Intensive Family Support
Service Model and Guidelines

2018 (Version 2.1)
## Version History

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</tr>
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<td>Updates in the line with Child Protection Reform Amendment Act 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Removal of evaluation data collection assessment</td>
</tr>
</tbody>
</table>
## Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VERSION HISTORY</strong></td>
<td>2</td>
</tr>
<tr>
<td><strong>1. INTRODUCTION</strong></td>
<td>5</td>
</tr>
<tr>
<td>1.1 Purpose</td>
<td>5</td>
</tr>
<tr>
<td>1.2 Audience</td>
<td>5</td>
</tr>
<tr>
<td>1.3 Background</td>
<td>5</td>
</tr>
<tr>
<td>1.4 Snapshot of how IFS works</td>
<td>5</td>
</tr>
<tr>
<td><strong>2. THE MODEL</strong></td>
<td>7</td>
</tr>
<tr>
<td>2.1 Active Engagement</td>
<td>7</td>
</tr>
<tr>
<td>2.2 Assessment of Safety, Risk and Child and Family Wellbeing at Case Commencement</td>
<td>7</td>
</tr>
<tr>
<td>2.3 Consulting the Principal Child Protection Practitioner</td>
<td>8</td>
</tr>
<tr>
<td>2.4 Collaborative Case Management - single case plan</td>
<td>9</td>
</tr>
<tr>
<td>2.5 Practical In-Home Support</td>
<td>11</td>
</tr>
<tr>
<td>2.6 Parenting Skills</td>
<td>11</td>
</tr>
<tr>
<td>2.7 Specialist Interventions</td>
<td>11</td>
</tr>
<tr>
<td>2.8 Brokerage Funds</td>
<td>12</td>
</tr>
<tr>
<td>2.9 Length of Engagement</td>
<td>12</td>
</tr>
<tr>
<td>2.10 Case Closure</td>
<td>13</td>
</tr>
<tr>
<td><strong>3. CONTEXT FOR DELIVERING IFS SERVICES</strong></td>
<td>14</td>
</tr>
<tr>
<td>3.1 Hours of Operation</td>
<td>14</td>
</tr>
<tr>
<td>3.2 Staffing</td>
<td>14</td>
</tr>
<tr>
<td>3.3 Role of the Specialist Domestic and Family Violence (DFV) Professional</td>
<td>15</td>
</tr>
<tr>
<td>3.4 Diversity and Culturally Respectful Practices</td>
<td>16</td>
</tr>
<tr>
<td>3.5 Referrals</td>
<td>17</td>
</tr>
<tr>
<td>3.6 Child Protection Notifications and Interventions</td>
<td>22</td>
</tr>
<tr>
<td>3.7 Consent Based Engagement</td>
<td>23</td>
</tr>
<tr>
<td>3.8 Information sharing without client consent</td>
<td>23</td>
</tr>
<tr>
<td>3.9 Framework and Tools</td>
<td>24</td>
</tr>
<tr>
<td>3.10 Outcomes</td>
<td>25</td>
</tr>
<tr>
<td>3.11 Local Level Alliances</td>
<td>25</td>
</tr>
<tr>
<td>3.12 Evaluation</td>
<td>26</td>
</tr>
<tr>
<td>3.13 Legislation</td>
<td>27</td>
</tr>
<tr>
<td>3.14 Duty of Care</td>
<td>28</td>
</tr>
<tr>
<td>3.15 Risk Management</td>
<td>28</td>
</tr>
<tr>
<td><strong>4. DATA COLLECTION AND REPORTING</strong></td>
<td>29</td>
</tr>
<tr>
<td>4.1 Output Funding and Reporting</td>
<td>29</td>
</tr>
<tr>
<td>4.2 Outcome Reporting</td>
<td>30</td>
</tr>
<tr>
<td><strong>APPENDICES</strong></td>
<td>32</td>
</tr>
<tr>
<td>Appendix 1 – Practice Principles</td>
<td>32</td>
</tr>
<tr>
<td>Appendix 2 – Culturally Respectful Practices</td>
<td>34</td>
</tr>
<tr>
<td>Appendix 3 – Common Assessment Tools</td>
<td>36</td>
</tr>
<tr>
<td>Appendix 4 – Principal Child Protection Practitioner (PCPP)</td>
<td>43</td>
</tr>
<tr>
<td>Appendix 5 – Collaborative case planning</td>
<td>48</td>
</tr>
<tr>
<td>Appendix 6 – Brokerage Funding Guidelines</td>
<td>52</td>
</tr>
<tr>
<td>Appendix 7 – Working with Families subject to an Intervention with Parental Agreement</td>
<td>56</td>
</tr>
<tr>
<td>Appendix 8 – Information sharing by Intensive Family Support Services</td>
<td>59</td>
</tr>
</tbody>
</table>
## List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARC</td>
<td>Advice, Referral and Case management</td>
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<tr>
<td>CALD</td>
<td>Cultural and Linguistically Diverse</td>
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<td>CAP</td>
<td>Collaborative Assessment and Planning framework</td>
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<td>CCR</td>
<td>Child Concern Report</td>
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<td>CRC</td>
<td>Children’s Research Center</td>
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<td>CSSC</td>
<td>Child Safety Service Centre</td>
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<tr>
<td>DFV</td>
<td>Domestic and Family Violence</td>
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<tr>
<td>ECEC</td>
<td>Early Childhood Education and Care</td>
</tr>
<tr>
<td>FaCC</td>
<td>Family and Child Connect</td>
</tr>
<tr>
<td>FAST</td>
<td>Family Assessment and Summary Tool</td>
</tr>
<tr>
<td>FGM</td>
<td>Family Group Meeting</td>
</tr>
<tr>
<td>FRE</td>
<td>Family Risk Evaluation</td>
</tr>
<tr>
<td>FRRE</td>
<td>Family Risk Re-evaluation</td>
</tr>
<tr>
<td>FWB</td>
<td>Family Wellbeing</td>
</tr>
<tr>
<td>I&amp;A</td>
<td>Investigation and Assessment</td>
</tr>
<tr>
<td>IFS</td>
<td>Intensive Family Support</td>
</tr>
<tr>
<td>IPA</td>
<td>Intervention with Parental Agreement</td>
</tr>
<tr>
<td>OASIS</td>
<td>Online Acquittal Support Information System</td>
</tr>
<tr>
<td>PCPP</td>
<td>Principal Child Protection Practitioner</td>
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<td>RIS</td>
<td>Regional Intake Service</td>
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<td>SDM</td>
<td>Structured Decision Making</td>
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<td>Tertiary Family Support</td>
</tr>
<tr>
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<td>The department</td>
<td>Department of Child Safety, Youth and Women</td>
</tr>
</tbody>
</table>
1. Introduction

1.1 Purpose

This document outlines the model of service delivery expected from funded service providers delivering Intensive Family Support (IFS) services and complements but does not replace the Service Agreement or the requirements set out in the Families Investment Specifications. It also provides information on the service delivery context, reporting requirements and the expected service outcomes.

1.2 Audience

This document is designed to inform the work of funded IFS service providers and for relevant government staff, particularly in the Department of Child Safety, Youth and Women (the department). This document, Version 2.1, replaces all previous versions.

Further information is also available on the department’s website:


1.3 Background

The IFS program is a critical component of the Queensland Government’s Child and Family Reforms undertaken in response to the recommendations of the 2012 Child Protection Commission of Inquiry. Along with Family and Child Connect (FaCC), IFS services provide a crucial frontline for families who need support to safely care for and nurture their children and reduce the need for Child Safety to intervene.

The IFS service model described in this document is based on relevant research and the experience and evaluations of previous and existing models of service delivery to families with multiple and/or complex needs. The current iteration commenced in 2015 and there are now over 40 services operating across the state, including new and existing services transitioning to the new IFS model. The commitment of the organisations delivering IFS to co-design and implementation in collaboration with the department and to evaluation processes has significantly contributed to the current model.

1.4 Snapshot of how IFS works

IFS services take a family-focussed, child-centred approach to working with families experiencing multiple and/or complex needs who have children unborn to 18 years of age. The service delivers parenting support through tailored interventions to build the skills and capacity of parents and carers to safely nurture and protect their children. The service also delivers parent support, which are interventions to address the issues that impact negatively on the ability of parents to attend to the needs of their children.

There are many pathways for referral to an IFS including FaCC, Child Safety, police, schools, early childhood education and care services, health professionals, other government and non-government agencies and families themselves (self-referrals).
The aim of IFS services is to provide intensive and extended, but time limited, support to improve safety for children and family functioning by building the skills and capacity of parents to a level that can be sustained by less intensive and more universally available services.

IFS services take a single case plan approach to working with families experiencing multiple and/or complex needs and actively collaborate with other agencies to ensure families get the services and support they need to achieve their case plan goals. Services engage with all family members who are willing to receive support.

The work of IFS services follows the process below:

- Active engagement through assertive outreach to referred families encouraging their engagement with the service.
- A lead case manager is assigned to assess the needs of family members and develop a single case plan with agreed goals.
- Families are assessed using common assessment tools, to determine safety for children and family wellbeing and to develop case goals.
- The lead case manager works collaboratively with the family and other agencies working with the family to coordinate the development and delivery of a single family case plan.
- The case manager and other IFS team members, as appropriate, deliver general and specialist interventions; practical in-home support; and link families to appropriate external specialists and other responses.
- Brokerage is available for specialist services and resources to support individual case plans.
- The IFS case manager continues to work with the family over an extended period until the case plan goals are met resulting in measurable improvement in the wellbeing of the children and their family and an increase in safety to reduce the risk of abuse and/or neglect for the child/ren.
- Final child and family safety and wellbeing reviews are completed at case closure to assess achievement of case plan goals and improvements in family functioning, safety and wellbeing.
2. The Model

A set of practice principles are central to best practice intensive family support service provision to vulnerable families, children and young people. The practice principles are outlined in Appendix 1.

Culturally respectful practice is critical to working effectively with Aboriginal and Torres Strait Islander families. Information on culturally respectful practices is provided in Appendix 2.

The following elements are requirements of IFS service provision:

2.1 Active Engagement

Assertive outreach to engage hard-to-reach families in their home or other community based locations is an essential component of the model. This includes unannounced visits or cold calling to make contact with families who may have been referred without consent, or perhaps reluctantly agreed to a referral, and actively encouraging them to engage with available support. Some families will not be aware that a professional from a prescribed entity1 such as a school principal, has concerns about the wellbeing of their children or that Child Safety has referred their family to the IFS. There are a range of reasons that families may be reluctant to engage with support services and the IFS needs effective strategies to connect and build trust to maximise engagement that is safe for all family members.

Child Safety through the Regional Intake Service (RIS) or Child Safety Service Centre (CSSC) will refer a proportion of families to the IFS. Where families have been referred by Child Safety and do not engage with the IFS service, the IFS will advise Child Safety that the family did not engage. This information will form part of the child protection history for the family and ensure that any further action from Child Safety will consider the family’s lack of engagement in secondary support services.

If a family has initially engaged with an IFS and then disengaged and the IFS had concerns for the safety of a child, it is appropriate to discuss these concerns with the Principal Child Protection Practitioner (PCPP) to help determine whether the concerns meet the threshold for a notification to Child Safety.

2.2 Assessment of Safety, Risk and Child and Family Wellbeing at Case Commencement

IFS use the Structured Decision Making (SDM) tools developed by the Children’s Research Centre (CRC) in the United States. The department provided initial training for organisations

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1 prescribed entity means each of the following entities— (a) the chief executive of a department that is mainly responsible for any of the following matters— (i) adult corrective services; (ii) community services; (iii) disability services; (iv) education; (v) housing services; (vi) public health; (b) the police commissioner; (c) the chief executive officer of Mater Misericordiae Ltd (ACN 096 708 922); (d) a health service chief executive within the meaning of the Hospital and Health Boards Act 2011; (e) the principal of an accredited school under the Education (Accreditation of Non-State Schools) Act 2001; (f) a specialist service provider; (g) the chief executive of another entity that— (i) provides a service to children or families; and (ii) is prescribed by regulation.

specialist service provider means a non-government entity, other than a licensee or an independent Aboriginal or Torres Strait Islander entity for an Aboriginal or Torres Strait Islander child, funded by the State or the Commonwealth to provide a service to— (a) a relevant child; or (b) the family of a relevant child.
prior to implementing these tools and a train-the-trainer model is now in place within each organisation for new staff and refresher training.

The suite of tools are comprised of the Safety Assessment, the Family Risk Evaluation (FRE), the Family Risk Re-Evaluation (FRRE) and the Family Assessment and Summary Tool (FAST).

The tools are a guide to practitioners and should not be relied upon in isolation. They are intended to be combined with the Collaborative Assessment and Planning (CAP) framework (and the associated practice tools) and the professional expertise of the case manager and their supervisor.

A case manager brings to their work with families their professional knowledge and framework, their practice wisdom, and the benefits of professional supervision and teamwork. Drawing on the expertise of other professionals/disciplines working with the family and combining knowledge and skills provides the best and most holistic service for a family.

Until the FAST is incorporated into the Advice, Referral and Case management IT system (ARC), IFS services will continue to complete an assessment of child and family wellbeing, using the Child and Family Wellbeing Domains at the case commencement and again at case closure.

Please refer to Appendix 3 for further background and guide to applying all tools.

The Single Case Plan should provide a comprehensive, clear and simple to understand final overview of the family’s strengths, worries and case plan goals after contribution has been sought from the family themselves, other professionals and the case manager.

All of these tools combine to guide the therapeutic work with the family.

2.3 Consulting the Principal Child Protection Practitioner

IFS services are able to access the Principal Child Protection Practitioner (PCPP) who is co-located in the FaCC service, to obtain expert generic child protection advice and guidance in accordance with Child Safety policies and procedures, statutory responsibilities, departmental objectives and current trends (See Appendix 4 – Principal Child Protection Practitioner).

The PCPP’s role includes providing a case consultation service to IFS services on complex cases, and ensuring cases that may require statutory intervention are reported to Child Safety when necessary. This includes cases transitioning to a Child Safety Intervention with Parental Agreement (IPA) that may remain with an IFS service.

The PCPP can be consulted about non-Child Safety referrals when during active engagement, it becomes apparent that the presenting issues for the family are concerning and a history check may confirm the family requires a greater level of intervention provided either by the IFS or by Child Safety.
2.4 Collaborative Case Management - single case plan

Collaborative case management is used when a family requires support from more than one agency to respond to multiple, complex and/or interrelated needs. The primary purpose of collaborative case management is for families involved with multiple services to have a lead case manager and a single case plan that focuses on improving wellbeing and safety outcomes for the family. This approach prevents overlap or duplication of service delivery and enables the provision of a realistic and holistic intervention tailored to the needs of the family.

Collaborative case management involves a participative process whereby relevant agencies and practitioners alongside the family, plan and work together to determine the most effective way of delivering services to the whole family in the right order and at the right time.

A collaborative case management approach recognises that navigating community support services is not easy for families, who often need more than one service to meet their needs. Collaborative case management puts the onus on service agencies to work together to support families. Consent from the family for the service to contact other agencies with whom the family is involved is critical to the success of the approach.

Effective collaborative case management requires:

- an agreed commitment by all stakeholders to working together in partnership
- shared goals of increasing safety and reducing the risk of harm to children and strengthening family functioning
- clear roles
- respectful relationships
- a high degree of trust between agencies
- accountability to partner agencies
- strong governance processes to drive implementation at the local level
- joint planning to develop processes so that families are supported seamlessly; and
- collective ownership of responsibility for delivering results

Cultural considerations should be at the forefront of any case planning and case work and may determine how the case plan is developed, who should participate and who is assigned to be the case manager for the family and whether the IFS is best placed to work with the family.

Information sharing for case planning and management

Whilst critical to the success of collaborative case work, sometimes families may be reluctant to share information or provide consent to contact other professionals or services with whom they are or have been involved. This may particularly apply in situations where relationships with other stakeholders are perceived as fractured or vulnerable.

Likewise, some professionals and service providers may be reluctant to share information that relates to the wellbeing of the family or their children. This can occur because consent has not
been obtained or providers are not confident to share information with service providers who they don’t know well.

Developing trusting respectful working relationships with other service providers is as important as relationship building with families.

**Family participation is empowering and crucial to the success of both case work and collaborative case management. It is important that the family, including children are involved in case meetings and discussions and lead the development of the case plan.**

**Family participation, including the participation of children should be encouraged at all family case planning meetings and requires careful pre-planning to ensure family members know what to expect, can participate fully in meetings and have realistic expectations about possible outcomes.**

**Developing a single case plan**

Developing a single case plan is a participative process that will result in strategies to address the family’s needs.

The single case plan should be family focused and set out:

- the details of which services the family has provided consent to share information with and for what purpose, including any specific restrictions
- the strengths and worries for the family drawn from the FAST or the Wellbeing Domains assessment. Consideration must be given to the family’s already existing informal support networks
- the goals for the family, including those of individual family members, and particularly goals linked to increasing child safety and wellbeing. These should also be drawn from the FAST or the Wellbeing Domains assessment
- negotiated timeframes for achieving goals
- the support services being provided by each agency
- achievements
- issues which arise during implementation of the case plan
- an exit plan developed by services, which includes transitions to step down services or other services and assistance to the family to engage with those services so change is sustained
- progressive assessments and case reviews involving all stakeholders.

**The range of services involved in collaborative case planning may include specialist services that provide drug and alcohol counselling, mental health services, physiotherapy and speech therapies, trauma counselling, domestic and family violence prevention and support, paediatric services and early childhood education and care services in the government, non-government and private sectors.**

Further information on collaborative case management, single case plans and the process for transferring an active case between IFS serves can be found in Appendix 5.
2.5 Practical In-Home Support

Practical in-home support is a critical element of intensive family support. In-home support provides tailored interventions applied practically in the home environment where the skills and strategies are needed most. Practical in-home support interventions will respond to issues identified during the assessment period and the development of the family case plan.

Examples include:

- establishing safe and practical routines
- providing basic advice on child development and attachment (appropriate to the skills of the in-home support worker and referring to a specialist counsellor, psychologist, or child health service where required).
- budgeting
- modelling basic skills in managing a household
- parenting programs
- meal preparation and cooking (including shopping); and

It is expected that practical in-home support will be available to families outside core business hours as necessary to develop and/or implement elements of family case plans (for example, early morning routine to prepare for school and evening meal preparation times).

2.6 Parenting Skills

Assisting families with parenting skills and developing positive parent-child relationships is a critical component to improving the safety and wellbeing of children and their families and core to the work of IFS services. Interventions and programs that help parents develop knowledge about child development and the factors that influence children’s development, skills for interacting effectively with children, and tools that support cooperative relationships will be provided both in the home and through external programs as needed. IFS staff actively support parents to apply knowledge and skills gained from parenting programs to their home environment. To strengthen their skills, practitioners should undertake appropriate training in evidence based parenting programs.

2.7 Specialist Interventions

Specialist interventions, linked to assessments, can be delivered by staff with relevant expertise within the IFS service, by partnering with specialist services or by linking families with external specialist services.

Depending on the identified needs of individual family members specialist intervention may include:

- infant and early childhood health services
- domestic and family violence support services
- early childhood education and school support
- mental health services
- youth services
• occupational therapy, physiotherapy and speech pathology
• drug and alcohol counselling
• specialist counselling and psychology services (e.g. trauma counselling)
• paediatric services

The IFS service must establish strong links to local specialists in relevant fields of expertise as required by the families they work with and draw on the skills and expertise of workers in their Local Level Alliance. Access to specialists will be driven by the case plan and brokerage may be used for specialist services if required.

2.8 Brokerage Funds

Brokerage is available to support families with their needs as outlined in the family case plan and to contribute to achieving case closure. Brokerage can be used to increase protective factors and reduce risk factors for children, enhance a family’s functioning and help maintain family relationships in keeping with case plan goals.

Case workers report that brokerage often assists in building rapport with families, particularly in the early stages of working with a family.

As well as facilitating access to specialist services, brokerage may be used where existing funded, fee-free services are unavailable, fully subscribed or have long waiting lists.

Examples include:

• ensuring the safety of the home living environment
• early identification of infant and early childhood health and development issues for children up to three years of age and to provide timely interventions to support healthy development.
• parenting programs
• skills development
• adult education programs
• short term access to early childhood education and care services; and
• resources that contribute to family functioning and child wellbeing

Brokerage funds are strictly to be used in respect of families experiencing serious concerns about the safety and wellbeing of the children; this pool of funds is not to be used as a substitute for emergency relief for families in need who do not have serious or complex concerns.

For further information see Appendix 6 - Brokerage Guidelines.

2.9 Length of Engagement

The department’s evaluation of IFS found that families with multiple risk factors for child abuse or neglect need to engage with support services for longer than six months, and ideally eight to nine months, to have most or all of their risk factors addressed and make sustainable
changes to family functioning. While some families may need a longer intervention, it is anticipated that families will generally engage with the IFS service for up to nine months.

**2.10 Case Closure**

When the family has met the case plan goals and addressed the identified needs, an exit plan will be developed and implemented with the family, identifying how the family will transition from intensive family support at the end of the intervention. This includes referrals to targeted, less intensive support services and universal services to ensure the family has continued support and change can be sustained.

The case manager reviews the strengths and worries identified in the CAP framework and the FAST to establish if case plan goals have been met. A FRRE is completed prior to case closure. A family should be assessed as low to moderate risk. (If the outcome of the FRRE is high risk, the IFS should continue to work with the family, if there is a safety plan in place, or refer to Child Safety). Until the FAST tool is incorporated into the ARC system, IFS services must complete another Child and Family Wellbeing assessment prior to case closure to determine the change that has happened during the family's engagement with the service.
3. Context for Delivering IFS Services

3.1 Hours of Operation

IFS services are required to operate for 52 weeks each year to receive referrals.

While the IFS service is not considered a crisis service, it will display flexibility and responsiveness in respect to working hours in order to maximise engagement and enable interventions with family members who may be working standard hours.

The case management function, including practical in-home support is also required to be available to families outside core business hours, including mornings, evenings and weekends as necessary to develop and/or implement elements of case plans.

3.2 Staffing

IFS services often work with families experiencing multiple and complex needs during times of heightened vulnerability when they are at risk of entering the statutory child protection system. Many families have had repeated contact with Child Safety Services and/or multiple secondary services due to entrenched intergenerational challenges that impact on their capacity to safely care for and nurture their children. The IFS program is designed to be delivered by highly skilled staff with qualifications commensurate with the knowledge and skills required to work effectively with this target group.

IFS case managers should hold university qualifications in human services or a relevant related field and have demonstrated skills in engaging hard-to-reach families.

IFS services are designed to operate as professional multidisciplinary teams which include specialist family support case workers, a full-time equivalent specialist domestic and family violence worker/s and workers with other relevant qualifications, skills and experience such as youth workers and early childhood health or education professionals. The department recognises that individual funding allocations will impact on the size and diversity of each IFS team.

On average, lead case manages will have a caseload of 18 to 23 families per year. It is anticipated that families with medium to high complex needs will access between 40 and 100 hours of support overall.

The department understands that in some circumstances such as in remote parts of Queensland, recruitment of staff with appropriate skills and experience can be difficult and a mix of qualifications, cultural connections and knowledge of the local area, skills and life experience may be reflected in the team. Organisations are expected to support all staff, including specialists, to successfully meet the requirements of their role through internal and external training, professional supervision and encouragement to attain appropriate professional qualifications.

Where a particular level or type of qualification is required by the department and the preferred candidate does not have that qualification the following process applies:
1. The organisation must provide the regional contract manager with a rationale for deeming the candidate the best person for the position, including experience, knowledge, skills and any current qualifications or course enrolment.

2. The region will provide endorsement, in consultation with the commissioning area, that both the department and organisation can record as evidence of agreement (an email exchange is sufficient).

3. The organisation should encourage the staff member, once appointed, to pursue further qualifications. However this should not be a condition of appointment or ongoing employment.

4. Should that employee leave the position, the organisation should seek to recruit someone with the required qualification.

Where an existing service has transitioned to a new service type with qualification requirements for staff, the department has consistently advised that it does not intend for existing staff to lose their position due to the requirement of the new program.

3.3 Role of the Specialist Domestic and Family Violence (DFV) Professional

An experienced full-time worker with specialist knowledge and skills in the area of domestic and family violence has been identified as a critical inclusion in the IFS team. This is in recognition of the high proportion of vulnerable families who are affected by domestic and family violence; the high level of risk that domestic and family violence poses to the safety of children, young people and their families; and the specialist skills required to identify domestic and family violence, engage with affected families, and develop appropriate service responses.

The role is designed to:

- provide specialist advice especially during case discussions
- assist co-workers to screen for domestic and family violence; and
- undertake risk assessments where domestic and family violence is identified.

This worker will:

- provide case managers with advice and support with engagement strategies for families affected by domestic and family violence, including strategies to assess, monitor and minimise risk to family members and workers
- participate in client home visits where appropriate; and
- support or work with case managers to engage all family members who require a service response, including fathers, and working with the whole family where it is safe to do so.

The role will include a level of direct client-related work as appropriate including counselling, risk assessment, risk management and safety planning. Where referrals to specialist domestic and family violence prevention and support services are identified as part of the case plan, this worker can assist family members to effectively engage with the appropriate service and
continue to inform risk management strategies. In some cases joint work with the specialist service and the IFS worker may be the best approach for the family.

This specialist role is not designed to lead case management or carry a case load.

There is potential for this role to be seconded from a specialist domestic and family violence service, providing information protocols are adhered to.

The department supports a Community of Practice (CoP) specifically for specialist domestic and family violence workers in IFS and FaCC services. The CoP is led by the Queensland Centre for Domestic and Family Violence Research at the University of Central Queensland. Requests to join the CoP can be made by emailing the Child and Family Team at faccandifssupport@cswy.qld.gov.au

3.4 Diversity and Culturally Respectful Practices

The IFS should aim to recruit a diverse team that reflects the cultures within the local catchment and a mix of male and female team members to maximise long term engagement and effective relationship building between families and the service.

Ensuring the safe care and connection of Aboriginal and Torres Strait Islander children and young people is vital to achieving the intent of the Supporting Families Changing Futures Reforms, the Our Way Strategy and the Changing Tracks Action Plan.

As part of Supporting Families, Changing Futures the department is focusing on improved outcomes for Aboriginal and Torres Strait Islander children and families by:

• building the capacity and capability of all child and family support services provided to Aboriginal and Torres Strait Islander children and families

• ensuring that all engagement with Aboriginal and Torres Strait Islander children and families in the delivery of services is conducted within the appropriate cultural context

• ensuring that Aboriginal and Torres Strait Islander families have the choice of receiving family support services from Aboriginal and Torres Strait Islander community controlled services.

If the IFS is not being delivered by an Indigenous organisation, in recognition of the over-representation of Aboriginal and Torres Strait Islander children in out-of-home care (also known as alternate care) and a commitment to support families to safely care for their children at home, the IFS is expected to recruit workers who identify as Aboriginal or Torres Strait Islander wherever possible. The service is required to develop effective links with local Aboriginal and Torres Strait Islander organisations and community representatives and to ensure that culturally respectful practice is a core component of staff development and training. Appendix 2 outlines the principles for responding effectively to Aboriginal and Torres Strait Islander children, young people and their families.
Information on the Queensland Government’s generational strategy for Aboriginal and Torres Strait Islander children and families, *Our Way*, can be found at:


In addition, an IFS service is required to be capable of responding in a culturally sensitive way to families from Cultural and Linguistically Diverse (CALD) backgrounds. Families from culturally and linguistically diverse backgrounds require services to be responsive to their specific needs. Services need to demonstrate their willingness and capacity to work with people from diverse backgrounds by developing specific strategies including linking with local multicultural organisations and engaging interpreter services. The department supports fee-free access to interpreters for funded service providers and clients from non-English speaking backgrounds who have difficulties communicating in English, and those requiring the assistance of Deaf Services Queensland.

To access a telephone interpreter, services first apply for a Telephone Interpreter Service (TIS) code at: interpreting.services@communities.qld.gov.au

Once a service has a TIS code, this code is quoted each time a TIS is booked for interpreting services and TIS will bill the department. If using Deaf Services Qld, please provide a paid invoice to the department to seek reimbursement.

If further information is required, there are fact sheets available at:


### 3.5 Referrals

**Referral criteria**

Referrals to IFS services must meet the following criteria:

- there is a child or young person (unborn to under 18 years) and
- the family has multiple and/or complex needs and
- the family would benefit from access to intensive and specialist support services through a case management model, and
- without support the child, young person and family are at risk of entering or re-entering the statutory child protection system and
- the child is not currently in need of protection.
Multiple and complex needs

Families at risk of entering the statutory child protection system often have multiple needs or challenges, which may be long-standing and entrenched, and that impact on their capacity to safely nurture and care for their children. Additionally, there are times when a single issue is so complex that it has impacted on family functioning over years, and sometimes generations. These issues require intensive support to develop sustainable strategies and skills for families to either overcome or effectively manage these challenges into the future.

Referring agencies should give consideration to the following when referring to IFS:

- there is at least one family member presenting with behaviours or circumstances that are having negative consequences for the family, particularly children, and

- there is more than one issue impacting on the child or family’s wellbeing, or there is a complex issue/s impacting on the child or family’s wellbeing.

Multiple and complex needs may include, but are not limited to issues such as:

- housing instability
- poor mental health
- drug and alcohol misuse
- domestic and family violence
- parenting challenges
- unemployment; and
- financial stress

Referral pathways

The local FaCC is a key referrer to IFS services. Referrals can also be accepted from professional reporters, Child Safety, other government and non-government agencies and families themselves (self-referrals).

1. Family and Child Connect referrals

Referrals from FaCC will be transferred via the ARC system after the FaCC has engaged the family, assessed their needs and gained the family’s agreement to be referred for support. The FaCC referral form is securely located on the FaCC and IFS website: [http://familychildconnect.org.au/secure/](http://familychildconnect.org.au/secure/)
2. Child Safety referrals

There are two types of referrals that an IFS service can receive directly from Child Safety:

**Referral with consent:** A referral with consent can occur where a full investigation and assessment (I&A) of a notification has been undertaken by Child Safety and the case is now closed or the family has been subject to a Child Safety intervention with parental agreement (IPA), and the case is now closed or will be closed once the family engages and commences working with the IFS. In these cases, Child Safety will have made contact with the family and will refer where intensive family support is deemed appropriate and the IFS referral criteria are met, to an IFS service with the family’s consent.

**Note:** Sometimes a family may consent to work with IFS in order to cease their involvement with Child Safety. So although they may have provided consent, they do not engage in meaningful intervention that will increase safety or reduce risk to their children.

**Referral without consent:** Where Child Safety have made an assessment of concerns received and determined it does not require further investigation, it is recorded as a Child Concern Report (CCR). In this case, Child Safety will not have contacted the family. Therefore, where intensive family support is deemed appropriate and the referral criteria are met, Child Safety may refer to an IFS service without the family’s consent. For CCR referrals, contact by the IFS service may be the first time a family will be informed that there has been a concern about their family brought to the attention of Child Safety.

3. Referrals without consent – prescribed entities

The Child Protection Act 1999 enables prescribed entities\(^2\) (159M) to make referrals to FaCC, Intensive Family Support services or other support services, without a family’s consent in order to ‘offer help and support to a child or child’s family to stop the child becoming a child in need of protection.

The rationale underlying this legislative provision is that sharing information takes precedence over the protection of confidentiality or an individual’s privacy because the safety, welfare and wellbeing of children and young people is paramount. However, although the legislation allows referrals to FaCC and IFS services (and between these services) without consent, best practice is that sharing information about a family should occur with consent and through engagement with the family wherever possible.

Prescribed entities are responsible for managing delegation related to this role, including policy and procedural direction, guidance and support for their staff.

It should be noted that some prescribed entities, particularly the Department of Education, have their own internal policy to gain consent from the parents before a referral is made regardless of their legislative ability to make a referral without consent.

\(^2\) Ibid, page 7
4. Professionals and organisation referrals

Any other professionals and organisations other than those listed as prescribed entities that identify vulnerable families who meet the referral criteria may, with the family’s consent, refer the family to an IFS service.

In 2017 Early Childhood Education and Care (ECEC) services became Mandatory Reporters under the Child Protection Act 1999 and received information on referring to IFS when a report to Child Safety is not required and the family meet the criteria for IFS. ECEC services are not prescribed entities and will therefore make referrals with the family’s consent.

5. Community referrals

Community members seeking assistance for vulnerable families who need support may refer a family, with their consent, to an IFS service or encourage the family to self-refer.

6. Self-referrals

Families may self-refer to an IFS service for support.

Prioritisation guidelines

IFS services will engage eligible clients based on their professional assessment of criticality-of-need, taking into account the following combination of factors:

- Referrals from FaCC or Child Safety whereby the family is deemed to not currently be in need of protection but the family is at high risk of entering the statutory system without an intervention
- The child/ren is/are under 3 years old
- The degree of vulnerability of child/ren given consideration of factors such as developmental delay, physical/intellectual disability, health/medical needs and challenging behaviours etc.
- Child protection history, if known (e.g. more than one child concern report/notification recorded within a 12 month period, consideration of cumulative harm (e.g. series or pattern of harmful events and experiences that may have occurred in the past or are ongoing)
- Complexity of need with multiple presenting factors (e.g. mental health, domestic and family violence, substance misuse, and disability issues, engagement in criminal activities)
- Social, environmental, cultural influences and networks (e.g. limited access to services, including housing)
- Other services currently involved, including the need for case co-ordination and/or access to more than one type of service.
Referral volume

Referrals to IFS services can originate from multiple sources. As a result, the numbers of referrals made to an IFS service are not regulated and the department acknowledges that this may result in high numbers of referrals (necessitating a service level prioritisation and waiting list). IFS providers are encouraged to raise incidences of high numbers of referrals with the FaCC service and other referring agencies, the Local Level Alliance and the department, with all parties committing to undertaking their best endeavours to resolving these respective situations.

Waitlist strategies

If IFS services need to implement a waitlist, strategies may include:

- regular phone contact to check the status of the family and review placement on the waiting list, reassessing if needs have escalated; and
- considering the family’s suitability for other available services, including, if appropriate group programs.

Managing sensitive referrals

There may be times when the service receives a referral that is deemed sensitive, such as a referral of family member of an employee. Best practice is to give the family the opportunity to choose whether or not they would like to receive support from the service. In these cases the service should be particularly mindful of the family’s privacy when contacting to offer support and consideration should be given to the best person in the organisation to make that contact. The ARC system allows for users with coordinator access to restrict particular workers (system users) from accessing information on a particular client. The worker would still see the client’s name listed but would be unable to access the case information.

Should the family choose not to work with the service, efforts can then be made, with the consent of the family, to link them with an alternative appropriate service

In extraordinary circumstances a service may advise a referrer that they are unable to accept a referral that is deemed sensitive, again being mindful of the family’s privacy, and supporting a referral to another service for that referral

Queensland Child Protection Guide

The Queensland Child Protection Guide is an on-line tool that assists those who have concerns about a child or young person to make a decision about whether to make a report to Child Safety or refer to a support service best placed to meet the family’s needs. The guide is available statewide and supports health and education professionals to report their concerns to Child Safety or refer the family to a support service, including a Family and Child Connect or IFS service.

3.6 Child Protection Notifications and Interventions

Once an IFS service is in receipt of a referral, an IFS staff member can seek a case consultation with the PCPP. The PCPP provides advice and information in relation to specific cases with a focus on:

- the suitability of the referral to an IFS service given the PCPP’s child protection experience and if needed, access to child protection history on the Child Safety database
- whether the referral provides information indicating a child may be in need of protection and therefore requires a report to Child Safety
- assisting with the identification and prioritisation of needs for a child and family
- assisting in safety planning and assessments
- assisting in developing engagement strategies when working with a difficult or resistant family
- undertaking a risk assessment
- assisting in negotiation with Child Safety in those instances where Child Safety has requested that an IFS service jointly work with a family during an Intervention with Parental Agreement (IPA) due to the existing relationship between the IFS and the family.

If during an IFS intervention, the IFS worker identifies an Immediate Harm Indicator when completing their Safety Assessment, best practice is, in collaboration with the PCPP, to report to Child Safety.

If an IFS service is offering support to a family and Child Safety begins an investigation and assessment, the service may continue to work with the family until the assessment is completed. However, if as a result of the investigation and assessment an ongoing statutory response is deemed appropriate, the IFS Service must immediately transition case management to Child Safety.

It is acknowledged that there are sometimes circumstances (e.g. impending reunification, one child in a family is on statutory orders but other children in the same family are not, or while an investigation and assessment is being completed) where continued support by the service is appropriate despite the family being reported to or within the statutory system. The appropriateness should be determined by an assessment of whether the situation, meets the intent of the initiative – that is, the service is working with the family so that they do not enter or re-enter the statutory system. As such, an IFS intervention is not appropriate where the child is subject to ongoing statutory intervention. The department funds other services such as Tertiary Family Support (TFS, also known as FIS services) to work with families who enter the statutory system.

IFS services are funded to prevent entry or re-entry of children and young people into the statutory child protection system. As such, the target group is children, young people and their families who are at high risk of abuse or neglect but are not currently subject to statutory intervention, with the exceptions outlined above.
Working with families subject to an IPA

The one exception to IFS services working only with non-statutory clients is when an investigation by Child Safety has deemed that a child is in need of protection and the best means to protect the child is via an IPA. If the family have a good working relationship with the IFS service, Child Safety may request that the IFS service remains involved until the family transition to an appropriate tertiary service. Please see Attachment 7 for the guidelines surrounding the joint work of an IPA case.

3.7 Consent Based Engagement

The intent of gaining consent is to ensure that families willingly engage with the service and take responsibility and ownership for achieving positive change.

Informed consent is critical to the service model. Family members need to agree to accept support by providing consent which includes permission to share information with other service providers that can assist them. There are numerous points at which family consent will be sought to share their personal information. Families have the option of limiting or not permitting information sharing with particular services or organisations.

Information sharing for families experiencing domestic and family violence must be guided by safety considerations, utilising the expertise of the domestic and family violence specialist.

Where a child or young person is able or it is appropriate for them to have some involvement in the work with their family, their views and wishes should also be considered when sharing information.

Where the adults in the family have different views about consent, the service will work to ensure the adult willing to engage with support is safely able to provide consent, including permission to share information, and access the services they need.

All families should be made aware of the duty of care service providers have to report significant harm or the risk of significant harm to relevant authorities, including Child Safety.

3.8 Information sharing without client consent

IFS services operate on a voluntary engagement basis and therefore in most cases client consent is required before information can be shared with other agencies or service providers.

It is not always safe, possible or practical to seek and obtain consent. Requiring consent can at times, prevent or delay a service engaging with a family and prevent the effective coordination of services where multiple services are involved. Professionals need to be able to share information about a child or their family so help and support is provided in a timely way to enable families to meet the protection and care needs of children.

While information sharing with consent remains best practice, the Child Protection Act 1999 now enables specialist service providers, including IFS and FaCC, to share information with each other, with other prescribed entities, and with other service providers to assess and
respond to a child’s needs or plan or provide services to a child or the child’s family to decrease the likelihood of a child becoming in need of protection.

Further details on information sharing with Child Safety can be found in Appendix 8.

*Domestic and Family Violence Protection Act 2012*

As IFS services do not fall within the definition of ‘Prescribed Entity’ under the *Domestic and Family Violence Protection Act 2012* in most circumstances information cannot be shared with other agencies and services without the client’s consent. In 2017 an information sharing provision was introduced as an addendum to the Act which allows for IFS services to share relevant information in the following circumstances;

1. *to assess whether there is serious threat to a person’s life, health or safety.* A Prescribed Entity may request information to assess whether there is a serious threat and IFS services through the Domestic and Family Violence Specialist, can provide relevant information without the client’s consent if necessary.

2. *to lessen or prevent a serious threat to a person’s life, health or safety.* A Prescribed Entity, Specialist DFV service or other support service, including IFS, can share relevant information without the client’s consent if necessary, to lessen or prevent (manage) a serious threat.

In all cases, the IFS service must reasonably believe the information they are sharing will help with the particular purpose for which they are sharing the information. Decisions about information sharing need to be made with consideration of the individual circumstances of the child and family.

**3.9 Framework and Tools**

Under the Child and Family Reforms, the department has implemented a new child protection practice framework, the Strengthening Families Protecting Children Framework for Practice developed in partnership with the Children’s Research Center (CRC) and SP Consultancy.

Resources –


Frame work for practice –


Foundational elements –

The Strengthening Families Protecting Children Framework sets out a strengths-based, safety-oriented approach to enhance Queensland’s child protection practice and deliver better outcomes for vulnerable children, young people and families in need. It identifies the range of sources of knowledge critical to effective child protection practice and highlights that, while research and practitioner sources of knowledge are valued, so too is the knowledge held by individuals and families, the community and culture, and the broader system in which children and families are located.

The framework has a focus on engagement, assessment, planning and organisational processes and a range of practice maps, tools and processes to strengthen the skills of both child safety professionals and non-government practitioners. The aim is to build collaboration through a common language and shared practice framework and to promote a shared understanding and consistent practice across all FaCC, IFS services and the department.

3.10 Outcomes

Under the Child and Family Reforms, the intent of the IFS services is to contribute to the outcomes below, specifically outcomes which demonstrate improved family functioning as a result of the intervention by the IFS service. IFS forms part of a service system that together with FaCC and Child Safety and other services supports the achievement of the following system-wide outcomes:

1. **Highly vulnerable families are stronger, capable and more resilient** – families are appropriately referred and engage with the support they need.

2. **Improved life outcomes for vulnerable children** – reduction in children in care; and reduction in risk factors for vulnerable children.

3. **More sustainable support services to vulnerable families** – government investment proportions shift from tertiary to secondary; and agencies refer to the most appropriate service.

It is expected that all IFS providers understand and embrace their role within the service system as the support service point for families experiencing multiple and/or complex needs with the objective of improving child and family wellbeing in order for families to safely nurture and care for their children at home.

The Outcome Measures for IFS services are:

- **Families have shown improvements in being safe and/or protected from harm;**
- **Families have improved life skills.**

3.11 Local Level Alliances

To support the delivery of IFS services and the broader child and family reforms, Alliances of local community and government services that are involved in supporting vulnerable families are being established to strengthen connections between local services. Alliances may build on existing or develop new networks of family support services.
It is the responsibility of the FaCC service to resource and support the Local Level Alliance. IFS services will be core members of the Local Level Alliance in the catchment.

The Alliance of non-government and government service providers works to strengthen the service system and ensure that vulnerable families receive the right service at the right time.

It is expected that the Local Level Alliance will work towards achieving the following outcomes:

- Building community capacity to provide a more efficient service provision for families and a thriving local community.
- Improved and more direct referral pathways for families to access appropriate services.
- FaCC is embedded as an alternate pathway for families to be connected to the right support at the right time.
- Improved information sharing between providers to enable more coordinated and effective responses to families.
- Responses aligned to better support vulnerable families and strengthen service integration, such as a shared practice framework and resources.
- Contribute to service system integration through identification of available services and gaps, improvement in the alignment between the configuration of the service system and the needs of local families.
- Contribute to place based planning for the development of an integrated suite of local services that provide families with responsive, accessible and effective support.

The active participation of the IFS in the work of the Alliance will be critical to successful place-based integration and outcomes at the local level.

The underlying principle is for the Local Level Alliance to include those members who are best placed to meet the goal of strengthening the local service system to effectively respond to vulnerable families. It is important that decision making representatives from agencies, including the IFS attend the Local Level Alliance meetings.

3.12 Evaluation

From 2015 to 2018, the evaluation of IFS by the Parenting Research Centre in conjunction with the University of Queensland examined a range of questions on:

- IFS service establishment and implementation
- referrals to IFS services
- engagement of families with IFS services
- allocation of support workers to families
- family demographic characteristics and the complexity of their presenting needs
- case planning and case management
support provided by IFS services in response to family presenting needs
referrals out to other services in the community to help these families
outcomes for families when they leave the IFS service
whether families have reduced the risk of harm to their children after receiving help from IFS

The evaluation found that IFS services were having a positive influence on outcomes for families experiencing multiple and/or complex challenges and that a substantial proportion of families had reduced or resolved their presenting needs by the time they exited IFS services.

3.13 Legislation

The Child Protection Act 1999 provides the overarching legislative framework that supports the implementation of Family and Child Connect and referral pathways to services for families who need support and sets out the legal framework for reporting concerns about children to Child Safety.

The Child Protection Act 1999:

- Reinforces that a child in need of protection is a child who has suffered, or is suffering, or at unacceptable risk of suffering ‘significant’ harm and has no parent willing and able to protect them.

- Clearly states that any person (including those professionals who are subject to mandatory reporting requirements) may report a reasonable suspicion that a child is in need of protection to Child Safety.

- Provides guidance on what to consider in identifying significant harm and developing a reasonable suspicion that a child may be in need of protection.

- Lists the Queensland professionals who are subject to a mandatory requirement to report a concern to Child Safety, that is, approved teachers, doctors, nurses, police officers with child protection responsibilities, officers of the new Public Guardian, Child Safety employees and employees of licensed care services.

- Requires that mandatory reporters must report a reasonable suspicion a child is a child in need of protection caused by physical or sexual abuse and the child may not have a parent able and willing to protect them from the harm. For licensed care services, a reportable suspicion relates only to the child having suffered, suffering or being at unacceptable risk of suffering significant harm caused by physical or sexual abuse.

- Allows prescribed entities to refer a family to a service provider where it is considered a child is likely to become in need of protection without support being provided to their family.
3.14 Duty of Care

IFS services must adhere to the relevant provisions within the:

- Community Services Act 2007
- Child Protection Act 1999
- Public Guardian Act 2014
- Family and Child Commission Act 2014
- Right to Information Act 2009
- Information Privacy Act 2009
- Public Records Act 2002
- Any future legislation relevant to services funded by the Department of Child Safety, Youth and Women.

Services should be aware of the Child Protection Act 1999 in relation to the principles of the Act and the reporting of child protection matters and privacy of information. In addition, it is a requirement that people who work with children in regulated employment (which includes counselling and support) are suitable. This is assessed through the ‘working with children’ suitability notice (blue card). Blue Card information is available at: https://www.bluecard.qld.gov.au/

It is important that IFS services ensure appropriate practices to work with children and young people. This information must also be supplied to other services that are contracted through partnering or brokering to work with the child and family.

Duty of care requires that the IFS service contact Child Safety if there is reason to suspect a child is experiencing significant harm. This includes if, after a referral, further information becomes apparent during assessment that leads the service to suspect a child has experienced significant harm. Information regarding reporting suspected child abuse is available at https://www.csyw.qld.gov.au/child-family/protecting-children/reporting-child-abuse. All services that work with IFS clients, including brokered services or partnering services, must also be aware of this responsibility.

IFS services are able to refer to the Child Protection Guide and this guide can assist you to make the right decision to report a child to Child Safety.


IFS services can also seek advice from the PCPP in their local FaCC about suspected harm to children they are working with to help determine whether a report should be made to Child Safety.

3.15 Risk Management

The funded organisations delivering IFS services need to develop risk management plans and be vigilant about implementing the identified risk mitigation strategies. This includes strategies to ensure worker and client safety.
4. Data Collection and Reporting

All IFS services enter client data on the Advice, Referral and Case management (ARC) system developed by Infoxchange. The department provided initial training for organisations delivering IFS and ongoing support can be accessed through the Infoxchange Helpdesk. There is also a user manual specifically for IFS services which can be found on the ARC landing page along with the latest news and tips. New staff should be trained by an experienced system user within the organisation.

De-identified data is extracted monthly from ARC by the department to meet the whole of program reporting requirements of IFS services and other programs that use these systems. For IFS services, this occurs on approximately the 8th day of the month. Services are required to enter the data on a regular basis so that data accurately reflects the delivery of services to clients. In particular, all data needs to be up to date by the 8th day of the month.

The only exception is that some identified data is extracted to report on an escalation measure tracking progress from an IFS intervention to the statutory system. A small defined number of departmental staff undertake the data matching exercise.

IFS services can extract a range of reports from ARC including monthly reports on referrals and caseloads which contains comprehensive service delivery data, including hours of service.

In order to complete performance reporting for compliance with the service contract with the department, services will be able to download an OASIS (Online Acquittal Support Information System) Report from ARC which can be used for quarterly reporting on OASIS.

Infoxchange provides a centralised help desk for ARC users, and issues or questions should be sent via:

- Email: srs-support@infoxchange.net.au or
- Infoxchange Helpline 1300 366 516 or 03 9418 7487

When contacting the help desk please quote the web address you use to access ARC and the workgroup you belong to.

You can also find generic Service Record System (SRS) Frequently Asked Questions and a feedback page via the online help at http://srs-support.infoxchangeapps.net.au/

4.1 Output Funding and Reporting

The department currently operates on Output Funding and Reporting, and as such there are Output Measures with agreed target hours and numbers of families stipulated in the Service Agreement.
The Output Measure for which all IFS services are funded is:

**A01.2.02 Case Management**

IFS services currently collect detailed data on time spent with or on behalf of a client as part of needs assessment and case management. Included in this Output are all the activities a service would undertake as they work with clients in a case management model.

The Output is measured by:

**Staff related hours of direct service delivery with or on behalf of a client**

The Department recognises that there are a range of activities that are essential to effective operation and delivery of services, and that not all activities are directly related to clients. For the purpose of Output Reporting, it is only the client related hours that need to be reported.

**Counting rules**

All IFS services enter client related data on ARC. Data collected on ‘time spent’ provides evidence of output hours against the targets set in service agreements, therefore accurate recording is critical.

All services will provide standard data relating to hours spent on service delivery, as per the *User Manual* including applying the following counting rules:

- Hours spent by each worker with or on behalf of a client (i.e. if two workers meet with a client for 1 hour, then the hour for each worker (total 2 hours) will be recorded as time spent with or on behalf of that client).
- Hours of travel directly attributed to a client (i.e. travelling to and from a visit to a client is considered work on behalf of a client. This takes into account that all the services are based on a core component of home visiting.).

ARC provides a service level report with the data required to enter on department’s OASIS reporting system quarterly. The corresponding OASIS List on ARC will provide services with detailed information to verify the data prior to submitting their quarterly reporting on OASIS.

**4.2 Outcome Reporting**

IFS services form part of a service system that together with Child Safety supports the achievement of system-wide outcomes.

**At a system level IFS services contribute specifically to the outcome:**

*Highly vulnerable families are stronger, capable and more resilient – families are appropriately referred and engage with the support they need.*
At an individual service level the outcomes set for IFS are:

- **Families have shown improvements in being safe and/or protected from harm**
  Measured by:
  
  o completion of the FRE that will be assessed as low to moderate risk, the FAST or Wellbeing Domains assessment and the Single Family Case Plan will have the majority of goals met.

  and

- **Families have improved life skills.**
  Measured by:
  
  o completing the FAST or Wellbeing Domains assessment and Single Family Case Plan with all or the majority of needs met via the case plan goals.

The department has set a target of 70% of all cases are completed with the majority of needs met.
Appendices

Appendix 1 – Practice Principles

Practice principles

Intensive Family Support (IFS) services adopt the following practice principles to provide best practice and positive outcomes for vulnerable families with children and young people:

Valuing and supporting families as the primary place of nurturing for children - The best way to promote the safety and wellbeing of children and young people and to protect them from harm is by supporting families to care safely for their children at home and by creating safe and supportive communities.

Building on strengths - Support and intervention builds on the strengths of the child, family and community, enhances capacity and resilience and addresses identified risks and/or problems. Service providers work collaboratively and in partnership with children, families, communities and other service providers where appropriate, to develop case plans and to make decisions.

Respecting and responding to family and community diversity and strengthening culture and connections - Family and cultural background has a strong bearing on the ways families and communities approach childrearing. Support and intervention respects and responds to diversity and promotes culture as a resource, seeking to build on the strengths and protective factors which particular cultural backgrounds may provide.

Holistic and integrated policy and practice - A holistic and integrated approach to service provision offers the greatest chance of longer-term success. In partnership with non-government organisations, government plays a leading role in bringing together relevant stakeholders and supporting genuine collaboration throughout planning, implementation, partnership development and evaluation.

Evidence-based policy and practice - Support and intervention is outcome driven and reflects contemporary research and evidence on what works best to achieve desired outcomes. Where appropriate, consideration is given to targeting activities and interventions toward the early years and other critical transition points to maximise investment and outcomes. Agencies commit to action learning processes and participation in the evaluation of service delivery both as part of the broader network of IFS services and in partnership with the department.

Purposeful, planned and matched to need - Supports and interventions are goal orientated and planned, within a sound theory of change. They are carefully coordinated and individually tailored to the specific nature and source of family difficulties. Parent engagement is maximised through family support based on goals that are specific and interventions that are well coordinated.

Relationship-based - Relationships are vital to service delivery. Workers aim for a therapeutic role and strive to develop a structured helping alliance with family members. Interventions will be delivered by appropriately trained, research informed and skilled staff, backed up by good management and supervision.
**Tangible and non-tangible forms of assistance** - A mix of practical, personal development, therapeutic and enabling services are utilised as appropriate:

- practical services address a specific need in the family, such as transport to medical appointments or respite care, establishing daily routines related to meals or getting to school
- personal support and development including information and advice, parenting skills courses, budgeting and household skills development
- clinical or therapeutic services include casework, counselling, emotional support, family mediation, anger management, domestic violence intervention programs, development of social supports
- enabling services to link the family to other supports via referral and advocacy (e.g. assist with access to housing, child care, emergency relief payment, rental assistance) and case management to coordinate service delivery.

**Engagement and participation** - Services focus attention on engaging families through the skills and persistence of their workers. The match between client need and services provided is considered crucial – if clients perceive the service is helpful they are more likely to stay engaged. Workers develop a partnership approach with parents that support parental engagement and responsibility. Multiple pathways in to the service are utilised to encourage self-referral (where available) and reduce stigma for families.

*Source: Tilbury C (2012) Intensive Family-Based Support Services for Aboriginal and Torres Strait Islander Children and Families: A background paper. SNAICC*
Appendix 2 – Culturally Respectful Practices

Culturally respectful relationships with Aboriginal and Torres Strait Islander families

In June 2017, the *Our Way* strategy and *Changing Tracks* were released by the Queensland Government.

*Our Way, a generational strategy for Aboriginal and Torres Strait Islander children and families 2017-2037* is a strategic framework that has been guided by Aboriginal and Torres Strait Islander perspectives to achieve generational change over the next 20 years. It represents a long-term commitment by government and the Aboriginal and Torres Strait Islander community to work together.

As part of the Our Way strategy, the first three-year action plan, *Changing Tracks* has been released that aims to:

- reduce the over-representation of Aboriginal and Torres Strait Islander children in the child protection system
- close the gap in life outcomes for Aboriginal and Torres Strait Islander people experiencing vulnerability
- ensure all Aboriginal and Torres Strait Islander children grow up safe and cared for in family, community and culture

More information can be found here:


Organisations delivering family support should understand and work in accordance with the Aboriginal and Torres Strait Islander Child Placement Principle which has relevance across the child and family service system. More information is available in the following resource:


The Child Protection Reform Amendment Act 2017 represented a significant shift in how the department supports the connection of Aboriginal and Torres Strait Islander children and young with people with their family, community and culture, acknowledging that stronger connections result in better outcomes for Aboriginal and Torres Strait Islander children and young people. The changes also recognise the significant and long-term effect of decisions on a child or young person, their family and community; and acknowledges the role of family and community as the primary source of cultural knowledge.

At the core of the legislative amendments are the five elements of the Aboriginal and Torres Strait Islander Child Placement Principle. All IFS services will need to be aware of and work towards incorporating relevant elements into their practices, particularly Prevention, Participation and Partnership:

Prevention – protecting children’s rights to grow up in family, community and culture by redressing the causes of child protection intervention
Connection – maintaining and supporting connections to family, community, culture and country for children in out-of-home care

Participation – ensuring the participation of children, parents and family in decisions regarding the care and protection of their children

Placement – placing children in out of home care in accordance with established placement hierarchy

Partnership – ensuring the participation of community representatives in service design, delivery and individual case decisions

To support the meaningful participation of Aboriginal and Torres Strait Islander children and families in tertiary child protection decision-making, the Child Protection Reform Amendment Act 2017 introduced the role of an independent Aboriginal or Torres Strait Islander entity for the child (known as an independent person).

Child Safety is required, with the consent of the child and family, to arrange an independent person to facilitate the child and family’s participation in significant decisions for an Aboriginal or Torres Strait Islander child who is the subject of a child protection notification or who is subject to intervention by the statutory child protection system.

Services should also reflect the Council of Australian Government’s (COAG) National Indigenous Reform Agreement which enshrines the following service delivery principles for programs and services for Indigenous Australians:

**Indigenous engagement principle**: engagement with men, women and children and communities should be central to the design and delivery of programs and services

**Sustainability principle**: programs and services should be directed and resourced over an adequate period (to meet COAG targets), with particular attention being given to supporting Indigenous communities to harness the engagement of corporate, non-government and philanthropic sectors

**Access principle**: programs and services should be physically and culturally accessible to Indigenous people, recognising the diversity of urban, regional and remote needs

**Integration principle**: collaboration between and within governments at all levels, their agencies and funded service providers to effectively coordinate programs and services.

More information can be found here:

http://mete.or.aihw.gov.au/content/index.phtml/itemId/645344
Appendix 3 – Common Assessment Tools

Under the Child and Family Reforms the department committed to service providers that it would provide Common Assessment Tools for use by both Intensive Family Support and Family and Child Connect services to support a shared understanding, language and consistent practice across all of these services. This is complementary to the implementation of the Strengthening Families Protecting Children Framework for Practice.

Why are Common Assessment Tools identified as beneficial to Family and Child Connect and Intensive Family Support services?

Enhancing Equity

One of the stated goals of the current reforms to child and family services is to enhance equity for all children, young people and families we work with. Equity is difficult to achieve without consistency in our assessments. Providing a common assessment system with shared language and consistent definitions provides more consistency across services in our assessment and planning and moves us one step closer to being a more equitable system that provides families with the right service at the right time.

Measuring outcomes achieved for a family

To measure outcomes across a service system, the domains and items assessed for a family in one catchment must be the same domains and items as those assessed in another catchment. The Family Assessment and Summary Tool (FAST) is able to capture the strengths and barriers for a family and whether they are meeting their goals. These domains and items need to:

- reflect the needs within families that services are expected to target to improve the safety and wellbeing of children and families
- have clear and comprehensive definitions, to support consistent application by all workers across all services
- help us measure whether we are providing the right service at the right time, i.e. prevention and early intervention assists families to avoid tertiary intervention.

Until organisations have been trained in the FAST and the tool has been integrated in to the Advice, Referral and Case management (ARC) system, the Wellbeing Domains assessment will continue to be used at case commencement and case closure.

Providing a common language and framework for use between services and supporting the implementation of collaborative case planning

A framework that can be applied across multiple service points (such as at referral, assessment of need, liaison with stakeholders, case discussions and case planning with families and other services, case plan review and/or referral to another service) avoids families having to tell their story multiple times, facilitates consistency in service delivery and clearly links assessment to case planning. The use of Common Assessment Tools in the voluntary sector ensures that services are able to communicate adequately worries and the risks relating to a family to Child Safety if required.
Supporting the consistent assessment of immediate safety, the likelihood of future harm, the identification of needs and quality case planning across catchments, to help identify issues that require planning or reporting to Child Safety

Having clear and comprehensive definitions (e.g. related to indicators of immediate harm), especially when working with high risk families, which is the FaCC and IFS target group, supports workers in their decision making at critical intervention points.

Common Assessment Tools can support consistent practice so that the same indicators of harm and risk of future harm, as well as strengths and barriers are considered for each family regardless of location. Using tools to inform case planning can also assist workers to identify any gaps that may have occurred.

Common assessment Tools mean that the voluntary sector has a similar risk threshold to Child Safety and families are referred to the tertiary system if this is the most appropriate intervention at that time.

Assisting to assess the demand for services based on the vulnerability of families across Queensland

Both active engagement provided by FaCC and interventions provided by IFS services are targeted at the most high risk and/or complex families. The application of an assessment tool that assists in identifying risk within a family, based on the likelihood of future harm to a child, strengthens and supports a holistic professional assessment about which families will benefit most from an intervention.

The common assessment tools will assist the Government to identify which areas in the state have the greatest need and therefore require the greatest concentration of services.

Trial and evaluation

In 2016 established IFS and FaCC services trialed the use of the following Structured Decision Making® tools:

- Safety Assessment
- Family Risk Evaluation (FRE)
- Family Risk Re-evaluation (FRRE) - IFS only

The evaluation confirmed that IFS and FaCC workers found the use of the tools helpful in assessing safety and risk and therefore contributed to decision-making about meeting the needs of children and their families. In 2017 the Statewide Implementation Group endorsed ongoing use of the Common Assessment Tools.

Context of SDM® within FaCC and IFS

The completion of SDM® tools is one part of comprehensive assessment and subsequent intervention regarding child and family safety and wellbeing, which:

- considers the immediate safety needs within a family
- the risk of future child maltreatment, and
the family’s wellbeing needs

This comprehensive assessment supports services to respond to a family in a holistic way that promotes the need to keep children at the centre of the service system.

SDM® tools are decision-support tools. The SDM® tools do not make decisions but help guide decisions – increasing our consistency and accuracy as a system. The application of SDM® tools supports a comprehensive professional assessment that informs a service’s decision making regarding their service delivery to families. This is in the context of understanding that IFS services are required to prioritise families based on risk of future harm to children. The following key decisions are supported by the application of SDM tools.

<table>
<thead>
<tr>
<th>Decision</th>
<th>Supporting SDM® tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there indicators of immediate harm to a child and therefore is an immediate safety plan required?</td>
<td>Safety Assessment</td>
</tr>
<tr>
<td>If there is an immediate harm indicator, what household strengths, protective actions and safety interventions can be implemented to create an immediate safety plan that addresses the harm and ensures a child’s safety?</td>
<td>Safety Assessment</td>
</tr>
<tr>
<td>Is there a reasonable suspicion that a child is in need of protection and a notification to Child Safety is required?</td>
<td>Safety Assessment</td>
</tr>
<tr>
<td>Is the likelihood of future harm to a child high enough that Intensive Family Support needs to be considered for this family?</td>
<td>Family Risk Evaluation (FRE)</td>
</tr>
<tr>
<td>What is the minimum frequency of contact recommended for this family?</td>
<td>Family Risk Evaluation</td>
</tr>
<tr>
<td>Is the likelihood of future harm to a child high enough that Intensive Family Support should continue working with a family?</td>
<td>Family Risk Re-evaluation (FRRE)</td>
</tr>
<tr>
<td>Has the likelihood of future harm been reduced such that we can and should cease IFS involvement?</td>
<td>Family Risk Re-evaluation</td>
</tr>
<tr>
<td>What are the particular or most salient strengths and barriers of the caregivers and children?</td>
<td>Family Assessment and Summary Tool (FAST).</td>
</tr>
<tr>
<td>What are the goals to address on a case plan?</td>
<td>Family Assessment and Summary Tool</td>
</tr>
</tbody>
</table>
Other Common Assessment Tools

A key goal of both the trial evaluation and ongoing development work is to identify an integrated, streamlined suite of Common Assessment Tools that avoids duplication and has ongoing applicability and efficacy. This work will include consideration of other Common Assessment Tools currently in use by Intensive Family Support services, namely:

The Wellbeing Domains Assessment

This tool records the assessment of a family's needs at intake and during interventions under seven wellbeing domains. At case closure services assess and record change within these domains to reflect outcomes of the intervention provided. Over time this tool will be replaced by FAST.

Interface with Collaborative Assessment and Planning (CAP) Framework

What is the CAP framework?

The Collaborative Assessment and Planning framework is designed to support a collaborative process of discussing, reflecting and recording assessment and case planning regarding child safety and wellbeing. The CAP framework is used with families and also with other key stakeholders, including referrers, colleagues and other services, in order to support shared understanding and agreement on concerns and plans to address those concerns. The CAP framework is also used in case consultation and supervision contexts as an organising framework, and as a prompt for family and safety-centred practice. The CAP framework is used throughout the duration of the work with a family.

Why is the use of the CAP framework encouraged?

The CAP framework supports a common language and framework for use with families and services.

The CAP framework can be applied across multiple service points such as at referral, assessment of need, liaison with stakeholders, case discussions and case planning with families and other services, case plan review and/or referral to another service). It avoids families having to tell their story multiple times, facilitates consistency in service delivery and clearly links assessment to case planning. Using tools with language that is easily understood by families and workers, whilst clearly articulating worries and strengths, goals, plans, and case planning progress, supports working with families to enhance the children’s future safety, belonging and wellbeing in an inclusive and collaborative way.

Who and when:

IFS services can use the CAP framework, and supporting practice tools such as Three Houses or Circles of Safety, from opening a case through to case closure. For example:

- At the enquiry/referral stage
- When assessing the appropriate response
- Seeking to engage the family
- Gathering or analysing information to inform the assessment of safety and wellbeing
- Developing and implementing a plan with the family and other stakeholders
- Reviewing a plan

**How do the CAP framework and SDM® interface?**

SDM tools are professional assessment tools to inform agency decision making in a consistent fashion by focusing on safety, risk of future maltreatment and wellbeing needs at critical decision making points in the process of working with families.

At each of the critical decision making points, the relevant SDM tool can be used to guide and reflect on the assessment and planning information that is captured in the CAP framework. While the SDM tools help support decision making, the CAP framework provides a method or guidance on how to work with a family and draw out their strengths and worries.

**Service delivery guidance**

Due to service demand there are times where families need to be prioritised, regardless of meeting a service’s eligibility based on the referral criteria.

The SDM tools can be used to inform (not direct) prioritisation of families within IFS. For example the outcome of the Safety Assessment and Family Risk Evaluation (FRE) can provide the following guide:
This guidance however must be balanced with an understanding of (for example):

- Known needs, worries and strengths within the family and their network
- A family’s willingness to meaningfully engage with the service to facilitate change
- Service eligibility, e.g. referral criteria
- Professional judgement
Appendix 4 – Principal Child Protection Practitioner (PCPP)

Under the Queensland Government’s Child and Family Reforms an out-posted child safety officer is based in each Family and Child Connect catchment to:

- provide child protection advice and guidance;
- support professionals and FaCC, IFS and Aboriginal and Torres Strait Islander and Family Wellbeing (FWB) workers to manage any child protection risks; and
- facilitate the involvement of Child Safety by acting as a link between the secondary and tertiary services sector.

The PCPP is an officer with extensive child protection experience. They remain under the employ of the Department of Child Safety, Youth and Women and work across services within their catchments.

The PCPP works collaboratively with local government and non-government service providers to support earlier and more effective intervention with children and families who have been referred for help. In addition, the PCPP will provide consultancy and advice to FaCC, IFS and Family Wellbeing services on child protection matters, as well as education on statutory child protection system processes and responsibilities.

As a departmental employee, the PCPP is required to adhere to the department’s mission, vision, business objectives and Code of Conduct. However, given the PCPP is co-located with a non-government organisation, it is also important that the PCPP embraces the ethos and abides by the policies and code of conduct of that organisation.

Role and responsibilities of the PCPP

The PCPP has a diverse role with the following responsibilities:

- Provide expert generic child protection advice and guidance to FaCC, IFS and FWB services in accordance with departmental policies and procedures, statutory responsibilities, departmental objectives and current practice;
- Provide a case consultation service to FaCC, IFS and FWB services on multiple and/or complex cases, and ensure cases that may require statutory intervention are reported to Child Safety. The PCPP role includes oversight of the reporting quality. This may include a child protection history check (where appropriate);
- Assist in safety planning; and identification and prioritisation of needs;
- Build the child protection expertise of FaCC, IFS and FWB services, and broader intensive secondary service providers through training and professional development initiatives;
- Support the implementation of the Child Protection Guide (CPG), and act as an agent of change through the provision of training and education (and/or training and education resources) to schools, police and health professionals;
• Perform a cross sector co-ordination role, establishing and maintaining effective working relationships with FaCC, IFS and FWB services, broader intensive secondary services, and other government and non-government agencies to promote better collaboration between services and with Child Safety;

• Actively participate in meetings with FaCC, IFS and FWB services, broader intensive secondary services, and other government and non-government organisations including the Local Level Alliance, as a representative of Child Safety.

Given the diverse functions of the role, the PCPP may also be contacted by the broader intensive secondary service providers, and other government and non-government organisations to perform specific or multiple functions.


**Contact with the PCPP**

The PCPP provides onsite support and assistance in line with any of the duties outlined in the *Role and responsibilities* section above.

Other government and non-government organisations can contact the PCPP directly to seek advice or engage them in one of these functions. This excludes the provision of a case consultation service as this is only available to FaCC, IFS and FWB.

The provision of ‘advice’ differs from a ‘case consultation’, in that advice involves a broad, generic conversation which does not pertain or reference a particular family, whereas a case consultation will relate to a specific family and identifying information will be shared with the PCPP.

The PCPP may also give advice to another government or non-government organisation, for example Queensland Health may contact the PCPP seeking advice on the Child Protection Guide.

**Reports to Child Safety from FaCC IFS or FWB service**

Where reasonable suspicion is identified that a child or young person is in need of protection, the service has a responsibility to ensure the matter is reported to Child Safety. Services are encouraged to consult with the PCPP regarding possible reports. However, if the report is urgent or it is clear that statutory intervention is required, then the service can contact the relevant RIS immediately and without prior consultation with the PCPP.

**Referral criteria for a case consultation**

When the FaCC, IFS and FWB worker receives information about a family and they are unsure of how best to support the family, a case consultation with the PCPP can be sought. The PCPP will provide advice and information in relation to specific cases with a focus on:

• the suitability of the referral to the FaCC, IFS or FWB service
• whether information indicates a child may be in need of protection and therefore requires a report to Child Safety

• the identification and prioritisation of needs for a child and family

• the safety planning and assessments

• developing engagement strategies when working with a family resistant to engaging

• undertaking a risk assessment.

For a case consultation to occur, the staff member from FaCC, IFS and FWB service will complete Part A of the Principal Child Protection Practitioner Case Consultation form. This section requests the referrer’s and family’s details. FaCC will also attach the FaCC referral form.

It is then the responsibility of the PCPP to complete Part B of the Principal Child Protection Practitioner Case Consultation form following the case consultation process.

Once completed, the form is printed, signed by the FaCC, IFS and FWB staff member, their Team Leader and the PCPP.

The PCPP will retain a copy of the above mentioned forms for the family’s records on RecFind.

**Note:** For record keeping purposes identifying information regarding the family will be recorded on the consultation form, however any information entered onto the PCPP database should be non-identifying.

**Case consultation outcomes**

1. **Report to Child Safety**

When the outcome of the PCPP’s consultation is that a report to Child Safety is appropriate, a report will be made to the appropriate RIS. The reasons why a report to Child Safety would be necessary include:

• the child is already subject to statutory child protection intervention; or

• there is a reasonable suspicion that a child is a child in need of protection due to:

  • an allegation of significant harm or unacceptable risk of significant harm to a child; and

  • the child does not have a parent able and willing to protect them from harm (section 10, Child Protection Act 1999).

The PCPP will advise the FaCC, IFS or FWB service the outcome of the case consultation and the rationale for this decision. The PCPP will ask the FaCC, IFS and FWB to complete a report to the RIS.
The service will complete an on-line report form, and provide the report reference number to the PCPP, who will enter the reference number into the consultation form. It is critical that the reference number is provided to the PCPP, as this action discharges the PCPP's responsibility in reporting the matter to Child Safety.

There may be occasions when the RIS assessment and the PCPP or the FaCC, IFS and FWB worker's views will differ regarding reporting concerns to Child Safety. Under these circumstances and given that the Child Safety intake officer will have consulted with their team leader and applied the Structured Decision Making tools, Child Safety retain the final decision on what actions are to be taken. The Child Safety intake officer will advise the FaCC, IFS and FWB worker and the PCPP of the department's decision on the matter.

**Note:** FaCC, IFS or FWB workers will be recorded as the notifier in Child Safety’s intake forms, and will therefore be afforded protection (section 186, Child Protection Act 1999).

It is possible that there may also be occasions when the PCPP recommends that concerns received warrant a report being made to Child Safety and this view is not shared by the FaCC, IFS or FWB staff member and/or their line manager. In these circumstances, a case consultation should occur with the different rationales discussed in an effort to reach a consensus. If after such discussion the PCPP remains of the view that a report to Child Safety is warranted, it will be the responsibility of the PCPP to complete a report to Child Safety. Discussion should then also occur between the PCPP, the relevant staff member and their line manager (if applicable) in these instances to discuss the rationale for this decision.

### 2. Report to Child Safety not required

If the PCPP assesses that an allegation of significant harm or risk of significant harm to a child does not provide reasonable suspicion that the child is in need of protection (harm in this context refers to any detrimental effect of a significant nature on the child’s physical, psychological or emotional wellbeing) the PCPP will recommend that FaCC, IFS or FWB continues to work/engage with the family. The PCPP is available to provide guidance about the ongoing management of issues regarding safety and risk.

**Child protection history checks**

The PCPP has access to the department’s Integrated Client Management System (ICMS). This enables the PCPP to check on previous child protection history of the family as necessary to support a case consultation decision. The PCPP is to use professional judgment when determining whether a full child protection history check is required or not. It is important to be aware that not all cases will warrant a full child protection history check. If there is sufficient evidence without a child protection history check to determine whether a report to Child Safety is required, a child protection history check will not be undertaken. The PCPP should provide the rationale for whatever action they choose to the worker.

Details to consider when determining a course of action include, but are not limited to:

- the age and vulnerability of the child; and
- indications from FaCC, IFS or FWB service that there may be a history of contact with the statutory system (irrespective of how recent or number of contacts).
It is important to remember that the default position is to advise the FaCC, IFS or FWB service to report to Child Safety if there is information suggesting a child may be in need of protection.

A child protection history check should only be completed as part of a formal case consultation and the PCPP will record the details of the request for a history check and the outcome into the ‘Child Protection History Check’ section in the case consultation form, within the PCPP database.

**Note:** The PCPP database cannot include any identifying information in respect of the family.
Appendix 5 – Collaborative case planning

The Single Case Plan should provide a comprehensive, clear and simple to understand final overview of the family’s strengths, worries and case plan goals after contribution has been sought from the family themselves, other professionals and the case manager.

Role of the case manager/lead professional

The case manager also referred to as the lead professional, has responsibility for ensuring the family or individual family member receives the right mix of services, in the right order and at the right time.

The worker acts as a single point of contact when a range of services are involved with that child or family and an integrated response is required. The lead professional will be well-trusted by the family, able to negotiate access to services and have access to brokerage to support the case plan.

The lead case manager works with families to identify and prioritise their assessed strengths and needs to develop the single case plan, to deliver intensive support interventions and engage families with specialist services within or external to the IFS service, as required.

The lead case manager is responsible for the cycle of assessment, planning, implementation and review of the family’s case plan.

<table>
<thead>
<tr>
<th>The role description of the lead professional is to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• support client engagement upon referral to the service</td>
</tr>
<tr>
<td>• seek informed consent from families to contact other services or practitioners the family is involved with</td>
</tr>
<tr>
<td>• develop an understanding of the primary needs of the family including consistent assessment of risks and needs using Common Assessment Tools determined by the department</td>
</tr>
<tr>
<td>• determine, access or deliver the most appropriate service to provide culturally respectful and competent service delivery for Aboriginal and Torres Strait Islander and culturally and linguistically diverse families</td>
</tr>
<tr>
<td>• support the functioning of individuals and families through individual and/or family support, non-therapeutic counselling and practical support</td>
</tr>
<tr>
<td>• act as a single point of contact for the family assuming responsibility for case management within the IFS</td>
</tr>
<tr>
<td>• advocate, negotiate and assist clients to access other services and maximise opportunity for optimum client participation in service delivery</td>
</tr>
<tr>
<td>• co-ordinate the delivery of actions agreed by relevant practitioners and services involved</td>
</tr>
</tbody>
</table>

Where domestic and family violence is present, the case manager will continually assess and monitor risk in conjunction with the specialist domestic and family violence worker to facilitate the safety and wellbeing of all family members.
Case meetings

Regular stakeholder meetings should be organised by the lead case manager, who may be an IFS worker or from another agency where the family or family member is a client. The IFS worker is expected to participate fully in collaborative case management meetings led by other agencies. All case meetings should be conducted in a location that is family-friendly and deemed appropriate by the family. Family members, and where appropriate, children should be encouraged to attend meetings along with all relevant stakeholders (i.e. other service providers).

Consideration should be given to meeting with children at the beginning or end of the meeting separate to the parents so that sensitive issues for children can be discussed separately. The Circles of Safety and Support Tool is useful in this context.

Meetings should be hosted in a family-friendly manner and be respectful of the issues family and individual members are facing. The issue of consent and family privacy should always be considered and revisited as necessary. The case plan should be available at the meeting and the lead case manager should determine a process to assess progression through the case plan goals, including discussion around any planned or unplanned deviation from the case plan. Decisions from meetings should be recorded and distributed to all stakeholders, updating the case plan. The single case plan does not restrict individual agencies from having a case plan with an individual but ensures that overall support is timely, appropriate and coordinated.

The lead case manager is responsible for ongoing management of the case plan and facilitating regular stakeholder meetings to support the implementation of the plan. Case plans, along with assessments of family functioning will be reviewed at regular intervals in collaboration with the family and key stakeholders. It is expected that case management will continue until all or the majority of support needs have been met.

Recording a case plan

The single case plan should be recorded in a format which is easy to understand and meets the family’s requirements. Generally, the overarching case plan will be shared amongst relevant service providers with the consent of the family.

Once established the case plan should be continuously monitored and adjusted accordingly.

Case Closure

If the IFS worker is the lead case manager, the closure assessments are completed as usual to determine changes to the family’s safety and wellbeing. If a worker from another agency is the lead case manager for the case and an IFS worker is also involved, the closure assessment is completed together. This is an opportunity to reflect on the effectiveness of the collaborative case management approach and to identify learnings for future joint work. This assessment of whether all or the majority of needs are met and changes in wellbeing domains are recorded in ARC and contributes towards outcome targets. The SDM tools and FAST are completed outside of ARC until these tools can be integrated into the system.
Transferring active Family cases between IFS services:

When a family receiving an IFS service is relocating to another catchment where an IFS service is available the following transfer process applies:

1. Discuss with the family if they wish to work with another IFS service when they move to their new location.

2. If the family wishes to work with the new service, gain consent to speak to the appropriate service.

3. Contact the service, by phone to discuss the family’s situation and timeframes for transfer. (Follow up with emails as appropriate)

4. A four week period is allocated for case transfer, during which time the current service commits to continue working with the family until the new service allocates a worker. (This may depend on when the family is actually moving and extended or shorter timeframes can be negotiated.)

5. The transferring family is prioritised by the new service, not added to a waiting list.

6. It is best practice for a warm handover meeting to occur where appropriate introductions take place and a verbal interaction between parties that will assist to pass not only the knowledge regarding a family but also the relationship and trust from service to service. Families may appreciate participating in a handover meeting where appropriate.

7. Contact should be made with other key stakeholders who have collaborated in the case management and single case plan. Where appropriate, they may also be included in a warm handover with the family.

8. A referral is made through ARC or email (if required) to the new service. Minimum requirements for transfer of information include the most recent assessments and the current case plan.

9. Once the electronic referral is accepted by the new service, the case is closed in the original service’s ARC system.
Appendix 6 – Brokerage Funding Guidelines

Purpose

Brokerage funding purchases additional support, services and/or resources for a client that is unable to be provided by the lead agency. Brokerage funding can only be used for clients who provide their consent to engage with the service and have a case plan. Brokerage funding is intended to be used only when publicly provided or funded services are not available and must be linked to the case plan.

Brokerage funding should assist families to sustain their role as carers. It is used to purchase services which:

- Assist family engagement, particularly for Aboriginal and/or Torres Strait Islanders and culturally and linguistically diverse families
- Reduce immediate risk or increase protective factors for children
- Support and sustain a family unit
- Enhance a family’s quality of family life
- Help maintain family relationships

Principles

The use of brokerage by Intensive Family Support (IFS) services and Family and Child Connect (FaCC) is guided by five principles:

1. **Client focused**

   Brokerage support is responsive to and driven by the needs collaboratively identified with the client, and is respectful of the rights, dignity and confidentiality of the client.

2. **Responds to identified needs and case plan goals**

   Brokerage funds can be administered for the purchase of goods, services or activities that respond to an immediate identified need to reduce risk or increase protective factors that impact on the safety and wellbeing of children and their families.

   Once a full case plan is developed brokerage funds can be used where necessary for the purchase of goods, services or activities directly linked to achieving client outcomes and completion of client case plans.

3. **Flexibility**

   The use of brokerage is driven by choice and flexibility in services and can be applied at any point during the client’s contact with the service.
4. **Avoid duplication of service provision**

Brokerage funds are used to purchase goods, services or activities only when existing services, supports or resources cannot meet the identified needs of the client or are not accessible.

5. **Value for money**

Interventions purchased with brokerage funds are to be as cost effective as possible. When deciding to commit brokerage funds, consideration is given as to whether the intended expenditure is the best use of resources to meet identified client outcomes.

**Eligibility and Priority**

Brokerage funds are available for individual clients according to their need for additional support, services and/or resources. The spending of brokerage funds must be clearly linked to a family’s identified needs or case plan.

Wherever possible parents and carers should be encouraged to prioritise and take responsibility for costs relating to their children and brokerage used to assist with other expenses.

Brokerage funding can be pooled to provide services for a number of families, where the same need is identified for a number of clients.

**Note:** There is no cap on the amount of brokerage funding any one family may receive; services are expected to prioritise families and their needs in an equitable and sustainable manner.

**Types of Expenditure**

Brokerage funds should purchase supports, services and resources on a short-term or episodic basis.

Examples of support covered by brokerage:

- Purchase of goods or services to address safety in the home or the safety of individuals. *For example: to access materials and trades people to repair doors/locks/fencing in order to keep the home environment safe for toddlers and young children.*

- Purchase of white goods. *For example: the purchase of a washing machine to ensure the family’s clothes and bedding can be regularly laundered.*

- Purchasing direct support services. *For example: to assist services to respond to the identified needs of Aboriginal and/or Torres Strait Islander/Culturally and Linguistically Diverse families and/or assist Aboriginal and/or Torres Strait Islander/ Culturally and Linguistically Diverse families access to mainstream services by purchasing interpreter services not available through the Telephone Interpreter Services.*

- Timely access to initial dental, health and speech therapy assessments and treatment. *For example: access to initial assessment by private practitioner to expedite entry into*
the public health system or specialist health services where public services are not available in the locality to meet specific needs of a client.

- Mental health assessments. For example: access to assessment by private practitioner for diagnosis and referral for diagnosed services in the public health system.

- Accommodation/personal expenses. For example: one off payment in times of financial crisis or to escape domestic and family violence.

- School/education expenses and supplies. For example: parents are not sending child/ren to school and it is identified that they cannot meet the financial costs of uniforms, books and general stationery items required.

- The purchase of household items (explore options of local charity groups in the first instance). For example: one off payment for essential items (such as bed and bed linen) to “set up” in new accommodation.

- House cleaning. For example: one off payment for cleaning and removal of excess rubbish for a family living in cluttered, unhygienic/unsanitary conditions and the service case plan is to work with the family to teach them general household living skills.

- Respite care. For example: referred child has a diagnosed disability and it is identified by the service that respite care would assist the family’s coping strategies.

- Child Care. For example: while the parent(s) of the referred child is attending a parenting course or counselling sessions for a six week period, brokerage funding is used to meet the cost of ordinary child care.

Service Gaps

Brokerage funds are frequently used to respond to gaps in the amount or quality of existing programs because:

- there is a gap between the demand for, and supply of, core community programs
- existing programs may be unable to provide a sufficient amount of support
- existing programs may have waiting lists of people needing a specific form of support and/or a time delay before assistance can be provided
- the type of support needed is not readily available
- existing programs may not be able to provide the necessary service quality or responsiveness

Limits on Expenditure

The amount of funds allocated to brokerage from the service budget must be negotiated and clearly recorded in the service agreement with the department. Up to $5,000 per $100,000 per annum (or 5% of total grant funding) is considered an eligible cost.

Brokerage is not to be the first or only service provided to clients with the exception of responding to immediate risk factors for children and their families.
Brokerage funds are only to be provided in the context of clients’ identified needs and case plans. Case plans must demonstrate the use of brokerage as part of a range of strategies to support the client to address identified needs and achieve goals which lead to case closure.

Prior to using brokerage funds to purchase a support, service or resource, alternative sources that may be less expensive or free should be explored. If an appropriate service is available and able to meet their needs, then clients should be referred to that service.

Family Support services are expected to quarantine brokerage funds from administration and organisational costs and cover the cost of administering brokerage funds within the general administrative costs of the service.

Brokerage funds are not to be used to reimburse a worker already employed within the service.

Brokerage funds are not to be used for any other funded initiative or service type provided by the organisation.

Supports, services and resources which are more ongoing in nature do not fall within the parameters of Family Support brokerage. Brokerage funds are provided for one off payments of goods or services and may not be used for the employment of staff or the subcontracting of services that form part of the existing service agreement with the department to another organisation or agency.

**Accountability**

The IFS services are required to:

- Ensure that brokerage funds provided by the department are used in accordance with these guidelines

- Record data about the use of brokerage as part of the client’s records and in the Advice, Referral and Case management ARC system.

- Develop a policy and procedures for managing demand for brokerage, including clear eligibility requirements and assessment processes based on the principles outlined in these guidelines.
Appendix 7 – Working with Families subject to an Intervention with Parental Agreement

Background

In May 2017 some changes were introduced to the Families Investment Specifications with the intent of ensuring families transitioning from a secondary, to a tertiary intervention service are well supported while referral activities are considered and finalised.

In addition to strengthening warm handovers between secondary and tertiary services, the changes will mean that early intervention providers, specifically Intensive Family Support (IFS) services, can in certain circumstances, and in consultation with the Principal Child Protection Practitioner (PCPP), continue to work with a family requiring ongoing statutory intervention.

The changes include:

- If the outcome of a Child Safety investigation results in an Intervention with Parental Agreement (IPA), it may be appropriate for the IFS to continue working with the family where there is a strong therapeutic relationship in place.

- In this case the IFS service’s role as case manager will cease and be transferred to Child Safety.

- A warm transfer will occur from the IFS service to a Tertiary Family Support service at the earliest opportunity.

Principles

The following principles should be considered during the transition phase and to determine the exceptional circumstances when IFS continues to work with the family on an IPA:

- Families requiring an IPA are the highest risk families for Child Safety as they are assessed as being a child in need of protection and yet the child remains at home with the family during the intervention. Tertiary Family Support services are funded to deliver these specialist services.

- IFS interventions in IPA cases should be time limited until an appropriate tertiary service is identified and a warm handover has been successfully achieved.

- The PCPP must be consulted in all cases where an IFS intervention in an IPA case is being considered.

- The Family Group Meeting (FGM) is potentially an ideal opportunity for families to transition to their new service provider and therefore should be considered as an appropriate transitional platform.

- If there are exceptional circumstances when an IFS service should continue working with a family after the FGM due to the strength of the therapeutic relationship or other similar factors, interventions must be focused on achieving case plan goals.

- After consultation with all parties, the IFS service makes the final determination as to whether they continue working with the family once the family is on an IPA.

- IPA arrangements will be subject to review every three months or more frequently, by the case manager, to ensure progress is being made.
**Process**

If a family already working with the IFS becomes subject to an IPA, the following steps should apply:

1. If Child Safety believe it would be helpful for the family to stay engaged with the IFS until a more appropriate service can be identified, following discussion with the PCPP, a request should be made in writing (such as an email), to the IFS service manager. This request should contain a rationale with supporting information, including details of the most recent notification, brief details of the assessment which has led to the IPA decision, child protection history, the immediate safety plan, a tentative date for the FGM, and the reasons why Child Safety would like continued IFS involvement.

2. In determining its response, the IFS should consider the family’s engagement to date, their willingness to work with the IFS staff and specialist agencies, and the progress achieved on the goals identified in the IFS family case plan. Consideration should also be given to the issues that led to the IPA decision by Child Safety. In consultation with the PCPP the IFS should review the IFS case plan to date assessing the information from Child Safety, including ICMS history. The PCPP can offer advice on the potential risks and benefits of the family continuing to work with the IFS until a tertiary support service is identified. At this stage, telephone conversations, email correspondence or a meeting could occur to discuss with Child Safety potential worries, gaps in information, recent events since the assessment or any other issues. Possible case plan goals (yet to be developed with the family in the FGM), and potential work agreements are to be discussed to ensure there is agreement on service provision and timeframes for involvement, prior to meeting jointly with the family.

3. The IFS then makes a determination on the appropriateness of the family continuing with the service and advises Child Safety. As a record for both parties this advice should be a documented reply (email is sufficient) to the original request from Child Safety which outlines the possible case plan goals to be discussed with the family in the FGM and timeframes for joint work (keeping in mind that case plan goals are determined in a FGM with the family and their supports and representatives so some flexibility may be required).

4. The IFS should advise the Regional Contract Manager by email of the request and their determination with a brief non-identifying rationale. The Child Safety Officer and/or Team Leader should be copied into this email. The Contract Manager will provide that advice to the Child and Family Commissioning Team for their information.

5. Where the IFS determines it is not appropriate for the family to continue, the case will be closed.

6. Where the IFS determines it is appropriate for the family to continue working with the service, Child Safety should arrange a meeting with the family and the IFS. The goal of this meeting should be to discuss with the family the plan for Child Safety and the IFS to work in parallel until a handover can occur with an appropriate tertiary support service. It should be made clear to the family that Child Safety is now the lead case managers for the family and IFS will work hand in hand with them, and inform Child Safety of any changes in circumstance for the family or any safety concerns for their children during this time. A family may have some ideas about how to work together during this period or may even prefer not to work with the IFS under these circumstances.
7. The IFS will close the current case under early exit Transitioning to IPA. Child Safety will refer the family under the referral type IPA Open (negotiated) - this is a new referral type in the ARC database. The IFS will open the referral as a new case for the family.

8. Child Safety is the lead case manager for an IPA and the IFS will work with the family on the case plan goals determined in the FGM with the family and Child Safety. This could also be a time that the family and IFS may wish to share the Single Case Plan developed with the family.

9. While the IFS is working with the family, Child Safety will continue to meet all of its responsibilities for an IPA, including contacts with the family, sighting children and contacting supports, e.g. schools. Some of these contacts may occur jointly with the IFS if both parties agree to this approach.

10. The IFS is required to provide Child Safety with information about the family’s engagement and progress on the Child Safety case plan goals.

11. A Family Group Meeting (FGM) should be arranged by Child Safety as soon as is practicable and ideally include the IFS.

12. The FGM should determine the most appropriate tertiary service to work with the family and a plan for transitioning the family from IFS to that service.

13. In exceptional circumstances, the IFS may be identified as the most appropriate service to continue working with the family. The IFS may choose to review the case (processes 2 and 3) before making a determination on continuing to work with the family. In these cases the IFS needs to advise the Regional Contract Manager and provide that same advice to the Child and Family Commissioning team.

14. When the IFS closes the IPA case, they should advise the Contract Manager who will provide that advice to the Child and Family Commissioning team.
Appendix 8 – Information sharing by Intensive Family Support Services

Information sharing with and without consent

Gaining a family’s consent to share information is best practice and will facilitate a positive working relationship with the family.

The informed consent of families is integral to the IFS service model operating within the child protection and family support system. The participation and active engagement of children and families are also key foundations of the Strengthening Families Protecting Children Framework for Practice implemented by Child Safety.

For consent to be informed and for people to fully participate in decision making, they should be given enough information to make the decision and should understand what they agreeing to. When seeking and obtaining consent, potential barriers to informed consent, such as disability, mental illness, age, culture or language should be identified and managed.

Seeking consent for sharing information underpins the development of engagement and a positive working relationship with a family.

When IFS services commence working with children and their families, they should inform them that their personal information may be given to other organisations in certain circumstances. People should also be informed when their information has been shared and the reasons it has been shared, unless doing so would create risks to them, the child or others.

Children and young people should be given the opportunity and supported to participate in decision making process relating to information sharing and have their views considered. The level of engagement of children in these processes needs to be based on their age, developmental stage and any particular needs.

When working with Aboriginal and Torres Strait Islander children and families, effective engagement needs to take into account the cultural and historical factors that have led to entrenched disadvantage and vulnerability within this community. Aboriginal and Torres Strait Islanders people should be supported and empowered to participate in decision making processes.

Care also needs to be taken to respond to any cultural and language barriers to the participation and understanding of families from Culturally and Linguistically Diverse backgrounds.

It is not always safe, possible or practical to seek and obtain consent. Requiring consent can at times, prevent or delay a service engaging with a family and prevent the effective coordination of services where multiple services are involved. Professionals need to be able to share information about a child or their family so help and support is provided in a timely way to enable families to meet the protection and care needs of children.

Chapter 5A, Part 4 of the Child Protection Act 1999 allows information to be shared without consent between entities. The sections enable broad information sharing about children and unborn children, where they may be at risk after they are born.

Section 159M defines the entities which can share information include Child Safety, prescribed entities (which includes specialist service providers) and service providers.
A key principle of the information sharing provisions is to obtain consent if it is possible, practical and safe to do so. It is best practice to seek a child or parent’s consent to share their personal information. However, consent is not legally required to share information under the provisions.

Entities are allowed to share information relating to unborn children without the consent of the pregnant woman for specific purposes. Prescribed entities and service providers may share information with each other to decide whether to inform Child Safety about concerns relating to an unborn child after birth. They can also give information to Child Safety to enable Child Safety to investigate whether an unborn child will need protection after birth.

Child Safety can also give information to entities to help them decide whether or what information to give to Child Safety. Information may also be shared to enable Child Safety to offer help and support to be offered to a pregnant woman.

The department has developed information sharing guidelines which are available here https://www.csyw.qld.gov.au/about-us/partners/child-family/information-sharing