Literature review: Intensive Family Focused Case Management

Prepared by Inside Policy for the Department of the Prime Minister and Cabinet

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1. Introduction

This document captures the findings of a literature review of effective intensive family-focused case management services in the context of family violence. The review scanned evaluation reports, peer-reviewed studies and grey literature on programs / services / interventions operating in Australia, the United States of America, New Zealand, United Kingdom and Canada.

This review sought to define intensive family-focused case management and its key elements, identify the outcomes such interventions can achieve and identify examples of effective interventions for families experiencing family violence.

Ultimately the findings of this review aim to identify the elements of effective family violence intensive family-focused case management approaches with a view to frame the design parameters for similar services which are to be designed under Priority 2 of the Third Action Plan of the *National Plan to Reduce Violence against Women and their Children.*

2. Intensive Family Focused Case Management defined

Intensive family focussed case management (IFFCM), also known as intensive family support, is a combined case management and case work approach to intensively engage with families, assess their needs and provide immediate and continual support in the home, while planning for ongoing support and referral to necessary specialist services.

IFFCM is often applied to individuals and families with multiple and complex needs who are engaged in child protection, juvenile justice, mental health, alcohol and drugs, housing and family violence services. Intensive family support has gained significant traction in Queensland, New South Wales and Victoria as model for working with families at high risk of having their children placed in out-of-home care.[1]

IFFCM draws together components from:

- intensive service models – intensive service models comprise "activities, programs, services and interventions designed to alter the behaviour or development of individuals or families who show signs of an identified problem, or who exhibit risk factors or vulnerabilities, by providing the resources and skills necessary to combat the identified risks".[2]
- intensive case management – intensive case management provides "intensive support to people with high needs" and involves "a high level of

[1] Queensland Government Department of Communities, Child Safety and Disability Services https://www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/10-general/10-14-referrals-to-family-and-child-connect-or-intensive-family-support-services/key-steps/2-roles-and-functions-of-intensive-family-support-services, date accessed 13 April 2017; New South Wales Government Family and Community Services, http://www.theirfuturesmatter.nsw.gov.au/family-preservation-and-restoration-programs, date accessed 13 April 2017; and Victorian Government Department of Human Services http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/programs/children,-youth-and-family-services/family-services-program, date accessed 13 April 2017.

[2] Macvean, M. et al (2015), page 2.

contact and intense relationship" with young people and their families that are receiving the service. The service aim is to reduce high-risk behaviour and increase stability. These services include "intensive outreach and support, extended hours of service availability, and after-hours crisis support and intervention".[3]

- family support services – these are preventative services that assist and support parents in their role as caregivers and are provided by community-based organisations. "Family support is any intervention which helps parents develop their strengths and resolve problems that could potentially lead to child maltreatment and family disruption". [4]
- family preservation services – in families that have become dysfunctional, preventative family support services may no longer be sufficient. In these situations, family preservation services aim to intervene and "avoid placement of children and youth into out-of-home care by ensuring child safety and improving family functioning and parenting practices" [5]. These services are short term, family-focused and generally also crisis-focused.

With these components in mind, IFFCM can best be described as:

- intensive characterised by a high-level of contact with, and level of participation by, the service user(s) which results in smaller caseloads for case managers[6]
- focused on families with high needs[7]
- specialist in that service users can access particular support to help them address their needs[8]
- flexible in that the intervention ebbs and flows at the pace of the user[9]
- strengths-based and practical in that IFFCM does not use a deficits model and assists users to achieve tangible outcomes,[10] and
- comprehensive in the needs that it addresses and how it addresses them by using referral pathways to link users into a broader network of supports.[11]

By providing this intensive family-level support, IFFCM – depending on its policy context – aims to:

- negate or minimise further involvement by statutory services such as Child Protection and Juvenile Justice in a family's life,[12]

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[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Berry Street, independent child welfare and family services provider in Victoria, from website at https://www.berrystreet.org.au/case-management accessed 27 March 2017; Taldumande Youth Services website at https://www.taldumande.org.au/how-we-help/intensive-family-support-program/ accessed 30 March 2017; MacKillop Family Services website at https://www.mackillop.org.au/case-management accessed 30 March 2017; Samartians website at http://www.samaritans.org.au/service/intensive-family-support/ accessed 30 March 2017.
[7] Ibid.
[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Ibid.
[12] Berry Street, independent child welfare and family services provider in Victoria, from website at https://www.berrystreet.org.au/case-management accessed 27 March 2017; Queensland Government Department of Communities, Child Safety and Disability Services https://www.communities.qld.gov.au/childsafety/child-safety-practice-manual/chapters/10-general/10-14-referrals-to-family-and-child-connect-or-intensive-family-support-services/key-steps/2-roles-and-functions-of-intensive-family-support-services, date accessed 13 April 2017; New South Wales Government Family and Community Services, http://www.theirfuturesmatter.nsw.gov.au/family-

- reduce family breakdown,[13]
- strengthen relationships,[14]
- build communication skills between family members,[15]
- build capacity to help manage complex issues,[16] and
- link families into appropriate specialist supports.[17]

How IFFCM applies to Indigenous communities

The following core elements form the basis of intensive family support services for Indigenous families:

- matching services to child and family needs
- working with the statutory agency
- building partnerships with family members
- providing a mix of practical, educational, therapeutic and advocacy supports to children and families
- intensity and duration of service delivery
- family participation in decision making and case planning, and
- providing services in culturally-competent and respectful ways.[18]

In the context of Indigenous intensive family support services, the case manager role also includes:

- consulting with the statutory agency, government and other non-government workers
- participating in and sometimes leading inter-agency case planning and review forums
- advocating for family members with other agencies, and
- organising referrals and appointments, and arranging transport.[19]

Case managers engage with Indigenous families that have usually experienced "entrenched, complex or multiple difficulties"[20] and may already have been in contact with health, welfare and other services. Case managers identify services that will meet the family's needs and refer the family on; these services may be in the case manager's own organisation, with an external specialist service provider, or may be a universal service. The key consideration for referral is to find the service that best meets the family's needs.

Case managers with Indigenous families also negotiate with statutory agencies to make the goals agreed with families meaningful and achievable.[21] For example, a statutory goal of stopping drug use may be unrealistic and will be negotiated by the case manager to become 'reduce drug use'. This negotiation role may be quite

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preservation-and-restoration-programs, date accessed 13 April 2017; and Victorian Government Department of Human Services http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/programs/children,-youth-and-family-services/family-services-program, date accessed 13 April 2017; and Day et al (2016).

[13] Taldumande Youth Services website at https://www.taldumande.org.au/how-we-help/intensive-family-support-program/ accessed 30 March 2017.

[14] Ibid.

[15] Ibid.

[16] MacKillop Family Services website at https://www.mackillop.org.au/case-management accessed 30 March 2017.

[17] Day et al (2016).

[18] Tilbury (2014), page 8.

[19] Ibid.

[20] Ibid.

[21] Ibid.

important in achieving effective service outcomes, as statutory goals for families are often:

- too complex (i.e. numerous goals involving numerous sub-goals)
- too vague (e.g. link family with drug and alcohol services, improve parenting), or
- redundant or based on incomplete information (e.g. complete drug or alcohol rehab course, which had already occurred).

Case management with Indigenous families in remote or regional locations is also often complicated – and arguably all the more necessary – by families re-locating to a regional centre or city while receiving services or transitioning from them (e.g. moving from Cape York or Palm Island to Townsville, or to Alice Springs from surrounding communities). "In some cases, parents have moved to where their children have been placed or to where medical treatment is available, and support services are not available in their home community" [22].

According to Tilbury (2013) service delivery within a case management framework, in which goals are developed, implemented and monitored and services coordinated, is a significant factor in "family support services achieving positive outcomes for Aboriginal and Torres Strait Islander families" where there are child protection concerns and complex and multiple needs.[23]

To be effective, intensive support for Indigenous families must be delivered using a case planning approach that matches services to family needs.[24] The case planning is necessary to:

- adopt a trauma-informed care approach which identifies and understands the root causes of family issues
- address practical barriers to achieving family goals, and
- build on family strengths for sustainable gains in family functioning.[25]

3. Key components of IFFCM

The literature highlights a number of common features across IFFCM models. These are: risk and needs assessment; case planning; case worker / coordinator; referral pathways; and wrap around support.[26] Each of these is described in more detail below.

Risk and needs assessment

The commencement of IFFCM involves some form of "family needs or strengths assessment" [27], which then informs the development of a family plan (see case planning below).

Led by a case-manager a comprehensive assessment at intake is conducted.[28] This can include an identification and assessment of:

- past and current service intervention data and information on the child(ren), parents and family

[22] Ibid.
[23] Ibid.
[24] Matthews et al (2013).
[25] Ibid, page 62.
[26] Macvean, M. et al (2015).
[27] Ibid.
[28] Child Trends, https://www.childtrends.org/programs/family-centered-intensive-case-management/, date accessed 27 March 2016.

- service providers currently involved in the family's life
- individual family member needs through self-assessments and / or clinical diagnostic tools, and
- the children, parents and family's strengths including the their aspirations.[29]

Risk assessment in family violence context requires providers to:

- understand what family violence is;
- understand what risk factors increase a family's exposure to violence (for example pregnancy); and
- seek input from victims of family violence as to their level of risk.[30]

This information is analysed and collated to form a case plan or family plan, which outlines how a family will address its needs and manage its risk.

Case planning

Following the assessment of need and risk, a case plan or family plan is developed. This plan – which in the instance of family violence or child protection includes a safety plan – is developed in close collaboration with the family.

The plan identifies the goals of the intervention and the actions the family must take to achieve them. The family plan is used as a guide for the IFFCM where all parties go back a reflect on their progress and adherence with what has been agreed.

Case worker / case coordinator

A highly-skilled case manager is responsible for:

- assessment of family needs or strengths
- individualised or family-based plan
- working in collaboration with families, and
- discussion, as opposed to didactic, lecture-style service delivery.[31]

To achieve the above, case managers need a range of intervention skills, they need to understand the service system within which they operate, understanding of. individual, family and societal issues impacting parents' protection and care of their children, and be knowledgeable in assessment and intervention frameworks in relation to family violence and child protection.[32]

Referral pathways

A critical element of case management providing referral pathways or connecting clients with providers of services identified in the family's case plan. Such services can include (and are not limited to) counselling, mental health, medical, addiction support, housing, education, employment.

It is also critical that IFFCM is connected with the right services to ensure that families have a clear and seamless entry point to IFFCM support.

Wrap around support

[29] http://www.community.nsw.gov.au/kts/case-management/elements#assessment, date accessed 13 April 2017.
[30] Family Violence Risk Assessment and Management Framework, http://www.dhs.vic.gov.au/__data/assets/pdf_file/0006/581757/risk-assessment-risk-management-framework-2007.pdf, date accessed 13 April 2017.
[31] Webster, M. (2013).
[32] Ibid.

Wrap around is "a defined, team-based process for developing and implementing individualised care plans for youth with serious and complex needs and their families".[33] In the IFFCM context, this often means a multidisciplinary team comprised of clinicians, social workers, care coordinator, mental health workers, child protection workers and others are involved in the planning of care for a family.

The involvement of these disciplines and their respective organisations means that a family and the individuals within the family are able to access a broader network of support, referral pathways are clearer making services easier to access, and risk can be better identified and managed through regular monitoring and communication between providers.

Mixed mode: outreach, group, individual and community settings

The literature suggests that outreach to families, including home-based interventions, are the most effective in the context of IFFCM.[34] However, most important is meeting the family in an environment that is comfortable to them. In some situations this may be a community organisation or within a service provider.

IFFCM is provided to the family and specific interventions or support can be provided to individuals within the family or the family as a whole on a group-basis (with other families) or individually.

Duration and intensity

The intensity of service delivery has been "characterised by high family support hours per week, low caseloads for workers, a consistent caseworker for each intervention and short-term time limited interventions" [35].

The highly effective MST-BSF model described below engages with families three times per week for between six to nine months. Other programs can last up to 18 months to two years.

The most effective non-MST-BSF interventions were delivered in the home over a period of no more than six months. [36] To be effective, interventions for families experiencing domestic violence, for teenage parents, for families with a child at risk of removal, and for trauma-informed interventions, required up to a year.[37]

4. What IFFCM can achieve

There is scant evaluative data and other studies on the effectiveness of IFFCM for addressing violence in Indigenous communities. Despite this, a number of mainstream IFFCM programs have been evaluated, with some studies being randomised controlled trials or quasi-experimental. These studies provide useful insight into what IFFCM can achieve with at-risk families.

Various quasi-experimental studies, randomised controlled trials and outcomes evaluations have found that different IFFCM approaches can:

- Reduce a family's involvement with statutory child protection.[38]
- Reduce the number of days a child is placed in out-of-home care.[39]
- Reduce, or in some instances cease, a parent's substance misuse.[40]

[33] Quick et al (2014).
[34] Macvean, M. et al (2015), page 2.
[35] Matthews, G. et al (2013), page 58.
[36] Macvean, M. et al (2015).
[37] Ibid.
[38] Schaeffer et al (2013), pp 596-607; and Day et al (2016).
[39] Stirling et al (2012).

- Reduce a parent's violent or abusive behaviour towards their child.[41]
- Increase a child's feelings of safety and wellbeing.[42]
- Reduce a child's feelings of anxiety and depression.[43]

In addition to the above participant level outcomes that can be achieved, IFFCM delivered from a strengths-based approach by a highly skilled case manager as with the Indigenous family program *Brighter Futures*, can rebuild trust between families – especially Indigenous Australian parents – and support services.[44] As a result, at-risk families are more likely to seek and maintain the assistance they require.

5. Examples of effective IFFCM services

Described below are four IFFCM programs that have achieved success at either a participant and / or family and community level. Each model explored describes the program, the outcomes achieved and how it achieved those outcomes.

In-home, intensive mixed-interventions: MST-Building Stronger Families

Designed in the United States, MST-Building Stronger Families (BSF) is a 'treatment model for families experiencing co-occurring physical abuse and/or neglect and parental substance abuse'.[45] This intervention applies Reinforcement Based Therapy for substance abuse in the home with families. It is strengths-based and grounded in a Social Ecological Model of practice.

MST-BSF aims to:

- negate the need for a child to be removed from their family and placed in out-of-home care
- keep children safe, and
- support the parent in attaining abstinence in substance misuse.[46]

A recent five-year randomised clinical trial showed medium to large effect sizes on clinically significant outcomes for participants as follows:

- reduction in parental alcohol and drug use during treatment
- improved mental functioning
- improved parent-child relationship
- reduction in mothers' maltreatment of children (by three times), and
- children were less likely to experience maltreatment.[47]

MST-BSF achieved the above by focusing on the nine MSF principles of:[48]

1. Finding the 'fit' – this involves understanding 'the "fit" between identified problems, how they play out and make sense in the entire context of the child's environment'.
2. Positive and strengths focused – this involves emphasize the positives they find and use strengths in the child's world as levers for positive change.

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[40] Schaeffer et al (2013), pp 596-607.
[41] Ibid.
[42] Crusto et al (2008).
[43] Ibid.
[44] Stirling et al (2012).
[45] Schaeffer et al (2013), pp 596-607.
[46] http://www.mstcan.com/multisystemic-therapy-building-stronger-families-mst-bsf/, date accessed 13 April 2017.
[47] Schaeffer et al (2013), pp 596-607.
[48] https://prezi.com/sitgskezbhko/multi-systemic-therapy-building-stronger-families/ and http://mstservices.com/what-is-mst/nine-principles, date accessed 13 April 2017.

3. Increasing responsibility – this involves designing interventions that promote responsible behaviour and decrease irresponsible actions by family members.
4. Present-Focused, Action-Oriented, Well Defined – this involves understanding what is currently going on in the child's life, the family building goals and monitoring their progress.
5. Targeting sequences of behaviour – this involves applying interventions to family, school, friends.
6. Developmentally appropriate – this requires interventions to be the right fit for the child's age and developmental stage.
7. Continuous effort – this requires all family members to adhere to the interventions and work towards the agreed goals on a daily or weekly basis.
8. Evaluation and accountability – this involves the MST team monitoring adherence.
9. Generalisation – this involves building the capacity of the family to continue their efforts beyond the program.

The above principles are applied to a home-based program of support where a clinical team works intensively with the family three times per week for between six to nine months.[49] The clinical team is comprised of a 'supervisor, three masters-level therapists, a family case manager and a part-time psychiatrist'[50].

The clinical team, led by the supervisor, works closely with Child Protection services to ensure that risks are appropriately managed.

While treatment strategies are family dependent, common treatments include:

- safety planning
- cognitive behavioural therapies for managing anger and addressing trauma
- reinforcement based therapy for substance misuse
- family therapy to improve communication and problem solving, and
- counselling with the parent(s).[51]

Family intervention for adolescents who perpetrate family violence: Family Focused Therapy

Family Focused Therapy (FFT) works with families where an adolescent in the family has behavioural or emotional problems. The family is generally referred to FFT services by juvenile justice, child protection, school or mental health services.[52]

A range of studies including randomised controlled trials of FFT have shown the intervention has, compared to control groups:

- reduced rates of recidivism
- reduced harm behaviours
- increased attendance at school
- reduced placements in out-of-home care, ands
- improved family dynamics including communication.[53]

FFT has achieved the above outcomes by working with families in clinical and home-based settings over a short-term period: 12-14 sessions for up to five months.[54] FFT

[49] http://www.mstcan.com/about/ , date accessed 13 April 2017.
[50] Ibid.
[51] Ibid.
[52] http://www.fftllc.com/about-fft-training/clinical-model.html, date accessed 29 April 2017
[53] http://www.fftllc.com/about-fft-training/fft-research.html, date accessed 29 April 2017.

is a strength-based model that identifies and amplifies a family's protective factors while identifying and reducing their risk factors.

FFT is built around the following five components:[55]

- Engagement – this centres around the therapists engagement with the family and building trust in order to set a solid foundation for the intervention.
- Motivation – this focuses on building hope for change while reducing hostility conflict and blame. Here a therapist will use techniques to interrupt negative interaction patterns between family members.
- Relational assessment – here the therapist observes the relationships between family members which sets the stage for planning in behaviour change.
- Behaviour change – the goal of this component is to improve family functioning. Here the therapist assists the family to improve their communication, address individual issues (e.g. substance misuse) and manage conflict.
- Generalisation – this involves helping the family to plan for life beyond the intervention. This includes referring the family to a suite of wrap around supports.

IFFCM with Aboriginal families: Brighter Futures, NSW

Offered to at-risk Aboriginal families in NSW, the Brighter Futures 'delivers targeted early intervention services to families with children aged under nine years'[56].

Brighter Futures was developed in direct response to the increasing rates of Aboriginal children being placed in out-of-home care. The aim of the program is to identify Aboriginal children at-risk of entering the statutory child protection system, provide these children and their families with intensive support, to divert them away from placement in out-of-home care. Children 'at-risk' included those who had experienced family violence.[57]

Families voluntarily participate in the program.

A four-year evaluation of Brighter Futures found that children of families participating in the program had less days in out-of-home care and fewer child protection reports compared to children whose families who did not participate.[58]

The evaluation found that while most parents participated in, and valued, the parenting program, most found it hard to implement the learnings at home due to a lack of:

- ongoing case worker support, and
- time.[59]

The program achieved this by offering three core services to families:

1. quality children's services
2. parenting programs, and
3. structured home visiting, including case management.[60]

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[54] http://www.fftllc.com/about-fft-training/clinical-model.html, date accessed 29 April 2017
[55] http://www.fftllc.com/about-fft-training/clinical-model.html, date accessed 29 April 2017
[56] Stirling et al (2012), page 5.
[57] Ibid.
[58] Ibid, page 20.
[59] Ibid, page 5.

The evaluation cited the relationship between the case worker and family / parent(s) to be critical for the family's ongoing participation in the program. This was achieved through assisting the family to talk through and confront issues as well as referring families to appropriate supports.

Wrap around services families: Child FIRST, USA

The 'Child and Family Interagency Resource, Support, and Training Program' or Child FIRST is a wrap-around service run out of Bridgeport, Connecticut.[61] Child FIRST targets children five years old or younger who have experienced or exposed to family violence and are at high risk or experiencing developmental issues or behavioural, social, and emotional difficulties.[62] Due to the centrality of the parent-child relationship in the child's development of self, trust, and integrity, the program aims to support this relationship through the coordination of services.[63] Initially, staff conduct assessments of new clients in their home or community to understand the level of violence in the family, development and emotional needs, and the wider needs of the family.[64] Once the needs are assessed, Child FIRST coordinates and provides access to a variety of services for their clients to create an individualised plan to fulfil their needs.[65] These services range over 12 domains including child development, child mental health, child protective services, adult mental health, child education, adult education, social services, medical, operational (such as legal services, advocacy), family support, recreation (such as summer camps, after-school programs), and family violence.[66] The participants within the evaluative study were recommended from 11 to 34 different services across the 12 domains.[67] Within 90 days, 84 per cent of families received the recommended service.[68]

The service evaluation found positive changes on the family, parent, and child levels. Firstly, the program was able to foster safer family environments with the child experiencing significantly fewer family and non-family violent and traumatic events.[69]Secondly, the parent's favourably rated Child FIRST and reported statistically significant decreases in stress and distress associated with parenting from the program.[70] Parents also improved in managing their child and reinforcing relationships.[71] Thirdly, the children's experience of intrusive and avoidance behaviours was statistically significant in its decrease.[72] Though not statistically significant, decreases were also found in depressive, post-traumatic stress, and dissociative symptoms, hyperarousal, and anger.[73] The decrease in symptoms for children was linked to the number of hours and time within the service.[74] Those who stayed longer within the program and had more hours with the service showed more

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[60] Ibid.
[61] Crusto et al., 2008:2-3
[62] Ibid.
[63] Ibid. p.2
[64] Ibid. p.3
[65] Ibid. p.2
[66] Ibid. p.13
[67] Ibid. p.14
[68] Ibid. p. 12
[69] Ibid. p.14
[70] Ibid. p.11, 14
[71] Ibid. p.14
[72] Ibid. p.10, 14; Such behaviours include flashbacks and nightmares, or emotional numbing and place avoidance respectively (Crusto et al., 2008:14)
[73] Ibid. p.14
[74] Ibid. p. 10-11, 14

improvement.[75] Those within the study stayed on average 7.5 months, receiving on average 55.27 hours of services.[76]

Relationships-based approach: Stand By Me Program, Berry Street

Berry Street provides a range of Intensive Case Management Services for young people who are 'high risk' and have 'high needs'.[77] One such service provided by Berry Street is the Stand By Me program (SBM) aimed at high-risk young people leaving care.[78] SMB is a three stage program which focuses on preparation, transition, and post-care support.[79] The program aims to foster relationships with the clients while they are still in care and from this support them more intensively once they leave through direct case management.[80] Thus, SMB supports young people aged 16, preparing to leave care, to 21 year olds.[81] In the preparation and transition phases, clients are actively encouraged to participate in planning their transition (such as accommodation) and are supported to deal with issues of trauma and anxiety that the turbulent period can shake up.[82] Once children have left care, the role of the SMB shifts to case management and facilitates mental health support, housing, financial assistance, education and training, connecting clients with their families, disability services, and government services.[83] The case manager is key to addressing the immediate and long-term needs of the out-of-care clients.[84] Notably, one participant within the pilot study became a parent during their transition and was given extra support by the program.[85] Relationships are at the centre of this program, thus the case manager's relationship with their client is of significance as well as maintaining relationships with previous carers and engaging with the client's family.[86]

As only an interim evaluation has been conducted, it is very difficult to see the long-term outcomes of SBM. However, SBM has been successful in re-establishing family contact and creating realistic expectations regarding family ties.[87] Some clients returned to their family once they left care, and SBM was there to provide a safety net if these family placements broke down.[88] Additionally, SBM helped clients to feel less isolated and vulnerable once they moved into independent housing and helped them with their housing needs.[89] In times of crisis, case managers were able to help the client access Centrelink support, advocate for their needs, and were able to continue their support no matter what the circumstance, such as if the client became homeless or moved out of the metropolitan area.[90] Feedback gained through the evaluation suggested that the flexibility, reliability, and consistency of the case worker helped the client to stay engaged with the service.[91]

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[75] Ibid. p.10, 14
[76] Ibid. p.4
[77] Berry Street, 2016
[78] Meade & Mendes, 2014:5,10
[79] Ibid. p. 8
[80] Ibid. p.10, 20
[81] Ibid. p.9-10
[82] Ibid. p.5, 33
[83] Ibid. p.5-6, 19, 33
[84] Ibid. p. 33
[85] Ibid. p. 34
[86] Ibid. p. 6, 9, 16
[87] Ibid, p.5-6, 18
[88] Ibid. p.18
[89] Ibid. p.17
[90] Ibid. p. 5, 16-17, 22
[91] Ibid. p.21

6. Implications for designing IFFCM services

The findings of the literature review highlight a number of implications for the design of IFFCM services for the purposes of the family violence service co-design project. Framed as possible design parameters for IFFCM services, the services designed should include the following:

- A trusted care coordinator. Ideally this person is Indigenous, operates from a trauma-informed practice framework and is well networked within the local social and health service system.
- Wrap around supports by way of a multi-disciplinary team. Care for a family is planned in concert with a team of clinicians and support workers. Referrals to services are enacted through this care team arrangement. Joint care coordination between a clinician and the care coordinator should be considered.
- In-home and outreach. Care for a family is delivered in the home as a starting point rather than at the provider's organisation. The care team makes regular visits to the family home. Where this is not possible the provider's premises is trauma-informed.
- Service integration. Local services (where available) are involved in a family's care planning, delivery and monitoring. This helps build a net of support which includes identifying and managing risk faster and more appropriately.
- Minimum six months, weekly engagement. Intensity of intervention is key. Higher risk families will require more frequent interaction with the care team for a longer period of time. Families at a lower level of risk will require at least weekly engagement for a minimum period of six months.
- Mix of interventions. The family unit and individuals within the family are able to access arrange of therapies and interventions including:
    - Perpetrator interventions.
    - Individual counselling.
    - Treatment for substance misuse.
    - Education and training.
    - Cognitive behavioural therapies.

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