

Addendum: Performance framework for Intensive Family Support

Supplementary guide to the *Performance
Framework for funded service providers*

November 2024

Overview

The *Performance framework for funded service providers* (the performance framework) sets out the broader framework through which the Department of Children, Youth Justice and Multicultural Affairs (the department) monitors and assesses all the department's outsourced service delivery contracts.

The performance framework operates across a spectrum that includes:

- measuring and monitoring performance
- developing collaborative relationships within a framework of risk management
- ensuring obligatory compliance
- and sharing learnings from high performing services

The framework promotes collaboration within a contract management relationship that encourages, recognises and promotes high performance by providers across the social services system. It involves a performance assessment approach that enables performance issues to be identified quickly and addressed before they become performance failures.

The *Addendum: Performance framework for Intensive Family Support* is intended to supplement the broader framework because Intensive Family Support (IFS) is the first service type to transition to an outcomes-focused performance framework (from 1 July 2022). This means performance assessments focus more on outcomes achieved through service delivery rather than on reported outputs, namely the total hours of support and the number of supported families.¹

IFS services are suitable for an outcomes-focused performance framework because:

- services are well-established
- the service model is robust, underpinned by a strong evidence base
- Advice, Referrals and Case Management (ARC) data provides significant insight into service operations such as the number of referrals, the proportion of in-scope families, consent rates and case plan outcomes
- the FAST (Family Assessment Summary Tool) was introduced in ARC from July 2019 and, as a co-designed assessment tool, supports workers to consistently identify priority areas and develop case plan goals to achieve long term safety and wellbeing for children and families²

Research and the experience of other Australian jurisdictions suggests a more balanced assessment of performance is realised by a greater focus on client outcomes, rather than outputs in isolation. This addendum provides guidance regarding how key performance indicators can be measured in future IFS contractual arrangements to determine whether:

- performance is currently on target
- performance is below target but is within the agreed tolerance range
- performance is below target and is outside the agreed tolerance range

¹ Additional questions about the IFS performance framework can be addressed to the Children, Youth and Families Team: childandfamilycommissioning@cyjma.qld.gov.au

² The initial FAST, when followed by periodic reassessment, assists family members, support workers, and their supervisors to assess changes in family functioning and assess the impacts of their work together.

Requirements

Performance elements

The performance elements outlined in the performance framework equally apply to all organisations funded to deliver IFS services. This allows for a comprehensive and holistic assessment, namely:

- accreditation against relevant quality standards and frameworks
- general service agreement delivery
- delivery against contracted performance measures/outcome indicators
- compliance with relevant regulatory, policy or procedural requirements
- financial management
- ongoing or emerging performance risks

Contract management support level

The department recognises that IFS providers generally carry a moderate level of risk due to assumptions regarding:

- vulnerability of clients using the service
- sensitivity of the issues being addressed
- higher than average funding levels

For this reason, a **medium** level of Service Contract Management (SCM) support is the initial assessment point for IFS.³ The final determination will vary depending on:

- each provider's individual circumstances – effectiveness of internal governance arrangements, prior performance, and overall maturity
- changes over time in response to program level developments
- emerging risks and issues, and a provider's performance track record

This means SCM meetings will generally occur six-monthly, although providers with sustained performance at higher levels may have less frequent meetings and vice-versa.⁴

Performance and outcome measures

Performance measures

To determine whether high-level objectives set out in service agreements are being delivered, IFS performance targets and thresholds have traditionally relied upon an outputs-focused approach. To date, primary deliverables have included a specified quantity of both case management hours and the number of service users (families) receiving support on a per annum basis.⁵ Detailed ARC performance reports also provide additional data to make an informed assessment.

From 1 July 2022, the primary deliverable for IFS contracts will be an outcome measure –

- OM4.1.01: Number of Service Users with cases closed with all or majority of case plan goals achieved.

³ See Appendix 1 in *Performance framework for funded service providers* for further detail.

⁴ Such as annual or quarterly meetings, respectively.

⁵ A performance target threshold of $\pm 10\%$ is often used for family support services.

This outcome measure is expressed as a proportion of the number of families who can be *potentially* supported.⁶ The number of potentially supported families will form the basis of a new target in the contracts. Downstream targets for consenting in-scope referrals and all/majority case plan goals achieved are set as a percentage of this new target.

The new IFS contracts will be structured around the following three targets:

- The new target number of families measure – *potential* support cases – represents **61-62%** of the total number of closed referrals (IS145) on average and is captured as a throughput measure:
 - IS245: Number of in-scope Service Users eligible to receive a service who have exited from the service
- The new target of consenting in-scope referrals – families that have *engaged* – is set at **75%** of the total number of potential support cases and is captured as a throughput measure:
 - IS134: Number of Service Users engaged
- The new outcome deliverable – families with all/majority of their case plan goals achieved – is set at **40%** of the target number of families measure (rather than as a percentage of consenting cases):⁷
 - OM4.1.01: Number of Service Users with cases closed with all or majority of case plan goals achieved
 - the associated unit price is the per annum funding divided by the target quantity
 - this replaces the existing A01.2.02 Case management deliverables (specified hours and number of service users per annum)

For each measure above, performance is assessed to identify whether the provider is meeting the stated targets and a rating is allocated using the performance thresholds set out in Figure 3 of the performance framework.⁸

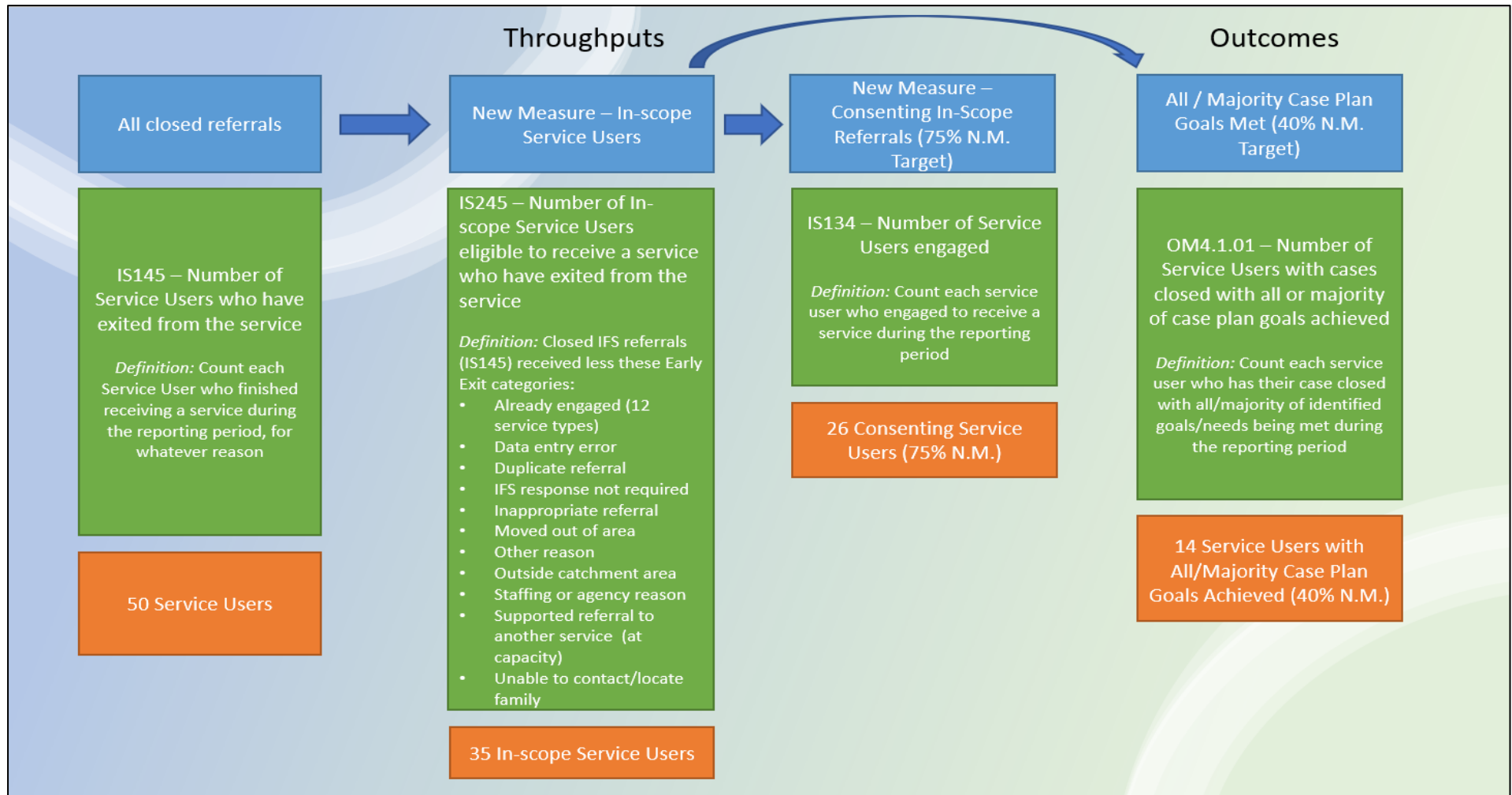
Application of the performance framework to IFS services is summarised in Figure 1 below with example service user figures.


⁶ The new target measure was derived from four years' worth of IFS data (2017-18 to 2020-21). It represents cases that are in-scope to receive a service; several early exit categories are removed since there is no prospect of a case ever being initiated.

⁷ This avoids creating an incentive to cherry-pick cases that may be easier to engage. If the total is only cases who consent, services could be discouraged from working as actively with families who are hard to reach and difficult to engage, but also eligible for an IFS response.

⁸ Namely: "Performing" – performance is currently on target; "Performance Flag" – performance is below target but is within the agreed tolerance range; and "Not performing" – performance is below target and is outside the agreed tolerance range.

Figure 1: IFS performance framework overview





IFS performance data will continue to be collated for the entire client group, and for First Nations peoples. Performance against targets for IFS services can fluctuate significantly across reporting periods, particularly where client numbers are relatively small. As confirmed by IFS evaluations, family support cases have a long duration on average:

- family interventions last a minimum of 6 - 9 months
- a majority of interventions last between 7 - 12 months
- 15 per cent of interventions last longer than 12 months

Contract managers should therefore consider IFS performance against targets across a period of 12 months, rather than reacting to a change in performance evident within a single period. A decline in performance in a single reporting period may trigger a watching brief to assess whether the change is sustained.

Underperformance should trigger an analysis of the cause, scale and time period, and if intervention should be considered. The level of performance concern is determined by the particular indicator, the seriousness of the issue, the speed with which the situation could deteriorate further, and the time it would take to achieve turnaround. The various measures included in the IFS service agreement should be considered as a whole, rather than in isolation.

Performance measures guide

Administering outcome focussed contracts requires a more considered approach to performance assessment than a contract based on outputs. As a guide, the contract manager may need to consider the following factors:

- The number of in-scope Service Users who have exited from the service (IS245) may be influenced by referral pathways in the catchment and other dynamics, leading to a lower or higher total number of closed referrals (IS145). In some instances, exit from the service may be delayed while the IFS seeks to identify an appropriate step-down service.
- The number of Service Users engaged (IS134) can be affected by the predominant referrer source. For example, consent rates for Police and Child Safety – RIS referrals are particularly low, so a service receiving many referrals from those sources is likely to have a relatively low consent rate (see *Appendix 1: Factors influencing suggested tolerance levels for IFS services*).
- A more generous performance threshold (>10 per cent) may be warranted for some service outlets, particularly against OM4.1.01: Number of Service Users with case closed with all or majority of case plan goals achieved. For example, cases created following referrals from Child Safety – CSSC, Child Safety – RIS, and Police have a lower rate of closure with all or the majority of case plan goals achieved than other categories (see Appendix 1).
- Tolerance adjustments should consider:
 - reports of average case complexity – multiple and serious presenting concerns reduce the likelihood of successful interventions
 - the size of the catchment – extra travel time may be necessary in regional and remote locations, leading to a longer-than-average intervention period and reduced throughput
 - referrer source (see above)
 - staffing impacts and other local circumstances
- In contract management discussions, the number of hours provided during the reporting period (A01.2.02HH) can continue to be discussed as a throughput measure, although a stipulated per annum target is no longer recorded.
- Further indications of performance might be demonstrated by the following throughput measures:

- IS201: Number of referrals received during the reporting period
- IS132: Number of Service Users with cases commenced during the reporting period
- IS133: Number of existing Service Users at the beginning of the reporting period

Greatly exceeding targets on some measures may indicate the service is not being delivered as the department intended. For example, an excessive number of families regularly exiting the service may suggest that the level of support provided to each family is insufficient to adequately address identified case plan goals.⁹ Contract managers should review these measures in conjunction with the outcome measure (all/majority case plan goals achieved) to determine if the level of performance is appropriate.

Outcome indicators

Outcome indicators provide insight into the impact and effectiveness of services. They are designed to encourage a focus on the value of services being provided, not just the volume. Due to the adoption of the new life course outcome deliverable focused on all/majority of case plan goals achieved, the following IFS outcomes measures are removed from all contracts from 1 July 2022:

- OM2.1.08: Number of Service Users with improved life skills
- OM2.1.01: Number of Service Users that have shown improvements in being safe and/or protected from harm

For the OM4.1.01 outcome indicator, performance is assessed to identify whether the provider is meeting the target and a rating is allocated using the performance thresholds set out in Figure 1.

Operation of the Performance Framework for IFS

Assessing performance and risk

Assessment steps

The performance framework section 6.4 provides detailed information on assessment steps. The material below is focused on factors relevant to IFS providers.

Step 1 – Identify performance risk

Firstly, performance issues, inherent vulnerabilities and emerging performance concerns should be identified by using quantitative and qualitative data from a variety of sources to provide a robust understanding of a provider's performance risks and issues. In the case of IFS providers, this may include:

- relevant P2i reports such as the RN05 – Performance Responses, RN07 – Service Outlet Status Report, and RN09 – Reporting Compliance
- ARC performance report
- ARC contract report¹⁰

If IFS is being considered at the organisational level, the contract manager would collate performance data from across all funded IFS service outlets, noting any geographic or regional trends. Contact can be made with the Children, Youth and Families team in Investment and Commissioning, to see if any datasets already exist for the relevant period.

This information is used to build an understanding of risk in relation to three performance categories:

⁹ This is not necessarily the case if certain IFS locations have families presenting with a lower-than-average level of complexity.

¹⁰ Upcoming ARC changes will rename the existing ARC OASIS report to ARC contract report.

1. Performance measures and outcomes

A particular focus on the following measures is useful to inform performance risk.

Primary measures

- IS145: Number of Service Users who have exited from the service during the reporting period
- IS245: Number of in-scope Service Users eligible to receive a service who have exited from the service
- IS134: Number of Service Users engaged
- OM4.1.01: Number of Service Users with cases closed with all or majority of case plan goals achieved

Secondary measures

- A01.2.02HH: Number of hours provided during the reporting period
- IS132: Number of Service Users with cases commenced during the reporting period
- IS133: Number of existing Service Users at the beginning of the reporting period
- IS201: Number of referrals received during the reporting period

2. Underlying risk factors

A range of factors can impact on the ability of an IFS provider to deliver high-quality outcomes for service users; for further detail see *Appendix 2: Risk factors for IFS services*.

While some areas of underlying performance risk may not be in the direct control of the provider – for example, the size of the local recruitment pool for qualified staff or availability of step-down services – they must still be acknowledged in the performance risk assessment. This ensures providers are managing concerns where possible and there is a shared understanding of the impact of these concerns.

The contract manager may request a provider to take reasonable steps to attempt to mitigate the impact of these factors, e.g. adopting different recruitment approaches or trialling different delivery approaches.¹¹ If the IFS provider has taken reasonable steps to mitigate these factors but they continue to impact on the viability of the service, contract managers should discuss with Investment and Commissioning whether a different approach may be more appropriate in that particular setting.

It should be stressed that these factors may contribute to performance *risk*, but do not on their own constitute poor performance.

3. Third party reports and other intelligence

From time to time the contract manager will become aware of performance issues or risks through third parties, including Child Safety Service Centres, Human Service Quality Framework (HSQF) audits, other funding bodies, government departments or verified complaints. Sometimes client feedback may identify potential service improvements.

Alternatively, program evaluations, independent reviews or commissions of inquiry may identify aspects of a service model that require reform to deliver improved outcomes for service users.

¹¹ For example, the [Intensive Family Support: Service Model and Guidelines](#) section 3.2 Staffing notes that preferred candidates for vacant IFS positions who do not have the relevant qualification can still be employed with the permission of the Children, Youth and Families Team.

Step 2 – Analyse performance

For further detail on key questions that can help inform the assessment of IFS performance, see: *Appendix 3: IFS performance assessment*.

A risk rating is determined for each performance category

Analysis is undertaken for each of the three performance input categories – performance measures and outcomes, underlying risk factors, and third-party reports/other intelligence – to determine a risk rating for each performance category.

Determining a rating for performance measures

Higher risk ratings are assigned where a larger proportion of the performance measures are not met and are declining.

As noted above, performance against some targets can fluctuate significantly across reporting periods, particularly where client numbers are relatively small. This will be particularly true of outcome indicators. Since IFS cases have a long duration lasting a minimum of six to nine months, contract managers should consider performance across multiple reporting periods, rather than reacting to a change in performance evident within a single period. A decline in performance in a single reporting period may trigger a watching brief to assess whether the change is sustained.

A lower level of performance in a single reporting period may reflect the complexity of a particular group of clients, rather than the quality of the support offered by the IFS provider. For this reason, it is critical for contract managers to consider both the performance against the target in that reporting period and the longer-term trend in performance in assigning a risk rating.

In determining a rating, greater weight should be given to primary IFS performance measures, namely:¹²

- IS134: Number of Service Users engaged (set at 75% of the total number of potential support cases)
- OM4.1.01: Number of Service Users with cases closed with all or majority of case plan goals achieved (set at 40% of the target number of in-scope Service Users)

Step 3 – Assess monitoring, support and intervention level

The framework includes four levels of monitoring, support and intervention:


- Superior
- Standard
- Performance support
- Intensive monitoring and support

Refer to section 6.4.3 *Assessing overall performance* in the performance framework for further guidance in making this assessment.

Step 4 – Addressing performance concerns

Once performance flags have been raised and overall monitoring level determined, the provider and the contract manager jointly develop a performance improvement plan. Refer to section 6.4.3 *Assessing overall performance* in the performance framework for further details on how to resolve performance concerns.

¹² IS245: Number of in-scope Service Users eligible to receive a service who have exited from the service is excluded when determining a rating, because it is outside the control of the service.



Once the overall performance assessment is completed, the suggested monitoring level is then matched to the recommended level of contract management support to identify the suggested frequency for SCM meetings; see section 6.4.4 *Determining meeting frequency* in the performance framework for further information.

Appendix 1: Factors influencing suggested tolerance levels for IFS services

Contract officers may modify suggested tolerance levels based on assumptions regarding:

- case complexity
- primary referrer source
- average length of intervention
- regional/geographical variables

The following state-wide IFS data for 2023-24 provides some guidance, although these factors may change over time in response to program level or other developments.

Case complexity

It is likely that CSSC, RIS and Police referrals will generally be more complex in nature than referrals from other sources, with multiple presenting concerns.¹³

Consent

Consent patterns differ greatly depending on the referrer source:

- The highest consent rate is for self-referrals (94.7%).
- High consent rates result from FaCC (84.2%), other prescribed entities referrals (84.7%)¹⁴ and other non-prescribed entities (78.9%).¹⁵
- Moderate consent rates result from Health (70.2%), Education (64.7%) and CSSC (63.3%) referrals.
- Lower consent rates result from Police referrals (59.5%) and Child Safety RIS referrals (53.3%).

All/majority case plan goals achieved

The proportion of in-scope referrals that have all/majority of case plan goals achieved differs significantly depending upon the referrer source. In descending order:

- Self-referrals (70.1%)
- FaCC (61.8%)
- Other non-prescribed entities (58.0%)
- Police (56.8%)
- Other prescribed entities (55.2%)
- Health (45.7%)
- Education (41.8%)
- Child Safety – CSSC (37.3%)
- Child Safety – RIS (36.1%)

Average length of intervention

The state-wide average and median number of days to close a case – 257 days (8.4 months) and 241 days (7.9 months), respectively – aligns with the IFS Service Model and

¹³ Families engaged with IFS have on average eight major presenting needs and risks which are associated with increased risk of child abuse or neglect.

¹⁴ Other prescribed entities include: Corrective Services, Disability Service, Housing Service, Family Wellbeing Services, Assessment and Service Connect, and Intensive Family Support.

¹⁵ Other non-prescribed entities include: Early Childhood Education and Care Professional, Domestic and Family Violence Service, Community/Friend/Family, Other - Government, Other - Non-Government, Elders, Educational/Employment Service, Housing/Homelessness Service, Mental Health Service, Neighbourhood Centre, Psychologist and Counsellor, Sexual Assault/Abuse and Trauma Service, and Youth Service.

Guidelines that state it is anticipated that families will generally engage for a period of up to nine months.¹⁶

IFS evaluation recommendations explicitly note families are engaged for longer if:¹⁷

- they present with more complex needs
- more time is needed for building trust with IFS services – often a concern for Aboriginal and/or Torres Strait Islander families
- in smaller regional communities due to:
 - a lack of support services in these areas, requiring more in-house support from IFS staff
 - the time devoted to travel instead of face-to-face service delivery
 - a lack of step-down services to refer families to after they leave IFS

One consequence of cases with a longer duration, especially in regional locations, is that fewer families will be seen by IFS staff per equivalent full-time position (FTE), and IFS staff in these areas often need to have smaller caseloads as a result.¹⁸

¹⁶ Note that families with less-complex needs are expected to engage for around six months. Some families may also require an intervention longer than nine months; in some complex cases families may engage for 12-18 months, particularly when there is limited access to support services.

¹⁷ Queensland Intensive Family Support Services Evaluation: Implementation Evaluation Report (2018).

¹⁸ IFS managers have noted in some areas that IFS staff caseloads had to be reduced to 6-7 families (from an average of 13-15 families in most other regions) to allow for additional travel time and extra in-house IFS support where specialist services are not available in the community.

Appendix 2: Risk factors for IFS services

Workforce availability, capacity and capability

- IFS providers in rural/remote locations may have difficulty in maintaining a full staffing complement or recruiting staff with the appropriate skills and experience.¹⁹
- Smaller IFS services, particularly in regional areas, are not always able to implement the specialist Domestic and Family Violence (DFV) practitioner requirement and/or the practitioners sometimes carry general case management work.²⁰
- During periods of staff turnover, staff vacancies, sickness, high workloads, or other program issues affecting the capacity to allocate new families, the team leader or other senior officer often holds cases in the initial assessment stage to meet immediate needs.
- If the IFS workforce is not fully trained, skilled, and experienced, they may be less likely to build strong relationships with families and provide effective case management to address case plan goals.
- Some larger IFS sites have additional, in-house, multi-disciplinary teams including specialist staff who contribute to service delivery and staff development.
- Some IFS providers will have more internal capacity to risk manage employment by increasing their FTE establishment beyond their funding footprint. For example: engaging locums, increasing part time hours to full time for a period etc. to manage staff leave, absences, or turnover.

Ability to respond to service user needs

- A high referral volume and waitlists are common for IFS services and the practice of 'active holding' takes significant resources away from active case management until a warm handover has occurred with a family support practitioner.²¹
- Differences exist between locations regarding the management of referrals and how service delivery is administered as a sector, including FaCC, IFS and FWS.
- A less diverse/smaller service system can lead to longer IFS interventions due to a lack of collaborative case management and step-down/specialist services to refer families to at case closure.
- Brokerage funding can be exhausted quickly in areas without specialists and step-down services.
- Meeting the regular support needs of families is more difficult in geographically dispersed areas.²²
- Referral patterns may lead to a greater proportion of families with a higher/more complex risk profile.²³

Leadership - clinical, professional, and other

- An effective leadership structure is critical for a well-functioning service, particularly when working with families who have multiple and complex needs and who are at risk of involvement in the child protection system.

¹⁹ The [Intensive Family Support: Service Model and Guidelines](#) allows for staff to be employed who have a mix of qualifications, cultural connections and knowledge of the local area, skills and life experience.

²⁰ DFV staffing vacancies can also lead to less effective service responses to addressed identified concerns.

²¹ Active holding usually involves weekly or fortnightly contact (via phone, text, or email) to check in on a family's safety and wellbeing, as well as any changes to their circumstances (re-assessing the key concerns/support needs), updating internal risk assessment tools and ascertaining if families wish to remain on the waitlist.

²² The implication is there should be reduced expectations around the possible caseloads held by workers and associated outputs/outcomes. Evaluations suggest caseloads in some regional and rural areas may need to be halved i.e. 7-10 maximum per IFS worker.

²³ In some locations, IFS referrals from Child Safety – RIS are reported to be very high risk.

- Positive leadership and the availability of coaching, mentoring, supervision, and ongoing professional learning for workers is essential for supporting IFS staff.

Rapidity of organisational growth or change

- Recruiting and retaining a skilled IFS workforce, particularly specialist roles like the specialist DFV practitioner, can be difficult, particularly for regional and remote locations.

Organisational culture

- Professional support, supervision, mentoring, access to training and self-care strategies are essential to quality outcomes for families.
- Higher caseloads can result in poorer outcomes for families and increase worker burnout over the long term.²⁴

Cultural capability

- Cultural competence is essential as Aboriginal and/or Torres Strait Islander families comprise approximately one-quarter of all IFS cases.²⁵
- Some IFS providers may employ few or no staff from Aboriginal and Torres Strait Islander communities or culturally and linguistically diverse communities.

Financial performance

- Significant unspent funds for IFS providers may result from extended staff vacancies or related factors. The impact is less family support is available to at-risk families.

²⁴ The [Intensive Family Support: Service Model and Guidelines](#) states that case managers will have a caseload of 18-23 families per year on average (cases last 6-7 months). This suggests full-time case managers should not have more than 10-12 cases (of mixed complexity) at any one time. Workers with highly complex cases might have far fewer on their caseload.

²⁵ The Aboriginal and/or Torres Strait Islander population in Queensland is nearly five per cent.

Appendix 3: IFS performance assessment

Key questions that can help inform the assessment of IFS performance include the following:

Who are the primary referrers?

- Referrals from Child Safety – CSSC, Child Safety – RIS, and Police are expected to have a greater number of presenting concerns, increased overall complexity,²⁶ lower consent rates, and a lower overall rate of success.
- Referrals from RIS and Police are likely to be “non-consenting referrals” and engagement rates are usually lower than for referrals that have been discussed with the family and where a warm handover has occurred.

What is the average level of family complexity?

- A higher level of complexity is associated with longer-than-average interventions (12-18 months instead of 6-9 months).²⁷
- The proportion of families who are low risk versus moderate/high risk (with safety plans) can affect IFS throughputs.

Is the IFS service receiving the “right referrals”?

- Some IFS services may receive a disproportionate number of referrals where a statutory response through an ongoing intervention may have been the more appropriate response; this impacts consent rates, the average intervention period, and outcomes for families.
- Conversely, some IFS services might receive a greater proportion of referrals with lower overall complexity, leading to a shorter average intervention period, a higher rate of consent, and more positive outcomes at case closure.

How many hours are spent with families?²⁸

- The service hours by case report on ARC can indicate whether more or less time is spent with families than average.
- Shorter engagement durations generally limit IFS outcomes as well as the sustainability of changed behaviours.

What is the average worker caseload?

- Achieving outcomes with families requires having sufficient workload capacity; most caseworkers have between 9-12 families on average (a case mix of low-moderate and high needs).
- Higher-than-normal staff caseloads are associated with less impactful changes for families, and conversely lighter-than-normal caseloads are associated with greater impacts.

How is performance across the longer term?

²⁶ At entry to IFS, families have on average eight presenting needs. In nearly all cases, child emotional or mental health problems are identified.

²⁷ Significant long-standing challenges such as substantial mental health problems, past trauma, unresolved DFV, long-standing physical health problems or disabilities, intellectual impairment or substance abuse slow the pace of change for families, reduce positive outcomes at exit, and affect the sustainability of changes achieved.

²⁸ Future iterations of the IFS performance framework may consider ‘escalation data’ in further detail i.e., those outlets with a high(er) proportion of families (re-)entering the child protection system. This may include the average number of support hours provided to families with an all/majority needs met outcome recorded.

- Quarterly performance reports have less meaning under the IFS performance framework; at least four quarter's worth of data is necessary due to the length of time families are supported under the service model.
- The primary deliverable (all/majority case plan goals achieved) should be considered in combination with other performance indicators for the relevant period, specifically the number of hours provided, number of referrals received, number of service users with cases commenced, and number of existing service users at the beginning of the period.

Does the service have a significant waitlist?

- Future ARC reporting capabilities will capture both the number and average of waitlisted families and the average length of time before a case is allocated.
- "Active holding" for a waitlist requires significant human resources due to the requirement for regular consensual contact (weekly or fortnightly), initial safety assessments, potential Principal Child Protection Practitioner (PCPP) and specialist DFV practitioner consults, and the meeting of any immediate support needs until a warm handover has occurred.²⁹
- Familial consent is far less likely if an IFS service is not offered as close to the date of referral as possible, preferably within a two-to-four-week period.

Are staffing circumstances impacting performance?

- Staffing impacts may include positions that are unfilled for extended periods, staff turnover, sickness/burnout, appointees without recommended qualifications, lack of access to a local PCPP / specialist DFV practitioner / Aboriginal and Torres Strait Islander specialist, and staff untrained in the IFS guidelines/framework.³⁰
- IFS providers with smaller teams may not always have dedicated specialist roles – staff may be needed for general case management work, or only work part-time in their specialist position.

Are local circumstances impacting performance?

- Regional areas may need to provide more in-house family support, leading to more complex casework, longer family engagement, and a lower overall caseload capacity.³¹
- Regional areas may have limited access to professional supervision, mentoring, training, and appropriate information resources (which promote high quality service delivery and staff retention).
- Other local circumstances may be relevant e.g., natural disasters, a limited existing local service system for collaborative case planning/step-down support.³²
- A greater proportion of culturally diverse clients such as Aboriginal and Torres Strait Islander families, immigrant or refugee families can impact staff confidence in achieving sustainable outcomes.³³

Are tolerance adjustments justified in the circumstances?

- In the future, consideration might be given to recalculating the expected percentage of families having all/majority case plan goals achieved in exceptional circumstances.³⁴

²⁹ Analysis of the 2020 calendar year shows that for providers with a waitlist, most families needed to wait 2-3 weeks before being allocated to a caseworker. In extreme cases, families waited 3-4 months for a service.


³⁰ Untrained or unprepared IFS staff can negatively affect the outcomes that can be achieved.

³¹ For instance, service gaps may exist in smaller regional communities or there may be limited specialist services to assist families. More community-based support options are known to help sustain family outcomes.

³² Specialist services found to be most useful for assisting IFS families include child and adult mental health services, housing assistance, drug and alcohol services, paediatric services, and disability services.

³³ In the absence of culturally appropriate assessment tools, resources, training and supports to improve service provision.

³⁴ Consultation with the Children, Youth and Families Team is required in this case.

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- Large catchments will necessarily require extra travel time (for staff and families) and lead to a longer-than-average intervention period, along with reduced throughputs.