drug addicted (Neonatal Abstinence Syndrome), was put on a morphine programme to help wean her off her addiction and was in the special care nursery for 11 days. Isabella cries a lot, is hard to settle and has problems feeding and gaining weight. PMH social worker told CS that the morphine-weaning programme that the hospital gave Kristy and Darren for Isabella finished on 24.05.10. Kristy and Darren didn't take Isabella to her scheduled follow-up appointment at KEMH on 25.05.10 to review Isabella's health and determine if she still needed morphine. Isabella didn't receive further morphine and is exhibiting signs of ongoing withdrawal. Two days ago (03.06.10), Kristy found Isabella with signs of vomit around her mouth and having difficulty breathing. Kristy phoned an ambulance and Isabella was taken to PMH, where she remains an inpatient. <p>COMPLICATING FACTORS</p> <ul style="list-style-type: none"> CS do not know if Kristy and Darren are using illicit drugs and how this might impact on their care of Isabella. PMH social worker told CS that on the first night of Isabella's admission, Darren told a nurse that he was worried that Kristy may have used amphetamines over the weekend. When Darren and Kristy met with the PMH social worker, they said that they are not using drugs and Darren denied making that comment to the nurse. Darren told the PMH social worker that he had previously been a heavy amphetamine user but had used only occasionally during the past 7 years, with his most recent use about 4-5 months ago. Darren said that he has to do regular and random drug tests for work. PMH social worker told CS that when Darren's sister and mother visited Isabella at PMH two nights ago, they told a nurse they were worried that Kristy was using drugs. PMH social worker told CS that Isabella's poor weight gain may be caused by her morphine withdrawal by another medical condition. This is being investigated by the hospital. Darren is currently working on the mines (three weeks on, one week off) and CS don't know how this might impact Kristy's ability to care for Isabella when Darren is away. Kristy is on the methadone programme and CS do not know how often she takes methadone and how this is managed. Kristy told the PMH social worker that she has a lot of conflict with her mother and sister. 	<p>To map initial CS assessment in preparation for meeting with family.</p> <p>GENOGRAM/ECOMAP/ CIRCLES OF SAFETY and SUPPORT</p> <p>CULTURAL CONSIDERATIONS</p> <p>Darren's family are Aboriginal. Kristy's family are of Malaysian descent (Kristy was born in Malaysia).</p> <p>CURRENT SDM SAFETY AND FRE LEVELS</p> <p>Initial SDM Safety Assessment identified the family as CONDITIONALLY SAFE. FRE level is HIGH.</p>	<p>PROTECTION & BELONGING</p> <ul style="list-style-type: none"> PMH social worker told CS that when Kristy was 32 weeks pregnant, Kristy told KEMH that she was using illicit drugs. Kristy stayed in KEMH for two weeks to detox and commence on the methadone programme. Kristy and Darren told the PMH social worker that during the past week when Isabella was unsettled (not feeding well and not sleeping well), Kristy phoned KEMH to ask for advice from a midwife and then a few days later, phoned to request contact details for the child health nurse and a paediatrician. Kristy made an appointment with a GP for 04.05.10 but was not able to attend as Isabella was admitted to hospital. PMH social worker confirmed these details with KEMH and the GP. Kristy phoned an ambulance for Isabella when she saw that Isabella had vomited and that she was having difficulty breathing. PMH social worker told CS that Kristy and Darren have provided all the practical care for Isabella since she has been in PMH and are loving and attentive and providing a good level of care. The child health nurse told PMH social worker that she visited on 19.05.10 and 20.05.10 and that Kristy and Darren were caring and paying attention to Isabella's health. The child health nurse said that Isabella was alert and well-hydrated on both visits. <p>STRENGTHS</p> <ul style="list-style-type: none"> Kristy and Darren have met with the PMH social worker on two occasions and have talked about their past drug use and about their concerns and the hospital's concerns for Isabella. Kristy and Darren were willing for the PMH social worker to contact other professionals to discuss what has been happening for Isabella. PMH social worker told CS that Kristy and Darren are willing to meet with CS to address any concerns about Isabella. PMH social worker told CS that Kristy is willing to do urinalysis to show she is not using illicit drugs. PMH social worker told CS that Kristy is willing to move in with family members when Darren is away if CS want her to do that. PMH social worker told CS that Kristy and Darren said that they have a lot of support from Darren's family and that his mother and father, Tom and Mary, live around the corner and his sister, Karen, lives across the road. Darren's other sister, Tracey, lives close by.

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

Bringing the framework to families

The purpose of any child protection intervention is to facilitate families making positive changes in their lives that will lead to increased safety, belonging and wellbeing for their children. Given that it is our intention (and hope) that our involvement with a family will lead to the family making the necessary changes to ensure future safety, belonging and wellbeing for their children, then it is essential that families are the key people who are thinking through the assessment and at the centre of future planning for their children. So in using the framework, we need to do everything we can to bring families right into the centre of the assessment and planning so that these processes are relevant and meaningful for the family and most likely to lead to real and sustained change.

So once you have 'mapped' the initial referral information that we have received about a family or the information that we have on file for ongoing cases, the next step is to bring the framework and the information that we have 'mapped' to families, both to elicit the views of the key people in the child's life: the parents, the children themselves, extended family members, friends and other professionals involved with the family, and to help them understand our views at this point in time. Bringing the framework to families and involving families and their networks in the process of thinking through the assessment and planning information is one of the most important steps in using the Child Safety framework for practice.

This section of the booklet will explore the 'how to' of bringing the assessment and planning framework to families and of putting the framework on the table with families. Before focusing on the 'how to' of introducing the framework in more detail however, it's important to think about the type of working relationship that will help you to do that most effectively.

Step 1: Building a constructive working relationship

The quality of our assessment with families is only as good as the information that we receive. And the willingness of family members and significant others in their lives to provide us with open and honest information about what is happening in the family will be determined by the type of working relationship we are able to develop.

When approached by child protection services, parents and family members may understandably feel very anxious about what will happen as a result of the conversation and are often scared that what they say (or don't say) might lead to their children being removed from their care. As a result, family members are often defensive and angry and unless we can find ways of helping to ease this anxiety, the conversation is likely to lead to little openness and sharing of information. So taking time to start to build a working relationship at this early stage of working with a family is critical; not only will a constructive working relationship significantly improve the quality of our assessment, but time spent now in building a relationship will also save enormous amounts of time in any ongoing work with this family to build future safety, belonging and wellbeing for the children.

Pause for a moment and think about a time when you have been able to build a constructive working relationship with a family member, despite the difficult issues that you needed to discuss. How did you do that? What did you do that helped to build a working relationship? If I was able to talk to that mum or dad, what would they say that you did that was most important in helping to build a relationship with you where they felt able to talk with you about what was happening in their family?

When I ask these questions of workers and families, there are a number of common themes that emerge:

People need to feel respected

Conveying respect for the person in your first interaction and all subsequent interactions is one of the most important factors in building a working relationship. When we are dealing with serious allegations about harm to children and the understandable high levels of emotion for the people involved, it can be easy to forget the basics of respectful ways of interacting. Showing respect can be as simple as offering parents a choice about meeting times and venues; letting parents or family members know that they can invite other people to attend the meeting with them; if the meeting is in the family home, asking where the family would like you to sit; if the meeting is in the office, offering a cup of tea or coffee and having water available on the table. While these may sound like simple actions, they can be powerful ways of conveying respect for the other person.

Communicating that the family's views are important

Acknowledging that while we have received some concerns that we have to take seriously (or have information on file that we have to take seriously), we know that the report is only one view about what is happening in their family and with their children and that we want to hear their views and the views of other significant people in their lives and the children's lives so that we are able to gain a more balanced view.

Paying attention to what's going well as well as the concerns

My experience has been that there are very few parents or caregivers who do not have some strengths or positives that we can acknowledge. Giving meaningful compliments and acknowledgements at this early stage signals to the parents that as well as talking about the concerns, we will also pay attention to their strengths and to positive aspects of their parenting. We want the compliments we give to be meaningful and relevant to the family and to do this, we can draw on the strengths and actions of protection in the family that were identified by the reporter/notifier, which is one of the reasons we ask questions of the reporter to identify strengths and actions of protection in this family.

Being as honest and open as possible

Being as honest and open as possible in describing your role, the process and your views. And remember that you will usually need to explain the process and what is happening over and over, as people may have difficulty retaining information due to the high levels of anxiety and/or distress that they may be experiencing.

Taking time to listen to the story of parents/family members

Taking time to listen to the story of parents/family members is a powerful way to start to build a working relationship, particularly for those people who have already been involved in the child protection system. And while this will certainly take time, it will significantly contribute to building your working relationship and so will save an enormous amount of time down the track.

Conveying a sense of hope

One of the most common emotions that families who are involved in child protection systems experience is a sense of despair. And without a sense of hope, it is very difficult for people to find the energy or motivation to make changes or to imagine that change is possible. Communicating that you believe it is possible for the parents to make the necessary changes to keep their children safe is a powerful way of bringing a sense of hope into the room and into your work together, and perhaps helping parents to begin to see a possible way forward.

Explaining our assessment and planning framework

Taking time to explain the assessment and planning framework is another critical step in starting to build a constructive working relationship and helping to ease parents' initial anxieties. This will be explored in more detail in step 3 below.

Step 2: Starting to talk about the concerns

In starting to talk to parents and caregivers about the safety of their children, an initial consideration is whether we share our concerns first or ask for the parents' views first. Remember, our purpose during this conversation is to elicit the parents'/caregivers' views about the safety and wellbeing of their children as well as to help them understand the professional views at this point in time (which will of course be informed by the parents' views), so it is important that these risk assessment conversations happen in ways that create and maintain the greatest level of openness with families.

The way I usually manage this is to provide a brief explanation of the concerns and the reason for our visit at the beginning of the conversation and then as quickly as possible, move to questions to try to elicit the parents' views. If we give too much detail of the concerns at this early stage, the conversation tends to get stuck in arguments about whether or not the allegations are true. In my experience, providing a small amount of detail at this stage is usually the best way forward, explaining that we will talk about this in more detail a little later. I usually say something like:

For intake cases/new reports:

“My name is Sonja Parker and I am a child protection worker with and as I mentioned on the phone, we have received a report that said that you were using drugs and that raised some concerns about your children. Now while I don't know whether this report is true or not, this is something that we need to take seriously and so I would like to talk with you and with other important people in the children's life so that I can understand what is happening for you as a family and for your children. And if there are problems, I would like to talk with you about how we can help you to sort those problems out so that your children can be safe and well in your care. So can I explain our assessment process to you and then start to hear from you about how things are going and what is happening for your family? Is that okay?”

For children in care/long term cases:

“My name is Sonja Parker and as I mentioned on the phone, I am your new caseworker. Now while I understand that having a new caseworker can feel difficult because it is another change and another new person you have to deal with, it can also be an opportunity for a fresh start and for us to look at the situation with fresh eyes. So if it's okay with you, I would like to start by hearing from you about where things are up to and what is happening for you as a family and for your children. We're using a new way of working with families now and of talking with families about the children's safety and wellbeing, so I would like to explain that to you and then hear from you about how things are going? Is that okay?”

If the parents are insisting on knowing who made the report and more details of what was contained in the report said, I usually respond by saying something like:

“I am really happy to talk to you about what was in the report, but I don't want us to get caught up arguing about whether or not that is true. I would rather start by hearing from you about your family and how things are going for you, as you are the people who know most about your family. So can I first explain our assessment process to you and hear from you about how things are going in your family and then we can come back to the details from the report later?”

Step 3: Introducing the Framework to families

In my experience, the most effective way to introduce the framework is to start with a blank piece of paper and to draw up the framework while explaining the different domains and elements to the

family.

At a minimum, it is important that you explain:

- The four key questions or domains of the assessment and planning framework, highlighting that we will focus on what is going well as well as the worries.
- That the purpose of the assessment is to get clear about what's happening in the family right now and what we are worried might happen to the children in the future, so that all the important people in the children's lives can be part of the process of working out what needs to happen for the children to be safe in the future.
- That the assessment will take into account the views of all the important people in the child's life, not just the professional views.
- That it is okay if the parents' views and the professional views are different (pointing to the first column and particularly to the harm and worry statements); what's important is that we are able to listen to each other's views and then work together to identify what future safety, belonging and wellbeing would look like for the children so that child protection services can close the case and get out of their lives.

When using the framework with families to elicit their views, it is really important to have the framework visually displayed so that everyone can see the information that is being recorded. Being able to see the information being written into the framework will help family members to understand the framework and how it is used and will also contribute to them feeling more a sense of ownership of the process. If a whiteboard is not available, large sheets of paper either on the wall or on the table can be used. Whatever you use, try to organise it so that everyone can see what is being recorded.

Step 4: Eliciting parent's views

The general process I use in bringing the framework to families is, after stating our concerns briefly as described above, to then use a questioning approach to elicit the parents' views first, before talking through the professional views. I do bring the initial framework with me, where I have 'mapped' my initial views, but I keep this in my bag and bring this out later in the conversation. And when I do move to exploring the agency views, I first ask parents what they think our views might be, before I offer the agency views. My purpose at this point is two-fold: to try to hear from the parents first and to understand their views, rather than getting into a debate about whether or not the report we received or the views held by child protection services are accurate, and to give parents the best opportunity to reflect on what is happening in their family before offering our views.

So the process I generally use is to:

- Firstly, ask the parents for their views,
- Secondly, ask the parents for their perception of the agency views, and
- Thirdly, to offer the agency views.

My experience has been that once parents have talked about their views and particularly when we start by focusing on what's going well in their children's lives, this usually creates a platform that makes it easier to then talk about the difficult issues.

Which part of the framework do you start with?

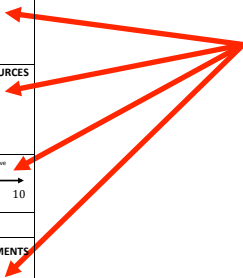
In using the assessment and planning framework with families, you can potentially start with any part of the framework and move around the framework in any order, as long as you cover all of the areas and elicit as much detail as possible in each of the areas. Remember that our purpose is to elicit the family’s assessment of the safety, belonging and wellbeing of their children and their ideas for building future safety, so we need to use the framework in a way that is going to create an environment of trust and openness. In my experience, if you start by asking families about the harm to the children or what they are worried may happen to their children in the future (worry statements), parents tend to get defensive and the conversation closes down pretty quickly.

I usually start either with the “what’s going well” elements (protection and belonging, and strengths) or with the scaling question or with the goal statements. Starting in any of these places can lead to constructive discussion and information sharing as we are communicating to parents that we are interested in what is going well and in their views about future safety, belonging and wellbeing. Very rarely do I start with the worries (harm, complicating factors or worry statements) and only if the family want to start by talking through their concerns.

But whichever part of the framework that you start with, the process is one of asking questions to elicit the views of family members across all of the framework and then sharing the views of the agency. This process of eliciting the family’s views and sharing the professional views may occur during one session or more likely, over a number of sessions. And you can elicit family members’ views individually, with all of the family together in a large meeting, or any combination of the two, depending on what is most appropriate for the family. I very commonly first work with the parents (either individually or together) to ‘map’ their views and to share the professional views, before meeting with the parents and the extended family/safety network together to elicit everyone else’s views and to provide an opportunity for them to hear the views of the parents and the agency.

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

WHAT ARE WE WORRIED ABOUT?	<i>PURPOSE OF THE CONSULTATION</i>	WHAT IS GOING WELL?
HARM	<i>GENOGRAM/ECOMAP/ CIRCLES OF SAFETY and SUPPORT</i>	PROTECTION & BELONGING
COMPLICATING FACTORS	<i>CULTURAL CONSIDERATIONS</i>	STRENGTHS & RESOURCES
	<i>CURRENT SDM SAFETY AND FRE LEVELS</i>	
SAFETY & WELLBEING SCALE <small>On a scale of 0 – 10, where 10 means the children are safe enough for Child Safety to close the case and 0 means there is not enough safety for the children to live at home at the moment, where do you rate the situation? (Place different people’s assessment on the scale below).</small>		
← 0	←————→ 10	
WHAT NEEDS TO HAPPEN?		
WORRY STATEMENTS		GOAL STATEMENTS
ACTION STEPS		



Most useful to start here or here or here.

Working through the framework with parents/ family members

This section provides a detailed exploration of how to work through each part of the assessment and planning framework with family members, including suggested questions that you can use. The questions have been phrased as if you are talking with parents or primary caregivers, but they can easily be adapted to use with extended family members, other professionals or with members of the family's network.

I am going to work through the framework in a linear fashion but as mentioned earlier in this booklet, you can start anywhere in the framework and move about within the framework, as long as each element is covered. If the energy of the parents/family members starts to decrease or if the conversation starts to feel stuck, you can move to the 'What's working well' column or in whatever element you are focused on, look for opportunities to acknowledge and compliment the parent on anything that is going well in their family.

1. What's going well?

Asking questions to find out what is going well within families and in their care of their children is a critical component of a rigorous and balanced assessment. This gives parents/caregivers and their networks the opportunity to describe the good things that are already happening in the family, which the child protection agency may or may not be aware of. These questions may elicit descriptions of strengths that can be drawn on in the process of building future safety and wellbeing for the children, or they may elicit examples of actions of protection and belonging, which are times when the parents/caregivers have taken actions to keep the children safe and well in relation to the worries that have been identified. And starting with "What's going well?" can bring a transforming sense of hope and energy into our conversations with family members, which is an important counter to the despair and hopelessness that family members may be feeling about their current life situation and are likely to be feeling more acutely, given that they are currently in a meeting with child protection workers.

Focusing on what is going well in the family also provides an opportunity for workers to compliment the parent/caregiver on the positive things that they are doing and provides family members with opportunities for reflecting on not only what they are doing well, but also on how they achieved these positive outcomes/changes. And through this process of reflection and the increased awareness of how these positive outcomes were achieved, we are hoping that parents/caregivers will be more likely to repeat these behaviours or draw on these resources in the future.

Family Strengths

If I am starting by eliciting information about what's going well in the family, I will usually start by asking questions about the strengths within the family. As discussed earlier, the strengths are those things that are happening in the family or resources/capacities of the family that makes things better for the children or that might help the family to protect the children, particularly in relation to the worries.

I usually start to elicit information about the family's strengths by asking questions such as:

- *I haven't met you before and don't yet know much about how you are as a mum/dad. What do you think is the most important thing for me to know about your family and about you as a mum/dad?*

- *What do you think is working well in your family?*
- *What are you most proud of in your family?*
- *What is your family like at its best?*

If you have already asked a scaling question, then you can ask:

- *What is happening in your family that has you scaling things as high as a 6 right now?*
- *What are you doing in your care of the children that has you rating things as high as a 9?*

Using circular or relationship questions (asking one person about the perspective of another) usually elicits a lot more information:

- *Who is the person in your life who sees you when you are parenting at your best? What would they say they most like about you as a mum/dad?*
- *If your baby/toddler could talk, what do you think they would say they most like about having you as their mum?*
- *What would ___ (partner, mother, friend, etc) say they most like about how you look after the kids?*
- *What would your kids say they most love about the times when you are not using drugs?*
- *Dad, what are the best aspects of mum as a mother?*
- *If I was a fly on the wall and could see you as a parent, what would I see you doing that I was impressed with?*

Asking for information about the people who support the family usually provides useful information (and sets the scene for strengthening/developing the family's network):

- *Who are the people who support you and help you when things are not going so well? What do they do that is most helpful?*
- *Who are the people who most help you with looking after the children?*
- *Who would your children say they feel safest with in your extended family?*
- *When you've had difficult times in your life before, who helped you through that time?*
- *As parents describe the positives, try to connect this back to the children's safety and wellbeing, by asking questions like:*
- *How does this make the situation better for your child?*
- *What do they do that makes things better for you and the kids?*
- *You said that your grandma is an important support to you and your children. What does grandma do that helps you to look after your children and that helps them grow up strong and well?*

As parents answer the questions above, make sure that you are honouring and acknowledging all of the positive things they are saying, both by giving genuine compliments and by recording the information in the framework using the parent's language. I can't emphasize enough the importance of acknowledging parents and family members for the positive things they are doing. One genuine compliment can shift the conversation from one where parents are feeling anxious and defensive and angry to one where you are able to talk together in real and potentially transforming ways.

Once you have elicited as much as possible of the parent's views, you can use questions to explore the parent's perceptions of the agency's views as a way of moving into offering the agency views:

- *While I don't yet know much about you as a parent or about your family, there are certainly some strengths that I have noticed (or heard about). What do you think are some of the things that I have noticed and written down in the framework?*
- *What else do you think I have noticed or heard about that is going well in your family?*

- *Absolutely, those are some of the things I have noticed. Can I tell you some additional strengths that I have noticed (or heard about) that we haven't talked about yet?*

Protection and Belonging

Once we have started to identify some of the positive aspects of their family life and their parenting, I then start to ask questions to explore any actions of protection and belonging (times when the parents have taken actions or made decisions that led to safety, belonging and wellbeing for the children).

Questions I use to elicit examples of actions of protection and belonging include:

- *Tell me about times when you have been able to look after your children and make sure that they are okay, even though you've been dealing with these other difficult things.*
- *Can you think of a time when you were really angry with the kids, but rather than hitting them, you found some way to calm yourself down?*
- *Can you tell me about a time when you were both really pissed off with each other but rather than yelling and hitting each other in front of the kids, you did something different to sort it out that wasn't scary or harmful for the kids?*
- *Can the think of a time when you decided you were going to use drugs and you then organised something for the kids so that they wouldn't be affected by your drug use?*
- *What would your kids (parents/friends/etc) say you have done at times to keep your children safe rather than letting them be affected by some of the problems you have been dealing with?*
- *I don't know much about you as a family yet, but what have you done in the past to make sure your kids are safe and looked after that you think I would feel good about?*

Any examples of protection and belonging that parents/caregivers can identify provides us with critical information about what the family has been able to do at times in the past to provide safety, belonging and wellbeing for their children. While these actions of protection and belonging are usually not enough for us to close the case, exploring past or current actions of protection and belonging is vital as it recognises that the problems within the family may not be happening all of the time and it identifies ways the family have found to provide safety for the children on some occasions. This information forms the basis of future planning with the family, as examples of what has worked in the past can obviously be built on to provide ongoing safety, belonging and wellbeing for the children in the future. These examples also provide us with further opportunities to compliment parents/caregivers about positive aspects of their parenting.

When I am training workers in using the assessment and planning framework, a question that is commonly asked is "What if parents tell us what they've been doing to keep the kids safe and this isn't true, or we don't think it is true?" My response is that if parents are able to describe any behaviour that would lead to safety, belonging and wellbeing for their children, I am happy to write this down, whether or not this has actually happened in the past. In my experience, if we get into a position of trying to prove whether or not something actually happened, this usually leads to parents getting defensive and the conversation shutting down.

What is much more effective in building future safety is to use follow up questions to elicit and then record the parents/caregivers' behaviour as specifically and with as much detail as possible and to explore the difference that the parents/caregivers saw their actions making for their children. Research into solution focused questioning tells us that the more specifically people can describe their preferred future, the more likely it is to happen. So rather than trying to determine whether or not these actions actually happened in the past, I am going to use questions to get as much detail as possible about what did happen, or could have happened in the past, as a way of indirectly asking parents to reflect in detail on what future safety for their children could look like.

2. What are we worried about?

Exploring parents and family members views of what they are worried about, and their perception of what the child protection agency is worried about, is an equally important part of bringing the framework to families. Some family members (particularly if they have contacted the agency to talk about their concerns) might want to start with talking about the worries. For other family members, this can be the part of the framework that is most difficult to talk through and you might touch briefly on the concerns before exploring the other elements of the framework in detail and then coming to the worries once a degree of trust and the beginnings of a working relationship has been established. As mentioned earlier, it doesn't matter which part of the framework you start with, as long as each of the elements are covered.

Harm

The harm element is the part of the framework where there is most likely to be conflict between professionals and family members. The disagreement is usually about whether or not the children were harmed and who was responsible for causing the harm. Trying to force agreement about the harm will usually lead to a breakdown in communication and will get in the way of building a working relationship. Family members and professionals do not need to agree about what happened in the past to be able to work together to create safety, belonging and wellbeing for the children in the future.

One simple way of minimising the time spent on arguing about the past harm is to acknowledge with families that it is very common for there to be disagreement about the past harm. Another way of minimising conflict is to explain to parents that the purpose in identifying the past harm is not to name and shame anyone, but to work forward from what has (or may have) happened in the past so that we can identify the future worries to the children and then everyone can then work together to focus on addressing these worries and identifying the changes that need to be seen (goal statements) for the agency to close the case in the shortest possible time.

In situations where there is general agreement or openness in talking about the concerns, I usually introduce the harm element by saying something like:

"This next part of the framework is the part where we could get most caught up in arguing about whether or not things are true. This is the part where we try to describe as clearly as possible any worrying things that have happened or may have happened to your children in the past, and this isn't usually an easy part for everyone to talk about. So I'm just going to say up front that we're not focusing on any harm that has happened to your kids as a way of having a go at you; this is about trying to be as clear as possible about what has happened or might have happened in the past so that we can work together to best sort things out so that nothing like this will happen in the future for your family. So is it okay with you if we talk about what we call the 'harm' now?"

In situations where the parents/family members are disagreeing about the allegations or report, I usually say something like:

"I understand that you don't agree with the report that Child Safety have received and while we're not going to just assume that the information is true or that it is the full story, we have to consider the possibility that it could be true and we have to take the report seriously. So we record this information here in the 'harm' section as this helps us to think through and talk with you more clearly about what we are worried might happen to the children in the future (pointing to the 'worry statements section'). Once we've got the future worries clear, we can then work together on identifying what needs to happen (point to the goal statements) so that everyone is confident that your children will be safe and well in the future. So is it okay with you if we talk about what we call the 'harm' now?"

Then I start a questioning process to explore the 'harm' with parents. I use the same questioning process as discussed earlier: starting by asking the parents for their views; then asking the parents for their perception of other people's and the agency views; and thirdly, offering the agency views.

Questions you can use to explore the 'harm' with parents include:

For ongoing cases/children in care:

- *What was it that was happening in your family and to your children that led to Child Safety being involved with your family/that led to your children being taken into care?*
- *So you were using drugs/hitting and yelling at each other in front of the kids (whatever is the issue that parents identify in the first question)? Can you tell me how long that was going on for? How often it happened (ask for specific details: who, what, where, when)?*
- *How did your drug use/fighting etc affect your kids? What was the worst of that for them?*
- *Who is the person who you think knows most about your family and who you are as parents? What would they say was happening in the past that most concerned them?*
- *What else was happening in your family and to your children that led to Child Safety being involved with your family/that led to your children being taken into care?*
- *This might not be an easy question for you to answer, but if your kids were here (and were old enough to speak), what would they say was the worst of that time for them?*
- *If your previous caseworker was here, what would they say happened that led to your children being taken into care?*
- *Of all the things that have happened in the past within your family, what do you think I would be most concerned about?*
- *Can I show you now the statements of harm that I had written down before I came to see you and we can see if there is anything I included that we haven't talked about?*

For new cases:

- *We've talked about a lot of things that are going well in your family and with your kids, but obviously we have received a concerning report which is why we are here. So it's important that I also hear from you about the things that are not going so well in your family. The more that you are able to be straight with me about the problems that you are facing, the more that we will be able to work together to get these problems sorted as quickly as possible so that we can get out of your life and let you get on with being a family. So if it okay with you if I now ask you about some of the things that are not going so well for you and for your kids?*
- *So you are using drugs sometimes/hitting and yelling at each other in front of the kids (whatever is the issue that parents identify in the first question)? Can you tell me how long that has been going on for? And how often would you say that that happens (ask for specific details: who, what, where, when)?*
- *What is it about your (drug use/fighting/mental health etc) that most worries you?*
- *How does your (drug use/fighting/etc) affect your kids? What is the worst of that for them?*
- *What do you think _____ (grandma, child, child health nurse, teacher etc) would say is most worrying about that?*
- *What do you think I would say is most worrying about your (drug use/fighting/mental health)?*
- *Can I show you now the harm statements that I wrote down before I came to see you and we can see if there is anything I included that we haven't talked about yet?*

None of this information may be easy for parents/family members to talk about and it may bring up some emotion or strong feelings, such as shame or guilt or grief about the past, as well as despair and a sense of hopelessness. Or people may feel angry and become defensive and start to shut down. It is important that you pay attention to how people are feeling and recognise that talking about the 'harm' may leave people feeling vulnerable. Slowing things down at this point by taking

time to acknowledge and honour people for their openness and for their courage in being willing to talk about the 'harm' can make a big difference for people and can help to develop a stronger working relationship. It can also be helpful at this point to remind people that we won't be going over and over the past and that our purpose in talking about the past is so that everyone can work together to make sure that nothing like this happens for their children in the future.

Complicating Factors

Complicating factors are those things that may make it more difficult for the parents to achieve future safety, belonging and wellbeing for the children, such as substance use, mental illness, poverty or isolation, but that have not (to the best of our knowledge) led to harm to the children. Complicating factors are also factors that make it difficult for the family and parents to work together, such as disputes between professionals and family, cultural misunderstandings, etc.

It is important to explore any significant complicating factors that are operating for the family, or that are present between the family and the agency, as these things may also need to be addressed or acknowledged before we can start to work together on building future safety, belonging and wellbeing for the children.

Questions that can help to explore any complicating factors with parents include:

- *Are there things happening in your life that make it more difficult for you to sort out these issues and make sure that your children will be safe and well in the future? What are these things?*
- *What would _____ (caseworker, children, grandma etc) say is happening in your life that will make it harder for you to make sure your children are always safe in the future and growing up strong and well?*
- *What do you think makes it harder for your family to deal with the things that everyone is worried about?*
- *What things do you think might make it more difficult for you to work with the child protection agency and show them that your children will be safe in the future?*
- *You said that your mental health might make it harder sometimes. How will your mental health issues make it more difficult for you to keep your children safe?*
- *How will your mental health issues make it harder for you to work with the child protection agency?*
- *In our assessment and planning framework, we describe these type of things as 'complicating factors'. Can I show you where they are written within the framework and summarise the things you have told me?*

As with each of the other elements, once you have elicited as much as possible of the parent's views, you can then move into offering the agency views:

- *While I'm only beginning to get to know you and your family, there are some things I have heard you talk about (or heard about from others) that I think might make it more difficult for you to get things back on track. Can I talk with you about you some possible complicating factors that I have noticed (or heard about) that we haven't talked about yet?*

Once you have recorded both the family and agency views about the complicating factors within the framework, you can then use questions to collaboratively explore which of the complicating factors are most important to address/pay attention to and which (if any) of the complicating factors might lead to the formation of a worry statement.

- *Of all of these complicating factors we have listed, which are the most important ones that you*

think we need to pay attention to? Can I offer you my thoughts on that?

- *Which ones do you think other people who will be working with you to help you keep the children safe in the future need to know about?*
- *Are there any of the complicating factors we have talked about that you think could lead to the children being hurt in the future?*
- *Can I explain to you why I am concerned about this complicating factor and how I think this could lead to the children being hurt in the future?*

3. The Safety and Wellbeing Scale

The safety and wellbeing scale is designed to be used with all the significant people involved with a family and can be a powerful way to elicit someone's views about how things are going in the family at this point in time. I will often start with the safety and wellbeing scale, particularly if the person is finding it difficult to talk about what is going on within the family.

A general safety and wellbeing scaling question is:

- *On a scale of 0 – 10, where 0 means the situation for these children is so bad that it is not safe for them to be in the care of the parents at this time and 10 means that there is sufficient safety for Child Safety to close the case, where would you say things are right now on that scale of 0 - 10?*

If people haven't been asked scaling questions before, the safety and wellbeing scaling question can seem a little strange, so it helps to introduce the question by saying something like:

- *I'd like to ask you a question now that might seem a little strange or*
- *I'd like to ask you a question now that is something that we call a scaling question, is that okay? So, on a scale of 0 - 10*

What you define as the '10' and the '0' on the safety scale can make an enormous difference in terms of how people respond to the safety scale question. When using the safety scale with parents, I usually set the '10' to be something that parents are likely to have an emotional connection with, such as:

- *On a scale of 0 – 10, where 10 means that you are able to be the mum (or dad) for your kids that you have always wanted to be, and 0 means that things are at their worst for your family right now, where would you say things are right now?*

With extended family members, friends, etc I will usually ask a scaling question such as:

- *On a scale of 0 – 10, where 10 means you are really confident that the children (your grandchildren, use children's names, etc) will be safe in the care of _____ (use their names) and grow up strong and well, and none of us need to do anything extra to support them, and 0 is that you are really worried about the children and think that the children need to stay with someone else until the parents are able to get the problems sorted. Where would you rate the situation right now?*

An important thing to remember about using the scaling question is that it doesn't really matter where someone places themselves on the scale. Whatever their scaling position, you can use questions about the person's position to explore their views further and to help them to understand other people's views.

Once people have scaled themselves on the safety and wellbeing scale (and remember to make sure that they can see their scaling position being visually recorded), you can then ask each person to identify:

1. The things that are going well in the family that have them scaling as high as they have.
2. Things that they are worried about that have them scaling as low as they have.
3. What they would need to see happening in the family to scale one point higher on the scale.

In this way, the safety and wellbeing scale can be used to elicit people's views across all the elements of the framework. For example:

- Things that have people scaling as high as they have can be recorded as either strengths or actions of protection and belonging.
- Things that have them scaling as low as they did can be recorded as either harm, complicating factors or if they are phrased as worries about what might happen to the children in the future, then they can be recorded as worry statements.
- What they would need to see to move higher on the scale can be recorded as either goal statements (if they are at the level of goal) or as next steps in working toward the goal statements.

Sometimes, parents, children and family members will scale at a 10. In my experience of working with families, this usually happens if people do not trust that they can be honest with us or are anxious about the consequences of scaling lower. Rather than trying to argue or dispute someone's stated view, you can still use their scaling position to explore their views further, by asking questions such as:

- *You obviously know your/the family a whole lot better than I do. What do you think are the most important things I need to know about what's going well in your/the family that has you scaling as high as a 10? What else? What else?*
- *It's great to hear all the things that are going well in the family at the moment. What do you think are the most important things the family need to keep doing to make sure they stay at a 10?*
- *It sounds like there are a lot of things that are going well at the moment and so can I also talk with you about what you/the family have done that has helped to sort out any problems from the past and that has helped you to feel so confident now? So in the past, when things might not have been going so well, what would be the lowest position that you would have been on that same scale? When might that have been? And what have you/the family done that has moved you from a 6 (whatever number they listed as their lowest position) to a 10? What else?*

There are also times when family members, foster carers etc might score at a 0 and you might have the sense that this is not a realistic assessment. Once again, rather than arguing with someone about their scaling position, you can use questions to explore their views in more detail. A question that I frequently use in this situation is:

- *You are obviously feeling pretty worried about the children and in a moment, I'm going to ask you what you are most worried about, but before we move away from the scaling question, can I ask you if there have been times when you have been higher than a 0. Where were you at your highest on that scale? What was happening then that had you that high on the scale?*

You can also use the scaling questions to help parents, extended family and safety network members to reflect on other people's views about what is happening in the family, including the views of the child protection agency. Once you have fully explored someone's scaling position and views, you can then ask where they think someone else (child, grandparent, foster parent, child protection worker) would scale things and then ask:

- What they think that person thinks is going well that would have them scaling that high.

- What they think that person would be worried about that would have them scaling that low.
- What they think that person would need to see happening to scale one point up on the scale.

Sharing your scaling position with parents/family members can be a contentious moment, as parents can feel deflated or judged by the fact that you may be scaling at a significantly lower position than they are. Before offering my scaling position, I usually first ask the parent/family member where they think I might be on the scale. This question can help to create some space for exploring our different scaling positions as parents will often volunteer that they think you will be fairly low on the scale and you can then both acknowledge your position ('Yes you're right, I am at about a 2...' or 'Actually, I'm a little higher than you think, I'm at about a 3....') and then explore with the parents what has you scoring as high and as low as you are.

willingness to talk together about the problems and to work together on addressing the problems has moved me higher on the scale (for example, from a 1 to a 2). The second is that I always try to make it clear that it is my hope and intention that as we focus on the future safety of their children and work together to increase the safety for their children, that my scaling position (and everyone else's) will continue moving higher and higher until we reach a 10 and there is enough safety to close the case.

4. *What needs to happen?*

Working collaboratively with families and their networks to identify what needs to happen for their children to be safe and well in their care in the future, is the most important part of using this framework with families. As discussed a number of times in this booklet, the more that the family and their network are involved in thinking through the future worries and planning for future safety, belonging and wellbeing for the children, the more likely it is that any plans will be meaningful to the family and result in real and sustained change.

The bottom segment of the framework is the planning component and this involves identifying:

- The future worries for the children (worry statements)
- Future goals to address these worries (goal statements)
- Next steps (to achieve these goals).

Worry Statements

Worry statements describe everyone's worries about what parents might do (or not do) in the future that could lead to the children being harmed. Involving parents and other family members in the development of the worry statements is critical, because if they are involved in thinking through and identifying the future worries for the children, they will be more able to meaningfully participate in thinking through the changes that need to be made (goal statements) to ensure that these worries don't happen and that the children will be safe and grow up strong and well in the future.

If there is disagreement between the family and the agency about the harm that has occurred, it is likely that there will also be disagreement about the future worries. Again, it is important not to get caught up in arguing about whether or not the identified worries will happen to the children in the future. Our focus is on explaining what we are worried MIGHT happen to the children and on exploring with the parents whether or not they are willing to work with us to show everyone that this WON'T happen in the future.

The process I usually use in working with family members to develop the worry statements is to:

1. Clarify and record my view on the worry statements before meeting with the parents (when I initially 'map' the case as explored earlier in this booklet).
2. Use a questioning approach with the parents/family to explore their views on the future worries for the children and record this in the framework that I have drawn up with them.
3. Share the worry statements I wrote earlier with the parents/family members.
4. Work together to explore the overlap in our views and then to construct worry statements that include everyone's worries about what might happen to the children in the future, that identify who is worried about each future worry and that use the family's language as much as possible.

Questions you can use to elicit the parents' views on the future worries include:

For new cases:

- *We've talked about some things that are not going so well in your family at the moment. If these problems were to continue, what are you worried might happen in the future that could lead to your children being hurt? What else are you worried might happen? What else?*
- *If your children were here (were old enough to talk to me) what do you think they might say they are worried might happen to them in the future if these problems were to continue?*
- *What do you think _____ (grandparents, siblings, neighbours, child health nurse, school etc) might say they are worried might happen to your children in the future?*
- *What do you think I would be worried might happen to you children in the future if these problems were to continue?*
- *What else do you think the child protection agency are worried might happen to your kids in the future?*
- *Can I show you now the worry statements that I wrote down before I came to see you and we can see if there is anything I included that we haven't talked about yet?*

For ongoing cases/children in care:

- *We've talked about some things that are not going so well in your family at the moment. If these problems were to continue (or reoccur), what worries do you have about what might happen to your children if they were to come back home to live with you?*
- *What worries to you think your children might have about what might happen if they were to come back home to live with you?*
- *If _____ (grandparents, siblings, child health nurse, school etc) was here, what do you think they would say they are worried might happen to your children if they were returned to your care?*
- *What do you think are my biggest worries about what might happen to your children in the future if they were returned back home to live with you? What else do you think I am worried might happen?*
- *Can I show you now the worry statements that I wrote down before I came to see you and we can see if there is anything I included that we haven't talked about yet?*

Developing mutually-constructed worry statements:

Once you have elicited the parents'/family's views about the future worries and shared your views, the process is then one of working together to create one set of worry statements that will be used in working together to build future safety, belonging and wellbeing for the children. Again, we are using a questioning approach to involve parents in the process of combining everyone's views to create one set of worry statements.

- *Looking at the things that you said you or other people are worried might happen to the children in the future and the things that I have written down as my worries for the children for the future, can we look now at which things we have both identified as possible future worries?*
- *Looking at the worry statements we have written down within your framework and the worry statements I wrote down before, can we look at what we have in common? What possible future worries have we both identified?*
- *So you and I are both worried that if Tasha is left alone with Uncle Greg, that he might try to touch her private parts and ask her to touch his, and that Tasha would be distressed and confused by that and might start to feel bad about herself. Let's write that down as the first worry statement.*
- *You said that you thought Tasha and your mum might also be worried that this might happen. If we find out that it is a worry for them, we can include their names at the beginning of the worry statement. Who do you think is the best person to talk to Tasha and your mum to find out if this is a worry for them?*
- *What other future worries have we both identified?*
- *Can we look now at the future worries that I have but that may not be worries for you? I am worried that you might get into a relationship in the future with someone where you would be doing things like hitting, punching and screaming at each other in front of Tasha, and that Tasha will be frightened by seeing and hearing that happen and that she could even be hurt if she gets caught up in that fighting. So let's write that down as a worry statement that at the moment is just my worry and then we can explore if there is anyone else who is also worried about this.*
- *Can I ask to what extent this might be a worry for you? So on a scale of 0 - 10, where 10 is you are 100% confident that you won't be in a relationship in the future where there will be any hitting, punching and yelling in front of Tasha, and 0 is that you think that it is pretty certain that that will happen in the future, where are you on that scale?*
- *You're at a 7, okay, so can I include you as being a bit worried about this particular future worry, or would you prefer that your name wasn't included in this worry statement?*
- *Is there anyone else who you think might be worried about this? Who would be the best person to talk with them to find out if this is a worry for them?*

So once we have talked with the other important people in your and Tasha's life, we can then be clear about who shares some of these worries with yourself and with Child Safety and we can include their names if that is appropriate.

So you can see from the suggested process above that the worry statements can be developed collaboratively with parents/family members and that everyone doesn't have to agree on all of the worry statements. What is important is that everyone can understand each other's views about the future worries and can recognise that addressing these worry statements is the purpose of the child protection intervention.

Goal Statements

Goal statements describe WHAT the parents will be doing (differently) in their care of the children in the future for the children to be safe and well and/or for the child protection agency to be willing to close the case. The goal statements provide a vision for future safety, belonging and wellbeing and provide the focus and direction for the creation of detailed plans.

When I am 'mapping' with a family, the goal statements are the part of the framework that I frequently start with, particularly with families where we have or could get stuck in arguments about what happened in the past. Asking parents to describe their ideas and hopes and dreams for keeping their children safe and well in the future often enables our conversation to focus on a vision for the future, rather than getting stuck arguing about the past. And what I have learnt is that

when families are able to talk with us about their visions for the future, hope and energy enters the room and enables us to build a platform for working together to create future safety, belonging and wellbeing for the children.

Time after time, when I have used careful questioning with parents to elicit their goal statements for their children, parents usually come up with most, if not all, of the desired changes that child protection services have identified that they would want to see happening. The key in eliciting specific and safety-focused goals with parents is using specific, purposeful and safety-focused questions that invite the parents to reflect their vision for future safety, belonging and wellbeing.

In asking parents about their goal statements, the initial question I ask is usually something like:

- *I don't want to get into an argument with you about whether the things that were reported to Child Safety actually happened or not, but instead I want to find out your ideas about the future that you want for your family. So let me ask you this question: Imagine that it is a few months in the future and that you have managed to sort out all of the problems that led to child protection services becoming involved with your family. What would I see you doing in the way you were looking after your kids if all the problems had been sorted out?*
- *I understand that having child protection services in your life might be the last thing you want, but imagine if having us involved in your life was actually a useful thing and made a positive difference for your family and your children. I know that might sound like a crazy idea, but imagine if our involvement was actually a good thing and we were helpful to you, what would be different for you and for your children?*
- *For child protection services to be able to get out of your life and let you get on with being a family, we need to see that you are looking after your children in ways that make sure that none of the things we are worried about will happen to your children in the future. And we need to talk together about your ideas of how you would be looking after your children and our ideas about what we would need to see you doing, so that together we can come up with some really clear goals. I want to start off by asking you for your ideas and finding out what you want your future with the kids to look like. So if you were able to be the parent you have always wanted to be and were able to look after your kids in ways that you feel good about, what would you be doing?*
- *I understand that you don't agree with all of the worries that we have, but what do you think you would need to be doing in your care of your children in the future to show us that the things we are worried about are not going to happen?*

I usually choose one of these questions (relying on my instinct about which will be most effective) and if that question doesn't work, try another. The question you ask is likely to elicit only some of the parent's ideas, so you will need to ask (and continue asking) "And what else would you be doing?" until parent/family member has identified all of their ideas.

As parents are identifying their goal statements, you can use follow up questions to help parents refine their goal statements to ensure that they are focused on the children, that they describe the changes in their behaviour and that they cover all of the identified worries. Examples of some follow up questions to help focus and refine the goal statements are listed below.

Focusing on the care of the children

The focus of goal statements is always on the care of the children. If we ask someone a general question such as 'What would you be doing?', we're likely to get a general answer such as 'I wouldn't be using drugs'. While stopping substance use is definitely something we want parents to achieve, this description doesn't describe what would be different for the children. So using follow-up questions such as the examples below can help the parent/caregiver shift their focus to their children and describe what they would actually be doing (differently) in their care of their children:

- *And if you weren't using drugs, what would be different in your care of your children? What else would be different? What else?*
- *And if you were managing your mental health better, what would be different in your care of your children? What else would be different? What else?*
- *If you had more friends/got a job/got your license, what difference would this make for the kids?*

Framing goal statements in the positive

When we ask someone what they would be doing in the future, people will often answer with what they wouldn't be doing, so it is important to use follow up questions to ask people to identify what they would be doing instead (framing the goal statements in the positive, which are both easier to measure and to achieve). For example:

- *Karen, you said that you wouldn't be spending money on drugs. What would you be doing instead?*
- *So when you and Tracy are pissed off with each other, you said that you and Tracy wouldn't be yelling and hitting each other in front of the kids. So when you and Tracy do get pissed off with each other in the future, which every couple does, what would you be doing instead of fighting around the kids?*

Asking questions from other people's points of view

Some people may find it difficult to imagine or describe what they would be doing in the future, so it can be helpful to use relational questions, which ask what they think other significant people in their children's lives would see them doing, for example:

- *If your mum was there, what would she notice you doing (differently) with the children?*
- *What would the kids notice you were doing?*
- *And if you weren't using drugs, what would be the first thing your children/your mother/child protection workers would notice was different in the way you were looking after your children?*
- *If I put a video camera in your future house and then watched it later, what would I see you doing in your care of the kids?*
- *What do you think your kids would say they would need to be different for them to always feel safe when they are with you?*

Covering all the identified worries

If the parent/caregiver doesn't cover all the areas that have been identified as future worries for the children, then use further questions to ask for their ideas about what they would be doing in their care of the children to make sure that each of these worries didn't happen. For example:

One of the things we are worried about is that your uncle Greg might try to touch Tasha on her private parts. What do you think you would need to be doing in your care of Tasha in the future to make sure that this didn't happen?

You said that you have had some times in the past when you were feeling really depressed and you weren't able to get out of the bed in the morning and look after the kids. If you do have times like that in the future, what would you want to do before or during those times to make sure that your kids are still looked after?

Distinguishing between goal statements and detailed action plan

When people are describing their goal statements, it is very common for them to start to talk about the details of how they will achieve the goals. This level of details is fantastic, but these details are what we want to include in the action plan. We first need the goal statements, which provide the broad or umbrella statement of what change will be demonstrated, and then we can work together to develop the action plan, which provides the details of how this change will be achieved and measured and sustained over time. If people have made their goal statements too specific and have started to go to the level of detail of the action plan without first getting the broad goal statement, I usually say something like:

Underneath your goal statement which says: 'Kerry is going to manage her depression better so that she is able to get out of bed in the morning and look after her kids, and if she can't, she is going to make sure that another safe adult is there to look after the kids', I've written down the ideas you had about how you might start to achieve that, such as seeing your doctor to talk about your depression and to find out if medication might help, and starting to see a counsellor to do some healing of your past. These ideas you have about how you are going to start to achieve this goal statement are fantastic and are what we want to start putting into the detailed action plan. We use the goal statements to describe broadly what will be different in your care of the kids and the action plan tells everyone the details of how you are going to organise your life and the children's lives so that the goal statements are achieved. So the goal statements are where you want to get to and the action plan is how you are going to get there. Does that make sense? So are you okay if we take these ideas out of your goal statements and put them on a separate page as part of the action plan. Once the goal statements are clear, then we can all start working together on the action plan.

Asking parents to reflect on the Agency Goal statements

After eliciting the family's goal statements, you can move into asking the parents to consider the agency's views on the goal statements. I usually do this only after I have used careful and extensive questioning with the parents to elicit their own goal statements and we have worked through the worry statements together, so that parents can reflect on what future actions they think the child protection agency would need to see them take to protect the children from the worries.

The place that I usually start is by first acknowledging the ideas that the parents have provided, and then asking them to consider which of these ideas or goal statements they think would be most important for the child protection agency to see in place. I usually ask a question such as:

- *We've talked about your ideas and thoughts about what you would be doing in the future to make sure that your children are safe and getting everything that they need and you've come up a whole lot of ideas that are helping me to feel a lot more confident. Which of these ideas do you think would be important to the child protection agency?*
- *Once we have explored the the parents' perceptions of what part of their goals would be important to the child protection agency, we then move to identifying any additional goal statements they think the child protection agency would need to see.*
- *What else do you think Child Safety would need to see you doing, in your care of the kids, for us to be willing to close the case? What else do you think we would need to see you doing?*
- *Looking at the worry statements, what else do you think you need to be doing with your children so that we are no longer worried?*
- *One of the things that we are worried about is that your dad might try to touch your daughter's private parts. What do you think we would need to see you doing to protect your daughter to make sure that this doesn't happen?*
- *Another thing that we are worried about is that when you and David get angry with each other*

in the future, that you might yell and hit each other in front of the children and that the children might be really scared and could even get physically hurt if they get caught in the fighting. So when you get angry with each other in the future, which all couples do, what do you think we would need to see you doing to make sure that the children aren't at risk of being hurt or scared in this way?

- *Can I show you now the goal statements that I wrote down before I came to see you and we can see if there is anything else I included that we haven't talked about?*

Developing mutually-constructed goal statements

Once you have elicited the family's goal statements and asked the family to reflect on the agency goal statements, you can then use a questioning approach to combine the different goal statements into one set of goal statements that are reflective of both the family's ideas and the requirements of the agency. Combining the goal statements will often involve incorporating the family's language or adding goals that are important to the family, but does NOT involve diluting the safety focus.

I usually introduce this next part of the process by saying something like:

The next step we need to take in working together is to come up with one set of goal statements that include both the things that you want to be doing in the future to keep your children safe and the things that the child protection agency need to see you doing to make sure that the things we are worried might happen to the children in the future don't happen.

Then to develop one set of mutually-constructed goals, I usually questions such as:

- *So looking at your goal statements and the goal statements I wrote down before, let's look first at what we have in common? What goal statements have we both identified? What other goal statements have we both identified? Let's write all of those down under the 'Goal statements' heading.*
- *Can we look now at the goal statements that are important to Child Safety but that you haven't included as part of your goal statements. I have included a goal statement that says: 'Kerry has ways of sorting out any conflict or arguments with future partners or other adults that are safe for Tasha and that doesn't involve anyone hitting, punching or screaming at each other in front of Tasha'. I understand that you feel pretty confident that you won't get into relationships like this in the future, but as you know it is still a worry for me and is still one of the worry statements, so I need to include this as a goal statement so that we can build our confidence that you have ways of sorting out any conflicts with people in the future that are safe for Tasha. Is this something that you are prepared to work toward and to show us that it is achievable for you? Yes? That's great! Are you happy with the way I have written this goal statement or do we need to change the way this is written?*
- *Let's look now at the goal statements that you have included but that are not in the goal statements I wrote. Which of these do you think it is important to include in the goal statements? If the kids were here/able to talk, which of these goals would they say were important and needed to be included? Let's add those to the goal statements.*

Introductory statement at the top of the goal statements

At the top of the goal statements, I include a statement that helps everyone to understand the process of involving a network and working from the goal statements to develop the detailed plan, and that also makes it clear that this is a collaborative process (see p.12). To introduce the introductory statement, I usually say something like:

You can see at the top of my goal statements that there is a bit of an introduction. We usually write this at the top of the goal statements to explain to everyone about the importance of having a family network and about all of us working together to come up with a detailed action plan that will explain how you are going to make sure these goal statements happen.

What I've written is: 'Kerry will work with the child protection agency and a network to develop and put into place a detailed plan that will show everyone that:'. Do you think it would be useful to include something like this at the top? How would you like to word it? Do you want to start to put the names of some of your family's network in here?

So we've got: 'Kerry and her mum, Debra, and her sister, Elaine, as well as other people who will be invited to join the family's network, are going to work with the child protection agency to come up with a plan that is going to show everyone that the goal statements beneath are going to happen for Tasha'. That's great!

Exploring a time frame

Once we have talked through all the details of the goal statements that need to be in place to address the worry statements and have come up with a mutually-developed set of goal statements, I then introduce the idea of these goal statements needing to be demonstrated over time. I usually say something like:

I think that we have come up with a pretty clear and comprehensive set of goal statements. If you have developed a detailed action plan that is achieving all of these goal statements, that will be enough for the child protection agency to be confident that your kids will be safe and well enough and that we are able to close the case and let you get on with being a family. Can we now talk about how long we would need to see you achieving these goal statements (and having the plan working) for us to be willing to walk away? How long do you think I would need to see you doing all of this, for me to be confident that it had now become part of the way your family life is organised and that it was going to keep happening? Do you think one week would be long enough for me? One month? One year?

The way we usually write this is something like: Child Safety will need to see the plan in place and working for a period of 6 months so that everyone is confident that the plan will keep working once Child Safety withdraw.

So you can see from this suggested process that you can use a questioning approach to move from the family goal statements and the agency goal statements to one set of mutually-constructed goal statements. It is these mutually-constructed goals that provide the vision and direction for our future planning work with the family.

Next Steps

Asking family members to identify the next steps that need to happen in working toward the goal statements is important so that family members are given the opportunity to reflect on what needs to happen next, so that they are able to contribute to and better understand the case planning steps.

Questions you can use to explore next steps with families include:

- *What do you think are the next steps you need to take in working toward these goal statements?*
- *What do you think the child protection agency need to do in supporting you to work toward the goal statements?*
- *So you've said that this (the goal statements) is what you want for your children and your family.*

- What do you think is the smallest next step that will help you move toward that happening?*
- *What do you think your children/your grandma/your partner etc would say is the next step you need to take in working toward these goal statements?*

If parents are finding it difficult to identify the next steps, you can work through the next steps for each of the identified goal statements, asking:

- *You have said that you want to sort out any arguments between you and David in ways that are safe for the kids. What do you think is the first step/next step in getting that happening?*
- *One of the goal statements we both think is important is that your children will always be in the care of an adult who is not affected by drugs or alcohol. What do you think is the next step you need to take to get that happening for your kids?*

If you have already explored the safety scale with family members, you can use their scaling position to help to identify the next steps, by asking a question such as:

- *You rated the situation 6 out of 10 on the safety and wellbeing scale. What do you need to do next to move things up one point on the scale to a 7? What else would you need to do to move up one point? What else?*
- *What do other people need to do next to move things up one point on the scale?*
- *I'm at a 5 on the scale. What do you think I would need to see you do for me to move one point higher on the scale? What else would I need to see?*

If you have used the Family Roadmap process or Future House tool with parents/caregivers or the Safety House tool with children, the next steps will have been identified on the roadmap or the safety path and these steps can be recorded within this part of the framework.

Case Example: Mapping the parents' views

Using the same case study (Isabella, 4 wks) that was used to illustrate the initial agency mapping in the previous section, we will now look at the 'mapping' of Isabella's parents views and the process that was used to elicit and record their views during my initial meeting with the parents.

Kristy and Darren's views, recorded within assessment and planning framework, are contained within the framework on the following two pages.

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father).
Whose views are included below: Views of Kristy (mum), Darren (Dad)

Date: June 6, 2010 (one day after referral).

<p>WHAT ARE WE WORRIED ABOUT?</p> <p>HARM</p> <ul style="list-style-type: none"> Kristy and Darren told Sonja that Kristy used subutex most days during her pregnancy up until she was 32 weeks pregnant. Isabella was born early (at 36 weeks) and she was born drug addicted and was put on a morphine programme to help wean her off her addiction. Isabella cries a lot and is hard to settle and has problems feeding and gaining weight. Kristy and Darren told Sonja that they think that the hospital and CS believe that Kristy and Darren made things worse for Isabella by not taking her to the follow up appointment at KEMH. The doctors at PMH have said that Isabella still needs morphine and is suffering from withdrawal symptoms, which is why she has breathing problems and vomited. Kristy and Darren told Sonja that they didn't realise that Isabella needed more morphine after her weaning programme was finished and that they thought the midwife at KEMH told them that they only needed to take Isabella to the appointment if she wasn't feeding or sleeping well, which she was at that point. 	<p>PURPOSE OF THE CONSULTATION</p> <p>To map initial CS assessment in preparation for meeting and planning with family.</p> <p>GENOGRAM/ECOMAP/ CIRCLES OF SAFETY and SUPPORT</p> <p>The genogram shows three generations. The top row consists of Tom (square) and Ken (square). The middle row consists of Karen (circle), Mary (circle), Tracey (circle), Darren (square), Lorraine (circle), Tabitha (circle), and Kristy (circle). The bottom row consists of Isabella (circle) with '4/32' written next to her. Lines connect Tom to Karen, Mary, and Tracey. Lines connect Ken to Lorraine, Tabitha, and Kristy. Lines connect Karen to Darren. Lines connect Mary to Darren. Lines connect Tracey to Darren. Lines connect Darren to Lorraine, Tabitha, and Kristy. A dashed line connects Kristy to Isabella.</p>	<p>WHAT IS GOING WELL?</p> <p>PROTECTION & BELONGING</p> <ul style="list-style-type: none"> Kristy and Darren said that Kristy told the doctors that she was using subutex when she was 32 weeks pregnant because she was scared for Isabella. Kristy went on to methadone and didn't use subutex or any other drugs for the rest of her pregnancy. Because the hospital knew about Kristy's drug use, they knew what to do to help Isabella once she was born. Kristy and Darren told Sonja that they do everything they can to look after Isabella, making sure she was given her morphine as the hospital showed them and spending hours trying to make sure she gets enough food to put on weight and holding her and rocking her when she cries and taking it in turns when the other person gets tired so that no-one gets too stressed. Kristy and Darren told Sonja that if CS could see them looking after Isabella and if CS talked to the nurses and midwives at KEMH and PMH, CS would realise that K & D are really committed to taking care of Isabella. Kristy told Sonja that when she realised that Isabella was starting to have problems feeding and sleeping again, she phoned the midwives at KEMH to ask for help and talked to Darren's mum and sister and then made an appointment with a GP as soon as she could. Kristy said that because the midwives didn't seem worried, she thought that the doctor's appointment would be soon enough and didn't realise that Isabella could get so sick so quickly, but she called an ambulance as soon as she realised it was serious. <p>STRENGTHS</p> <ul style="list-style-type: none"> Kristy and Darren said that they have a lot of support from Darren's family and that they live really close and visit often. Kristy and Darren said that they have talked to Darren's family and they are willing for Kristy and Isabella (and Darren when he is home) to move in with them if that is what CS want. Kristy and Darren told Sonja that they are happy for Sonja/CS to talk to anyone in their family and to the hospital staff and to Darren's boss and gave Sonja everyone's contact details. Darren said that he does random drug testing for work and that he has been clean for about 5 months. Kristy said that she is taking methadone and meeting with Dr Gordon every week and is really committed to staying off drugs. Kristy said that she is willing to do urinalysis to show CS that she isn't using any illegal drugs. Kristy and Darren said that they have a really good relationship and rarely argue and that it never gets violent between them and never has. Kristy said that she realises that she has messed up in the past and not given Isabella an easy start and that she is willing to do whatever she needs to do to show CS that she and Darren can look after Isabella. Darren said that he has used all his holidays at work but that he would be willing to talk to his boss and ask for some compassionate leave if CS thought he needed to be around more in the next few months.
<p>COMPLICATING FACTORS</p> <ul style="list-style-type: none"> Kristy has to leave the hospital every day at lunchtime to get her methadone and is away from Isabella for about 3 hours. The doctors don't know why Isabella isn't putting on weight. It might be because of the drug withdrawal and it might be another medical problem. Darren has to go back to work in two weeks and Kristy and Darren don't know whether CS will be more worried because he isn't around. Kristy and her family don't get on and when she tries to get herself clean, they always think that she is going to mess up. 	<p>CULTURAL CONSIDERATIONS</p> <p>Darren's family are Noongar and are a strong family with a lot of family members. Kristy's family are of Malaysian descent (Kristy was born in Malaysia and grew up in Australia).</p> <p>CURRENT SDM SAFETY AND FRE LEVELS</p> <p>Initial SDM Safety Assessment identified the family as CONDITIONALLY SAFE. FRE level is HIGH.</p>	<p>PROTECTION & BELONGING</p> <ul style="list-style-type: none"> Kristy and Darren said that Kristy told the doctors that she was using subutex when she was 32 weeks pregnant because she was scared for Isabella. Kristy went on to methadone and didn't use subutex or any other drugs for the rest of her pregnancy. Because the hospital knew about Kristy's drug use, they knew what to do to help Isabella once she was born. Kristy and Darren told Sonja that they do everything they can to look after Isabella, making sure she was given her morphine as the hospital showed them and spending hours trying to make sure she gets enough food to put on weight and holding her and rocking her when she cries and taking it in turns when the other person gets tired so that no-one gets too stressed. Kristy and Darren told Sonja that if CS could see them looking after Isabella and if CS talked to the nurses and midwives at KEMH and PMH, CS would realise that K & D are really committed to taking care of Isabella. Kristy told Sonja that when she realised that Isabella was starting to have problems feeding and sleeping again, she phoned the midwives at KEMH to ask for help and talked to Darren's mum and sister and then made an appointment with a GP as soon as she could. Kristy said that because the midwives didn't seem worried, she thought that the doctor's appointment would be soon enough and didn't realise that Isabella could get so sick so quickly, but she called an ambulance as soon as she realised it was serious. <p>STRENGTHS</p> <ul style="list-style-type: none"> Kristy and Darren said that they have a lot of support from Darren's family and that they live really close and visit often. Kristy and Darren said that they have talked to Darren's family and they are willing for Kristy and Isabella (and Darren when he is home) to move in with them if that is what CS want. Kristy and Darren told Sonja that they are happy for Sonja/CS to talk to anyone in their family and to the hospital staff and to Darren's boss and gave Sonja everyone's contact details. Darren said that he does random drug testing for work and that he has been clean for about 5 months. Kristy said that she is taking methadone and meeting with Dr Gordon every week and is really committed to staying off drugs. Kristy said that she is willing to do urinalysis to show CS that she isn't using any illegal drugs. Kristy and Darren said that they have a really good relationship and rarely argue and that it never gets violent between them and never has. Kristy said that she realises that she has messed up in the past and not given Isabella an easy start and that she is willing to do whatever she needs to do to show CS that she and Darren can look after Isabella. Darren said that he has used all his holidays at work but that he would be willing to talk to his boss and ask for some compassionate leave if CS thought he needed to be around more in the next few months.

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

*Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father).
Whose views are included below: Dr Greenwood, Joanne (Nurse manager), Karen (ward social worker)*

Date: June 8, 2010 (three days after referral).

<p>SAFETY & WELLBEING SCALE</p> <p style="text-align: center;"> ← 0 3 4 → 10 </p> <p style="text-align: center; margin-left: 100px;">Joanne/Karen Dr Greenwood</p>	
WHAT NEEDS TO HAPPEN?	
<p>WORRY STATEMENTS</p> <ul style="list-style-type: none"> • PMH staff are worried that Kristy and Darren will use drugs in the future and then not be able to give Isabella the care that she needs, like following the weaning programme, bringing her to future medical appointments to review whether she still needs morphine, noticing the signs that Isabella is suffering from drug withdrawal, and making sure she is feeding enough and putting on weight. PMH staff are worried that if this happens, Isabella might develop breathing problems, could have seizures and vomiting, could quickly become dehydrated and could become seriously ill or die. 	<p>GOAL STATEMENTS</p> <p>To be at a 10 and be confident that Isabella is safe in Kristy and Darren's care, PMH will need to see that:</p> <ul style="list-style-type: none"> • Isabella is receiving the morphine she needs to be weaned off her drug dependence and the decision to take Isabella off morphine is made by a doctor. • If Kristy and Darren use drugs, they make sure that there is an adult looking after Isabella who is not affected by drugs and who understands Isabella's care needs. • Isabella is putting on weight and reaching her developmental milestones.
<p>ACTION STEPS</p> <ul style="list-style-type: none"> • Kristy and Darren are going to room in for the next 4 days and Isabella is going to stay in the room with them so that K & D can show that they can manage Isabella's fulltime care. • The hospital will develop a clear schedule for follow up appointments once Isabella is discharged and will immediately follow up with the family if any appointments are missed. • PMH will liaise with Wilcock Medical Centre to schedule regular appointments once the PMH appointments have finished. • PMH will arrange for the child health nurse to visit twice a week when Isabella is first discharged and then once a week for up to 3 months. • Others in the family need to be trained in administering Isabella's morphine so that there are back up people who can care for Isabella. 	

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

Process of 'mapping' with Kristy and Darren

To elicit Kristy and Darren's views, I used an extensive questioning approach and drew up the assessment and planning framework on a whiteboard. We began by exploring their goal statements (their perception of what they would be doing as parents and what life for Isabella would look like if she was getting everything she needed to grow up strong and well and safe). We then moved to the safety and wellbeing scale to explore their views about how much of this future vision was already happening. We then explored the family strengths and actions of protection and belonging, starting with identifying what had them scaling as high as they did. I then asked questions to elicit their views on the harm, complicating factors and worry statements, before revisiting the goal statements to make sure that we had covered all of the identified worries. We then finished with their views on the next steps.

After eliciting Kristy and Darren's views within each element, I asked for their perspective on the child protection agency's views. For the safety and wellbeing scale, they said they thought I would be about a 3. I explained that prior to talking with them I had been a 1-2, but was now a 3 after hearing from them about their thoughts and actions. I then gave them a copy of my initial mapping (explaining that I would be updating the framework to include their views) and talked through my initial mapping. This entire process took a couple of hours, with a break.

By the end of this session, Kristy and Darren had not only spoken at length about their views and provided detailed information about what they thought they needed to do to provide safe care for Isabella, they had also identified most of the concerns of the child protection agency and most of the goal statements that the agency needed to see. This made presenting the agency's views a much easier conversation and set us up to begin to develop a mutually-constructed set of worry statements and goal statements (shown in the next section).

Once I had finished the 'mapping' session with Kristy and Darren, I provided them with a copy of what was recorded on the whiteboard (a printout from the electronic whiteboard) as well as blank copies of the assessment and planning framework for them to write down any additional thoughts that they had later, and to use in explaining the framework to their families.

We then had a conversation about who else they wanted me to talk with and who else I wanted to talk with as part of the assessment and planning process, and who they were willing to involve in a family network. The network will be developed over time as we move to comprehensive planning to ensure Isabella's long term safety, belonging and wellbeing (see reference list for more detailed information on planning and networks), but at this point we had initial conversations about the need for a network and the role of this network in helping to develop and implement a detailed plan.

Kristy and Darren asked me to meet with both their families and also to speak to Darren's boss to find out more about the drug testing that Darren was required to do for his work. I explained that I would also be meeting with the hospital staff tomorrow (which they were welcome to be part of) to gain the hospital's views on what needed to happen for Isabella to be safe in Kristy and Darren's care and would be speaking later today to the hospital staff where Isabella was born. Darren and Kristy said they were talking often with the PMH medical staff and didn't think that they needed to attend that meeting, but asked me to particularly speak to the nurses at PMH as they were the ones who were seeing what Kristy and Darren were doing with Isabella, and to the midwives in the special care nursery at KEMH where Isabella was born.

We then talked about organising a family meeting at the hospital in three days time for all the significant people in Isabella's life to plan for her safe discharge from hospital. We agreed that they would invite family members and friends and I would invite the relevant professionals. We also agreed that I would meet with them the next day prior to the planning meeting to go through the information that I had gathered from others and to be clear with them about the child protection agency's views prior to the meeting.

On the next two pages are two examples of some of the 'mappings' that were developed in subsequent days with other significant people as part of the initial assessment and planning process for Isabella. On each occasion, people's views were elicited and the agency views were shared in a similar process to the one described above for Darren and Kristy.

Case Example: Views of PMH Medical Team

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father).
Whose views are included below: Dr Greenwood, Joanne (Nurse manager), Karen (ward social worker)

Date: June 8, 2010 (three days after referral).

<p>WHAT ARE WE WORRIED ABOUT?</p> <p>HARM</p> <p>Princess Margaret Hospital medical team agreed with the harm statements as recorded in the initial CS 'mapping' (05.06.12) that were based on the referral from PMH medical team.</p>	<p>PURPOSE OF THE CONSULTATION</p> <p>Eliciting any new information from the medical team assessment following the referral.</p> <p>GENOGRAM/ECOMAP/ CIRCLES OF SAFETY and SUPPORT</p> <p>The genogram shows a family structure with Tom and Karen at the top left, connected to Tracy and Mary. Tracy and Mary are connected to Lorraine and Tabitha. Lorraine and Tabitha are connected to Ken. Below this, Darren is connected to Kristy. Kristy is connected to Isabella (4/52). A dashed line connects Darren and Kristy, indicating a relationship.</p>	<p>WHAT IS GOING WELL?</p> <p>PROTECTION & BELONGING</p> <ul style="list-style-type: none"> Kristy and Darren showed PMH that they know how to administer Isabella's morphine and brought the programme they followed at home. Darren brought in the leftover morphine and it was the correct amount. Kristy and Darren are doing all of the hands-on care of Isabella in hospital, including feeding her (she is breastfed with supplementary formula feeds), bathing her, settling her to sleep and providing her with her morphine as per the weaning programme. Kristy and Darren's care of Isabella is very good and they are always gentle and loving with her. Two days ago, Kristy asked the nurse to teach her how to score Isabella on the NAS score sheet, so that Kristy could monitor Isabella's response to the morphine and her wellbeing. The sheet is quite subtle and Kristy is going a good job of noticing the signs to score, including the pitch of Isabella's cry and sleep tremors. <p>STRENGTHS</p> <ul style="list-style-type: none"> Kristy and Darren have told the PMH social worker and doctors that they will do anything they need to do to show people that they can look after Isabella and make sure that she stays well. Kristy and Darren were initially angry about the referral to CS but very quickly accepted that they had made some mistakes and that the concerns the hospital staff hold for Isabella are serious and real. Darren's family is visiting most days and Kristy's mother and sister visit every couple of days. All of them are very focused on Isabella and seem to be aware of the issues.
<p>COMPLICATING FACTORS</p> <ul style="list-style-type: none"> The PMH social worker spoke to the KEMH maternity ward, who said that it may not have been made clear to Kristy and Darren that the review appointment of 25.05.10 was important. The KEMH midwife said that lots of parents do not attend this appointment. KEMH did not follow up with Kristy and Darren after they missed the appointment. Because of Isabella's drug dependence, she cries a lot and is difficult to settle and to feed. PMH don't know if Kristy will be able to manage on her own when Darren is working away. 	<p>CULTURAL CONSIDERATIONS</p> <p>Darren's family are Noongar and are a strong family with a lot of family members. Kristy's family are of Malaysian descent (Kristy was born in Malaysia and grew up in Australia).</p> <p>CURRENT SDM SAFETY AND FRE LEVELS</p> <p>Initial SDM Safety Assessment identified the family as CONDITIONALLY SAFE. FRE level is HIGH.</p>	

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

*Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father).
Whose views are included below: Dr Greenwood, Joanne (Nurse manager), Karen (ward social worker)*

Date: June 8, 2010 (three days after referral).

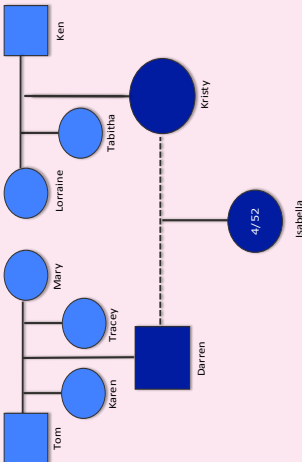
<p>SAFETY & WELLBEING SCALE</p> <div style="text-align: center;"> </div>	
<p>WHAT NEEDS TO HAPPEN?</p>	
<p>WORRY STATEMENTS</p> <ul style="list-style-type: none"> PMH staff are worried that Kristy and Darren will use drugs in the future and then not be able to give Isabella the care that she needs, like following the weaning programme, bringing her to future medical appointments to review whether she still needs morphine, noticing the signs that Isabella is suffering from drug withdrawal, and making sure she is feeding enough and putting on weight. PMH staff are worried that if this happens, Isabella might develop breathing problems, could have seizures and vomiting, could quickly become dehydrated and could become seriously ill or die. 	<p>GOAL STATEMENTS</p> <p>To be at a 10 and be confident that Isabella is safe in Kristy and Darren's care, PMH will need to see that:</p> <ul style="list-style-type: none"> Isabella is receiving the morphine she needs to be weaned off her drug dependence and the decision to take Isabella off morphine is made by a doctor. If Kristy and Darren use drugs, they make sure that there is an adult looking after Isabella who is not affected by drugs and who understands Isabella's care needs. Isabella is putting on weight and reaching her developmental milestones.
<p>ACTION STEPS</p> <ul style="list-style-type: none"> Kristy and Darren are going to room in for the next 4 days and Isabella is going to stay in the room with them so that K & D can show that they can manage Isabella's fulltime care. The hospital will develop a clear schedule for follow up appointments once Isabella is discharged and will immediately follow up with the family if any appointments are missed. PMH will liaise with Wilcock Medical Centre to schedule regular appointments once the PMH appointments have finished. PMH will arrange for the child health nurse to visit twice a week when Isabella is first discharged and then once a week for up to 3 months. Others in the family need to be trained in administering Isabella's morphine so that there are back up people who can care for Isabella. 	

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

Case Example: Mapping extended family's views

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father).
Whose views are included below: Mary (paternal grandmother), Tom (paternal grandfather), Karen (maternal aunt).
Date: June 7, 2010 (two days after referral).

<p>WHAT ARE WE WORRIED ABOUT?</p> <p>HARM</p> <ul style="list-style-type: none"> Kristy took drugs while she was pregnant and so Isabella has been born with drug addiction and has had a pretty hard start to life. <p>COMPLICATING FACTORS</p> <ul style="list-style-type: none"> Darren working away means that things could be pretty stressful for Kristy if she is on her own. Isabella is hard to feed and settle and we're not sure how long this will continue for. Kristy doesn't get on well with her family and they argue a lot. Tom and Mary are not sure how much Kristy's family will be around to support Kristy. 	<p>PURPOSE OF THE CONSULTATION</p> <p>Hearing the views of paternal family members and helping them to understand the assessment and planning process.</p> <p>GENOGRAM/ECOMAP/ CIRCLES OF SAFETY and SUPPORT</p>  <p>CULTURAL CONSIDERATIONS</p> <p>Darren's family are Noongar and are a strong family with a lot of family members. Kristy's family are of Malaysian descent (Kristy was born in Malaysia and grew up in Australia).</p> <p>CURRENT SDM SAFETY AND FRE LEVELS</p> <p>Initial SDM Safety Assessment identified the family as CONDITIONALLY SAFE. FRE level is HIGH.</p>	<p>WHAT IS GOING WELL?</p> <p>PROTECTION & BELONGING</p> <ul style="list-style-type: none"> When Isabella was in KEMH, Kristy and Darren learnt a lot from the midwives about how to settle Isabella and they are really good at comforting her and settling her when she is upset. They don't get stressed when she cries and stay very calm with her. <p>STRENGTHS</p> <ul style="list-style-type: none"> Tom and Mary want Kristy, Darren and Isabella to move in with them and are happy for them to stay for as long as they need to. The family are absolutely prepared to help look after Isabella and make sure that she is okay once she is discharged. Tom and Mary are happy for CS to visit whenever they want to, to check on how things are going. Tom, Mary, Karen and Tracey want to make sure that no-one is using drugs around Isabella or while they are looking after her. They have all been through a lot in the past with Darren's drug use and they know what the signs of drug use are. Darren used to use amphetamines pretty heavily when he was younger and now he has really got his life sorted out and he isn't using drugs anymore. He has been doing drug tests at work for about 5 months and hasn't ever had a negative test. When Darren is away, someone in the family can bring Kristy & Isabella to the medical appointments. Tom, Mary and Karen think that what happened with Isabella going into drug withdrawal and getting so sick has really shown Darren and Kristy how serious this is and how vulnerable Isabella is. Kristy and Darren are listening to everything the doctors are saying and will do anything they need to do to make sure that Isabella will be okay.
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Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

*Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father),
Whose views are included below: Mary (paternal grandmother), Tom (paternal grandfather), Karen (paternal aunt)*

Date: June 7, 2010 (two days after referral).

<p>SAFETY & WELLBEING SCALE</p> <p style="text-align: center;">Think CS are about a 3 - 4</p> <p style="text-align: center;">0 ← → 10</p> <p style="text-align: center;">6 7</p> <p style="text-align: center;">Mary Tom/Karen</p>	
WHAT NEEDS TO HAPPEN?	
<p>WORRY STATEMENTS</p> <ul style="list-style-type: none"> • Tom, Mary and Karen are worried that if Darren is away with work and Kristy is doing the parenting on her own, that Kristy might feel so stressed that she starts using drugs again and then not be able to manage Isabella's morphine withdrawal properly and that Isabella might have another episode of respiratory distress or other serious medical problems and could get really sick. • Tom, Mary and Karen think that CS are worried that Kristy and Darren will start to use drugs again and then not be able to look after Isabella and she could get really sick or do something like stop breathing and die. 	<p>GOAL STATEMENTS</p> <ul style="list-style-type: none"> • When Darren is away, Kristy and Isabella need to come and live with Tom and Mary until we know that Isabella is well and that Kristy can cope on her own. • Isabella needs to be taken to all of her medical appointments to make sure that she is withdrawing from the drugs in a safe way and she needs to keep being given morphine until the doctor says that she doesn't need it any more. • Kristy and Darren need to stay off drugs and make sure looking after Isabella is their first priority. • If Kristy and Darren decide they want a night off or to do something like get drunk or use drugs, they need to make sure that Isabella is being looked after by someone in the family or someone who is going to take good care of her. • Tom, Mary and Karen think that CS will want Kristy, Darren and Isabella to stay with family so that other people can keep an eye on Isabella and make sure that Kristy and Darren are not using drugs.
<p>ACTION STEPS</p> <ul style="list-style-type: none"> • Tom and Mary want to know when all the medical appointments are so that they can also make sure that Isabella is getting to her appointments. • Everyone needs to sit down together and sort out what's going to happen once Isabella gets out of hospital. 	

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

Drawing each session to a close

As you work with each of the family members or significant people involved with the family (parents, teenagers, extended family members, etc) to 'map' their views, there are a number of important things to do as you draw each session to a close:

1. Reiterate that the purpose of the session has been to gain their views about what is happening in the family and to share the views of the agency, so that everyone can work together to build enough safety for the children in the parents care in the future for CS to be confident enough to close the case and let the family get on with their lives.
2. Make sure that whoever you have been working with receives a copy of what was recorded within the framework. There are a number of ways of doing that: If you are working on an electronic whiteboard or smartboard, you can print a copy for the family; you can type up the notes within the framework and email, post or deliver that to the parents; the parents and yourself can take a photograph of the whiteboard (using a mobile phone) so that they have an immediate copy and then once the notes are typed up, they can be forwarded to them; you can take a photo of what is recorded on the paper to type up later and the sheets of paper can be left with the parents as their record. Whatever method you use, the important principle is that the parents/family members have an immediate record of what was recorded on the day and are sent a typed record once the notes have been typed up.
3. Also leave the family with a blank copy or copies of the framework so that they can add anything after the meeting and also talk with other family members to get their views.
4. Discuss the next steps in the process so that everyone understands what is happening next, including who else you will be talking with and who else will be involved in the assessment and planning process.

Bringing everyone's views together

Once you have elicited the views of all the significant people in the family's life, you will then have a number of different documents. Each of the documents will be a record of the views of that particular person or group, organised and documented within the framework. Depending on the age of the children or young people, you may have their views expressed within the framework, or perhaps within the 'Three Houses' or 'Safety House' that can be added to the appropriate segment of the framework.

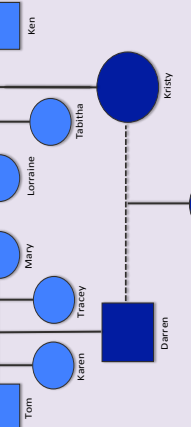
The next step in the process is to bring all of these views together, so that you have one shared assessment and planning document. This shared document contains everyone's views at this point in time and clearly identifies the information that has been used to guide the assessment and planning decisions of the child protection agency. The process of bringing everyone's views together involves combining the different views and positions so that you have one set of statements under each element. This process is not as complex or difficult as it might sound and the case example below illustrates this process.

This combined 'mapping' was developed at a meeting with the identified family members and professionals. While I won't attempt to provide detailed information on how to facilitate family conferences within this booklet, I will explain briefly the process that was used within this meeting to share everyone's views and then to work together to develop mutually-constructed danger statements, goal statements and next steps. A subsequent booklet will explore in detail the process for facilitating family conferences.

Case Example: Combined 'mapping'

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father), Whose views are included below: Kristy (Mum), Darren (Dad), Mary (paternal grandmother), Tom (maternal grandfather), Karen (paternal aunt), Tracey (paternal aunt), Lorraine (maternal grandmother), Tabitha (maternal aunt), Dr. Greenwood (paediatrician), Joanne (Nurse manager), Karen (ward social worker), Sonja (CS)
 Date: June 9, 2010 (4 days after referral).

WHAT ARE WE WORRIED ABOUT?	WHAT IS GOING WELL?
<p>HARM</p> <ul style="list-style-type: none"> Kristy and Darren and PMH social worker told CS that Kristy used illicit subutex most days during her pregnancy up until she was 32 weeks pregnant. Isabella was born early (at 36 weeks) at King Edward Memorial Hospital (KEMH) and she was born drug addicted (with Neonatal Abstinence Syndrome) and was put on a morphine programme to help wean her off her addiction and was in the special care nursery for 11 days. Isabella cries a lot and is hard to settle and has problems feeding and gaining weight. Kristy and Darren and PMH social worker told CS that Kristy and Darren didn't take Isabella to her scheduled follow-up appointment at KEMH on 25.05.10 to review Isabella's health and check if she still needed morphine. Isabella didn't receive further morphine and on 03.06.10, Kristy found Isabella with signs of vomit around her mouth and having difficulty breathing, which Dr Greenwood said are signs of drug withdrawal. Kristy phoned an ambulance and Isabella was taken to Princess Margaret Children's Hospital (PMH), where she remains an inpatient. Kristy and Darren told Sonja that they didn't realise that Isabella needed more morphine after her weaning programme was finished and that they understood from the midwife at KEMH that they only needed to take Isabella to the follow-up appointment if she wasn't feeding or sleeping well, which she was at that point. 	<p>PROTECTION & BELONGING</p> <ul style="list-style-type: none"> Kristy and Darren, PMH staff and KEMH staff told CS that when Kristy was 32 weeks pregnant, she told KEMH staff that she was using illicit drugs. Kristy said she did this because she was scared for Isabella. Kristy stayed in KEMH for two weeks to detox and start on the methadone programme. Kristy told CS that she didn't use any illegal drugs for the rest of her pregnancy. Because the hospital knew about Kristy's drug use, they knew what to do to help Isabella once she was born. Kristy told PMH and CS that when she realised that Isabella was starting to have problems feeding and sleeping again in the week after Isabella's morphine programme was finished, she phoned the midwives at KEMH twice to ask for help (once to ask for advice from a midwife and then a few days later, to ask for contact details for the child health nurse and a paediatrician) and she talked to Darren's mum and sister and then made an appointment with a GP as soon as she could. Mary, Karen, KEMH staff and the GP confirmed that this happened. Kristy said that because the midwives at KEMH didn't seem worried, she didn't realise that Isabella could get so sick so quickly, but she called an ambulance as soon as she saw that Isabella was having difficulty breathing. Kristy and Darren, PMH and KEMH told CS that K & D did/are doing all of the hands-on care of Isabella in hospital and are providing a very good level of care, including feeding her (she is breastfed with supplementary formula feeds), bathing her, settling her to sleep and providing her with morphine as per the weaning programme. The child health nurse told PMH social worker that she visited on 19.05.10 and 20.05.10 and that Kristy and Darren were caring and paying attention to Isabella's health. The child health nurse said that Isabella appeared alert and well-hydrated on both visits. PMH, KEMH and both families said that Kristy and Darren are very good at comforting Isabella and settling her when she is upset, and they don't get stressed when Isabella cries and stay very calm with her. Kristy and Darren told CS they take it in turns holding Isabella and rocking her when she cries so that they don't get too stressed. Kristy and Darren showed PMH and KEMH that they are able to administer Isabella's morphine correctly and Darren showed PMH staff the weaning programme that they followed at home. Darren brought in the leftover morphine, which was the correct amount according to the programme. Kristy asked a PMH nurse to teach her how to score Isabella on the NAS score sheet, so that Kristy could monitor Isabella's response to the morphine and her wellbeing. Jo (nurse manager) said that the sheet is quite subtle to score and Kristy is going a good job of noticing the signs to score, including the pitch of Isabella's cry, muscle tone and sleep tremors.
<p>PURPOSE OF THE CONSULTATION</p> <p>Combined mapping to share everyone's views and to develop collaborative worry statements and goal statements for Isabella</p> <p>GENOGRAM/ECOMAP/ CIRCLES OF SAFETY and SUPPORT</p> 	<p>CULTURAL CONSIDERATIONS</p> <p>Darren's family are Noongar and are a strong family with a lot of family members. Kristy's family are Malaysian Australian (Kristy was born in Malaysia and grew up in Australia).</p>
	<p>CURRENT SDM SAFETY AND FRE LEVELS</p> <p>Initial SDM Safety Assessment identified the family as CONDITIONALLY SAFE. FRE level is HIGH.</p>

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father). Whose views are included below: Kristy (Mum), Darren (Dad), Mary (paternal grandmother), Tom (paternal grandfather), Karen (paternal aunt), Tracey (paternal aunt), Lorraine (maternal grandmother), Tabitha (maternal aunt), Dr Greenwood (paediatrician), Joanne (Nurse manager), Karen (ward social worker), Sonja (CS)

Date: June 9, 2010 (4 days after referral).

COMPLICATING FACTORS	5	6	7	8	10
<ul style="list-style-type: none"> Both Kristy and Darren have a history of illicit drug use and CS and PMH do not know if K & D will use drugs in the future. Because she has been born with NAS, Isabella cries a lot and is difficult to settle and feed. This might continue for a few months. Darren is currently working on the mines (three weeks away, one week home) and has to go back to work in two weeks. CS, Tom, Mary, Glenys, Tracey, Tanya and Karen think that caring for Isabella on her own will be really stressful for Kristy and don't know if this might lead to Kristy starting to use drugs again. Kristy told PMH and CS that she and her family don't get on and that when she tries to get herself clean, they always think that she is going to mess up. Lorraine (Kristy's mum) and Tabitha (Kristy's sister) said they do argue a lot, particularly if they think that Kristy is using drugs. The PMH social worker spoke to the KEMH maternity ward, who said that it may not have been made clear to Kristy and Darren that the review appointment of 25.05.10 was important. KEMH did not follow up with K & D after they missed the appointment. 	Jo/Dr Greenwood	Lorraine/Tabitha/Mary	Tom/Karen/Tracey	Darren	
<p>STRENGTHS</p> <ul style="list-style-type: none"> Kristy and Darren have met with the PMH social worker on two occasions and have talked about their past drug use and about their concerns and the hospital's concerns for Isabella. Kristy and Darren were willing for the PMH social worker to contact other professionals to discuss what has been happening for Isabella. PMH social worker told CS that Kristy and Darren are willing to meet with CS to address any concerns about Isabella. PMH social worker told CS that Kristy is willing to do urinalysis to show she is not using illicit drugs. PMH social worker told CS that Kristy is willing to move in with family members if that is necessary. PMH social worker told CS that Kristy and Darren said that they have a lot of support from Darren's family and that his mother and father, Tom and Mary, live around the corner and his sister, Karen, lives across the road. Darren's other sister, Tracey, lives close by. 					

SAFETY & WELLBEING SCALE



WORRY STATEMENTS

- CS and Maitland Children's Hospital staff are worried that Darren and Kristy might get back into using drugs and then won't be able to manage Isabella's morphine programme and withdrawal safely. Tom, Mary, Karen, Tracey, Glenys and Tanya are worried that if Darren is away for work and Kristy is doing the parenting on her own, that Kristy might feel so stressed that she starts using drugs again and then won't be able to manage Isabella's morphine withdrawal safely. CS, PMH and Kristy and Darren's families are worried that if Isabella's morphine programme isn't managed safely, that in the short term Isabella might develop breathing problems, could have seizures and vomiting, could quickly become dehydrated and could become seriously ill or die.
- CS and Maitland Children's Hospital staff are worried that Darren and Kristy might get back into using drugs and then won't be able to make sure that Isabella gets the nutrition she needs to keep putting on weight and that because of this, in the short term Isabella could become sick and in the long term, she won't grow and develop properly.
- CS and Maitland Children's Hospital staff are worried that Darren and Kristy might get back into using drugs and then won't be able to give Isabella the calm and loving care that she needs, for example, rocking her and holding her to help her settle when she is distressed and unsettled. CS and PMH are worried that if this happens, that Isabella will feel anxious, scared and unloved and that when she is older, this will make it difficult for her to form healthy relationships with other people.

WHAT NEEDS TO HAPPEN?

GOAL STATEMENTS

- Kristy and Darren and a network for Isabella, made up of Tom, Mary, Lorraine, Karen, Tabitha and Tracey (and of some other friends who K & D will talk to), agree to work with CS to make a plan for Isabella that will keep her safe and show everyone that:
 - Isabella is always cared for by an adult who is not under the influence of drugs and who understands what Isabella needs and is able to take good care of her.
 - Isabella is taken to all her medical appointments to make sure that she is withdrawing from the drugs in a safe way and she keeps being given the right amount of morphine until the doctor says that she doesn't need it any more.
 - Isabella is always getting what she needs, like being fed when she is hungry and getting enough food to put on weight, getting all the love she needs, and being held and rocked calmly to help her settle and sleep, so that Isabella is thriving and meeting her developmental milestones.
- Everyone wants to see safety plan in place and working for a period of 6 months so that everyone can be confident that the plan will keep working for Isabella once CS withdraws.

Based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); The Partnering for Safety Assessment and Planning Framework (Parker and Decter, 2012) and The Massachusetts Safety Map (Chin, Decter, Madsen, and Vogel, 2010).

COLLABORATIVE ASSESSMENT AND PLANNING FRAMEWORK

*Family details: Isabella Brown (4 weeks), Kristy Peters (mother), Darren Brown (father),
Whose views are included below: Kristy (Mum), Darren (Dad), Mary (paternal grandmother), Tom (paternal grandfather), Karen (paternal aunt), Tracey (paternal aunt), Lorraine (maternal grandmother), Tabitha (maternal aunt), Dr Greenwood (paediatrician), Joanne (Nurse manager), Karen (ward social worker), Sonja (CS)*
Date: June 9, 2010 (4 days after referral).

ACTION STEPS

- Kristy and Darren will start rooming in with Isabella today in the hospital and they will look after her fulltime for the next four days to show everyone that they know what to do to care for her. The hospital will review her health three times per day and if she continues to be well, will agree to her being discharged on the fifth day.
- For Isabella to be discharged from hospital into the care of Kristy and Darren, they will need to move in with Tom and Mary and stay there until CS and Kristy and Darren and the network agree that Isabella will be safe with them in their own home.
- Kristy and Darren and their families and some other people for Isabella's safety network will meet with Sonja again in two days to work out the details of the safety plan for Isabella. This will be the plan about what everyone will do to make sure that Isabella is safe and getting everything that she needs. CS won't agree to Isabella going home with the family until there is a safety plan that everyone is happy with and that includes details of how CS will know that the safety plan is working.
- Sonja will give everyone examples of some plans developed with other families so that everyone has some idea of the type of detail that is needed in the plan for Isabella.
- Tom, Mary, Glenys, Tracey, Karen and Tanya will meet with the hospital staff over the next few days and learn how to administer morphine for Isabella and how to understand her weaning programme and the signs of withdrawal.
- PMH will develop an appointment schedule for once a week appointments for Isabella for the first month after she is discharged and will immediately follow up with the family and contact CS if any appointments are missed.
- Jo will liaise with Wilcock Medical Centre to schedule regular appointments once the PMH appointments have finished.
- PMH will arrange for the child health nurse to visit 2x/week for the first two weeks after Isabella is discharged and then once a week for up to 3 months, depending on how long this is needed for.
- Kristy and Darren will talk to their neighbours, Peter and Kerry, and to Kristy's friends, Tina and Maria, about being part of Isabella's network and invite them to the meeting on 11.06.10.

Process of bringing everyone's views into one 'mapping'

As mentioned above, a conferencing process was used in this case to bring everyone's views together within one framework. A family conference can be the most time-efficient process for bringing everyone's views together, but if this is not possible or appropriate, you can sit down with the parents and go through everyone's views and then work with the parents to combine everyone's views into one document, or at a minimum, combine the views yourself into one document and then go through this document with the parents and the network.

With Isabella's family, everyone met together in a large meeting room and the first thing I did was to draw the framework up on a large whiteboard and briefly outlined the framework again. I then explained that the purpose of the meeting was to talk through and hear each other's views within each of the elements so that we could then work together to come up with:

- One set of worry statements that identified what people were worried might happen to Isabella in the future and who was worried about this.
- One set of goal statements that identified what everyone would need to see Kristy and Darren doing in their care of Isabella to be confident that she would be safe in the future.
- The next steps everyone would need to take in working toward these goal statements .

I explained that this process didn't mean that everyone had to agree about what happened in the past and that it was like that people wouldn't necessarily agree with everything we heard, but that if we were able to at least hear and understand each other's position, that would make it possible to then work together to plan for Isabella's future safety.

In starting to work through the framework to share everyone's views, I asked Kristy and Darren where they wanted to start and they said that they wanted to start with the 'protection and belonging' element. Knowing that the medical team had acknowledged some important actions of protection and belonging, I asked the medical team to start and first recorded their views on the whiteboard. I then went around the room, asking everyone to identify the actions of protection and belonging that they had seen Kristy and Darren demonstrate. Where different people held the same view, this was documented by adding their name to a previously recorded statement. When different language was used to describe the same thing, we used the family's language. In the same way, we then worked through the strengths, the harm and the complicating factors. At this point, we took a break and then came back to work through the safety and wellbeing scale, then the worry statements, the goal statements and the next steps.

The process of developing mutually-constructed worry statements and goal statements is a critical step in using the assessment and planning framework effectively. For families to have the best opportunity to make significant changes in their lives, they need to be at the centre of the process of identifying the future worries to the children (worry statements) and the changes in their behaviour that need to be demonstrated (the goal statements). The questioning process that I used with the group to develop mutually-constructed worry statements and goal statements is outlined in a previous section. You might like to revisit that now.

General principles in bringing everyone's views together

Some general principles for bringing everyone's views into one document include:

- As much as possible, do this step in collaboration with the family and other significant people in the family's life (whoever is involved in the process at this point). This process of identifying the common ground and the different views and of organising the information within the framework

to reflect everyone's views is of itself a critical step in the assessment and planning process. I will often do this within a family meeting, with everyone having a copy of their own views recorded within the framework (or another assessment tool such as the family roadmap or three houses) and we then work together to combine it within one framework.

- If there isn't time to meet with all the different people individually, everyone's views can be elicited in a family meeting or conference, but at a minimum, I will meet with the parents beforehand in as many sessions as it takes to elicit their views and to share the agency's views with them. If you are eliciting and sharing the views of the other significant people for the first time in a family meeting or conference, you will need to plan a long enough meeting to work through the entire process (with a break) or you might do it over two sessions or more sessions.
- People's names or roles are used to identify who holds a particular view or who provided particular information. For example: *The child health nurse told PMH social worker that she visited on 19.05.10 and 20.05.10 and that Kristy and Darren were caring and paying attention to Isabella's health. The child health nurse said that Isabella was alert and well-hydrated.*
- If there are common statements or views held by different people, just state the view once and include all the names of the relevant people. For example: *Kristy and Darren, PMH staff and KEMH staff told CS that when Kristy was 32 weeks pregnant, she told KEMH staff that she was using illicit drugs. Kristy said she did this because she was scared for Isabella.*
- Remember that there does not need to be agreement between everyone; the information can be recorded to show who holds a particular view and conflicting views can be identified. For example: *Kristy and Darren and PMH social worker told CS that Kristy and Darren didn't take Isabella to her scheduled follow-up appointment at KEMH on 25.05.10 to review Isabella's health and check if she still needed morphine. Isabella didn't receive further morphine and on 03.06.10, Kristy found Isabella with signs of vomit around her mouth and having difficulty breathing, which Dr Greenwood said are signs of drug withdrawal.... Kristy and Darren told Sonja that they didn't realise that Isabella needed more morphine after her weaning programme was finished and that they thought the midwife at KEMH told them that they only needed to take Isabella to the follow-up appointment if she wasn't feeding or sleeping well, which she was at that point.*
- The most important elements within the framework in terms of working toward future safety for the children are the worry statements and the goal statements. As described earlier, these elements need to be mutually-constructed wherever possible or at a minimum, everyone needs to understand the thinking that underlies the worry statements and goal statements that have been developed by the child protection agency. If you are attempting to bring everyone's views together and you realise that there continues to be confusion or major contention about the worry statements and goal statements, you will need to take a step back and again use a questioning approach (as described in detail in the previous section) to explore everyone's views about the future worries and the goal statements and to help them to understand the views of the child protection agency. Without a shared understanding of the worry statements and goal statements, you will not be able to work forward together to focus on building future safety and detailed planning.
- Use this process of bringing everyone's views into one form to reiterate that the assessment and planning process is an ongoing and dynamic process and to help everyone understand which parts of the framework are likely to stay the same throughout the assessment and planning process and which parts of the framework are likely to change. This is explored in more detail in the next section.

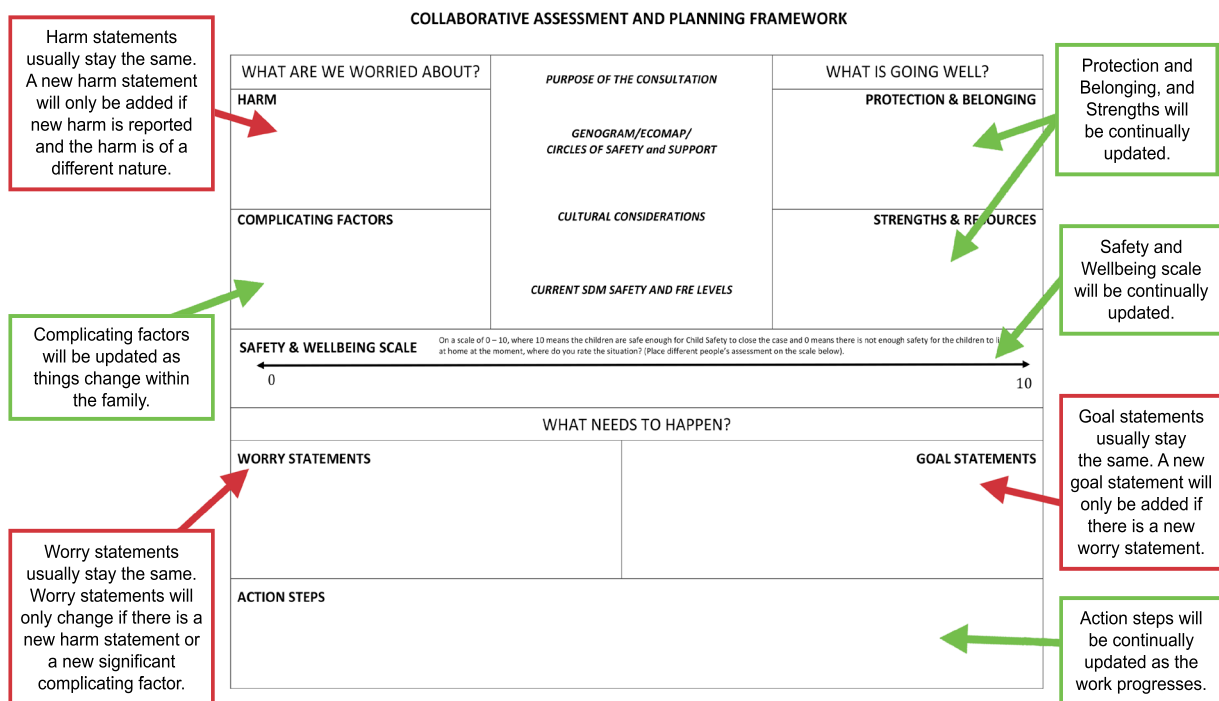
Ongoing Assessment and Planning: Using the framework as a working document

The collaborative assessment and planning framework is a working document and using this framework is not a one-off event. What this means in practice is that the framework is updated regularly as we continue to gather information about what is happening in the family in relation to the safety and wellbeing of the children and as we work together with the family and network in building future safety, belonging and wellbeing for the children.

Wherever possible, updating the information within the framework is done through discussion with the family and the other significant people in their lives, so that everyone is involved in reflecting on the changes that the family are making and in thinking through how this information impacts our assessment of the children's safety, belonging and wellbeing.

People who are new to this type of collaborative and strengths-based practice approach will often feel overwhelmed at this point and think that this will be an enormous amount of additional work, and it certainly does take a substantial amount of time to gather the views of all the significant people in the child's life and to involve them in the assessment and planning process. But once you start putting this process into action with families, you will quickly come to realise that it actually saves time in the long run as all of our work with the family becomes focused on defining, demonstrating and monitoring future safety and wellbeing for the children.

When you are using the CAP framework as an ongoing assessment and planning document with families, some elements will frequently be updated and some will remain the same.



The safety and wellbeing scale will be continually updated and the extent to which the family are making progress toward the goal statements will be reflected in everyone's scaling position. The scaling question is continually asked of everyone involved in working with the family (including the children and the parents) to explore the changes and progress toward the goal statements.

Within the 'What's Working Well' column, the protection and belonging element will hopefully be continually added to as the parents demonstrate new actions of protection and belonging. There may also be new strengths that become apparent and these will be included in the framework. If people have moved higher in their scaling position, you can ask what they have seen (actions of protection and belonging, or strengths) that has them scaling higher on the safety and wellbeing scale.

Within the 'What are We Worried About' column, the harm statements will remain the same, unless there has been new and different harm to the children. If there has been a new report of harm that is of a similar nature to the previous harm (eg. another incident of family violence in front of the children), then this will be recorded as part of an existing harm statement and with a new date and details of the incident added. Only if there is new harm that is of a different nature to the previous harm (eg. physical harm to the children when this has not happened before) will there be a new harm statement added.

The complicating factors will possibly be added to if a new and significant complicating factor emerges during the process of working with the family. And it is possible for complicating factors to be modified or removed from the form if the issue has been resolved. If this is the case, there will need to be information recorded under the strengths or protection and belonging elements that documents what has happened that led to the change in the complicating factors.

The worry statements, which identify what we are worried the parents might do in the future that could have harmful impact on the children, will usually remain the same. These are the identified future worries and they will only be added to if new and different harm has occurred or if there is a new significant complicating factor that leads us to worry that something new and different might happen to the children in the future. Unless there has been significant changes to the past harm or complicating factors, the worry statements will remain the same.

The goal statements will only change if there has been an additional worry statement added. Unless this happens, the goal statements will remain the same.

The next steps is the other part of the framework that will continually change. The next steps are the case planning steps and so as the work with the family progresses, the next steps are continually reviewed and updated. As an identified action step has been achieved, this will usually be recorded as a strength or action of protection and belonging, or a complicating factor may be modified, and the new next steps that need to happen in working toward the goal statements will be identified and recorded with the framework.

Once everyone has worked together to come up with one set of worry statements and one set of goal statements, we have identified the purpose and direction for our work with the family. The worry statements make explicit our purpose for being involved with the family (we are worried that these things might happen to the children) and the goal statements describe where we want the family to get to - the change we need to see - to be confident that the children will be safe and well in the future. We can now work with the family and their network to develop the detailed action plan, which provides the details of how this change will be achieved and sustained over time.

Conclusion

When I am training practitioners in solution-focused and strengths-based practice with families, I am often asked for more detailed information about the 'how to' of bringing the framework to families and of using the framework over time as a collaborative assessment and planning document. It is my hope that this booklet will help workers to develop their confidence and expertise in using the the framework to undertake collaborative and meaningful assessment and planning with families.

Wherever I work in the world, I am privileged to witness or hear about and learn from child protection practice that is full of creativity, passion, compassion and sometimes, what can only be described as sheer, utter brilliance! I think that child protection work is some of the most difficult, overwhelming and heart-wrenching work in the world and it is also some of the most deeply satisfying and transforming work - and I wouldn't want to be doing anything else! So I wish you all the very best on your journey with this work and hope that this booklet might make a small, positive contribution to the difference that you make in the lives of families and children.

Additional Resources

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