Intensive Therapeutic Transitional Care (ITTC) – Operations Guide

For Funded Service Providers (FSP) and Department of Communities and Justice (DCJ) practitioners supporting children and young people in ITTC homes

Document approval

The ITTC Operations Guide has been endorsed and approved by:

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1 Purpose of Guide

1.1 Purpose

The ITTC Operations Guide has been designed to guide Funded Service Providers (FSP) and Department of Communities and Justice (DCJ) staff supporting children and young people in ITTC. The guide aims to promote consistency across all ITTC providers by setting out standardised processes, recording templates, and roles and responsibilities.

The Guide outlines:

- overarching principles about the pathway for children and young people in ITTC
- processes and recording protocols that have been agreed by the ITTC Working Group.

1.2 Background and policy links

This document was developed in consultation with the Central Access Unit (CAU) and the ITTC Working Group.

There are a range of resources for FSP delivering the Permanency Support Program (PSP) on the DCJ website, including the following documents which should be read together with this operations guide:

- ITC Service Overview
- PSP Case Management Policy
- Aboriginal Case Management Policy
- PSP Away from Placement Policy
- Charter of Rights for children and young people in out-of-home care
- PSP critical events in statutory OOHC

Other resources available on the DCJ website include information about the PSP funding model, contractual information, legislation and policy that informs PSP practice, record keeping, and sector workforce development and training.

1.3 Scope and application

The ITTC Operations Guide applies to all ITTC service providers, ITC Providers, other Funded Service Providers that interface with ITTC (including Permanency Support Program foster care providers) and DCJ staff such as caseworkers and CAU.

2 Definitions

The table below contains a list terms, keywords and/or abbreviations used throughout this document.

Term	Definition
Formulation	Formulation is a process of building a narrative of the

Term	Definition
	child or young person and identifying their challenges and potential hypotheses to understand their presentation. Formulation is a tool that guides the assessment plan.
ITTC Assessment Report	Final ITTC report drafted for children and young people. It records the child or young person's final Formulation and recommendations to inform future planning and assessments.
Therapeutic Care Plan	Plan that is developed by the ITC Funded Service Provider supporting the child or young person's ongoing/long term placement following exit from ITTC. (Not ITTC)
Care Team Meeting	In ITTC, Care Team meetings are a forum for focused review and monitoring of actions developed as part of Formulation (includes Assessment Plan). Care Team meetings provide an avenue for: sharing insights and data collected by the direct care team; and developing strategies for future support for the child or young person.
Care Team	In ITTC, the care team compromises of the house manager, direct care staff, Therapeutic Specialists and the Multidisciplinary Specialist Team, case manager, education, and other stakeholders important to the child or young person and their family.
Referring provider/agency	The Funded Service Provider or DCJ District that has case management responsibility at the point of entry to ITTC.
Receiving provider/agency	The Funded Service Provider or DCJ District that will have case management responsibility at the time the child or young person exits ITTC.
Case management in ITTC	For the duration of a child or young person's placement in ITTC, case management is retained by the referring agency (FSP or DCJ). Case management responsibilities for the case managing agency are outlined in Section 6. Note, the ITTC provider does not hold primary case management responsibility.

3 Intensive Therapeutic Transitional Care

3.1 Service Overview

The ITTC Service Overview and minimum service requirements are available on the DCJ website.

3.2 Intensive Therapeutic Transitional Care (ITTC)

Outlined below is a summary of ITTC which includes excerpts from the Service Overview and describes its aims and structure.

3.2.1 Aims

ITTC units facilitate delivery of a range of evidence informed, tailored assessments and interventions in a home-like and child-centred environment. Assessments undertaken help inform the child or young person's most appropriate placement and support plan following ITTC. This is especially important when a child or young person's needs or the type of placement best suited to their needs and/or goals is unclear.

Children and young people are supported through the delivery of consistent and planned daily interactions and a structured program of activities and assessments.

The primary objectives of ITTC are to provide a safe and child friendly environment where baseline behaviours can be established in order to:

- accurately assess needs
- review existing assessments and/or complete comprehensive assessments
- determine future needs and the most suitable transition pathway for children and young people
- enable formulation of case planning
- ensure that specialist service referrals have been identified
- identify presenting need/s and provide treatment (only if appropriate given short-term nature of placement)
- contribute to identifying the best placement option, and
- work with the CAU and other Service Providers to successfully transition the child or young person.

The timeframe (maximum 13 weeks) for an ITTC placement allows for:

- assessments to be validated by working directly with the child or young person within a program that is guided by an overarching philosophy of Therapeutic Care
- transition planning for the child or young person's next placement.

3.2.2 ITTC structure

The ITTC unit provides children and young people with direct care supported by a highly skilled and multi-disciplinary specialist team (qualified staff with experience in (but not limited to) trauma informed behavioural assessment, therapy, psychology or allied health services led by a Therapeutic Specialist). Support can be provided by the in-house team or purchased from other specialist agencies to support delivery.

ITTC supports a consistent approach to addressing behavioural, emotional, psychological, educational and physical needs of children and young people.

In ITTC, the Therapeutic Specialist and House Manager have pivotal roles in the operation of the unit.

While the ITTC is a unit delivered by ITTC providers it operates as part of a multi care system that includes:

- ITTC staff (MDST, Therapeutic Specialists, House Manager, Direct Care staff)
- the case managing agency
- Education, Health and/or Police (as applicable)
- Other stakeholders important to the child or young person.

This multi-care system collaborates to deliver a range of assessments and tailored interventions that reflect best practice and research in trauma, attachment, neglect and resilience to accurately determine and address a child or young person's immediate and ongoing needs.

The final ITTC Assessment Report (see Section 11) completed by the ITTC unit should inform development of the child or young person's Case Plan following their exit from ITTC.

ITTC units will be located in geographic areas where they will be integral to the overall delivery of ITC.

3.3 Client group

The client group for ITTC placement is children and young people in the Permanency Support Program who have been assessed by the CAU as eligible for entry. Children and young people suitable for ITTC have complex and high support needs, a CAT score of high, are 12 years of age and over, and would benefit from a suite of assessments that help determine the best placement for them and supports better understanding of their complex needs.

It is expected that the ITTC will accept all eligible and suitable referrals from the CAU and will work closely with the CAU to facilitate timely placements. The CAU will identify risks and vulnerabilities for the child or young person and discuss these with the Therapeutic Specialist so that the ITTC provider is able to identify strategies to support the child or young person within the ITTC grouping.

3.4 Minimum service expectations

ITTC will be expected to meet the expectations outlined in the Permanency Support Program Requirements and the Ten Essential Elements.

The ITTC is a stand-alone unit which provides accommodation, care, assessment, intervention and planning for up to six children and young people for up to 13 weeks. The ITTC provider allocates each child or young person a case manager[1] to ensure that their individual needs are integrated into the day to day running of the unit. The case manager supports the child or young person through the process of entry, assessment, and the development of their case plan in partnership with the agency that holds primary case management.

It is expected that the ITTC unit is staffed 24 hours per day with a minimum of two direct care staff rostered on at all times including active overnight shifts. Direct care

[1] The ITTC case manager is in addition to the child or young person's allocated caseworker provided by the agency with primary case management.

staff must provide day to day care and supervision in line with the child and young person's case plan and in consideration of any emerging assessment of need and/or risk.

The Therapeutic Specialist, House Manager and ITTC Multidisciplinary Specialist Team will further enhance the care and support to children and young people to ensure that routines and structures are specifically designed to meet their individual needs.

ITTC case managers should be available for face-to-face contact with children and young people on a daily basis so that children's individual needs are identified and met.

Each ITTC has a full time House Manager based in the unit and spends the majority of time onsite. ITTC staff must attend regular house meetings.

The Therapeutic Specialist, House Manager, ITTC Multidisciplinary Specialist Team, and the Care Team will:

- develop a Formulation and assessment plan for children and young people
- undertake tailored assessments for children and young people
- implement evidence informed assessment and strategies
- plan, support and facilitate transition of children and young people to their next placement with the case managing agency
- be flexible and responsive to meet the therapeutic needs of the children and young people

3.5 Therapeutic Specialist – in ITTC

As outlined in the ITTC Service Overview Therapeutic Specialists supporting children and young people in ITTC have specific roles that include:

- working closely with the CAU to:
    - facilitate Provisional Formulation
    - facilitate Care Team meetings
    - develop the ITTC Assessment Report
- leading the ITTC Multidisciplinary Specialist Team
- collecting feedback/data from the House Manager about children and young people's daily functioning and ensuring direct care staff are integrating Therapeutic Care into daily interactions with children and young people
- developing the Formulation document and assessment plan
- conducting and facilitating or coordinating assessments to inform decisions about the child or young person's case plan goal, child needs packages and specialist packages
- ensuring a planned and well executed exit or transition to the young person's next placement. This will include early engagement with case management (agency responsible for child or young person's case plan) to facilitate referrals to Family Group Conferencing where restoration/family placement has been identified as being safe and appropriate for the child or young person
- liaising with several agencies at any one time, as children and young people progress through the ITC service system.

3.6 House Manager – in ITTC

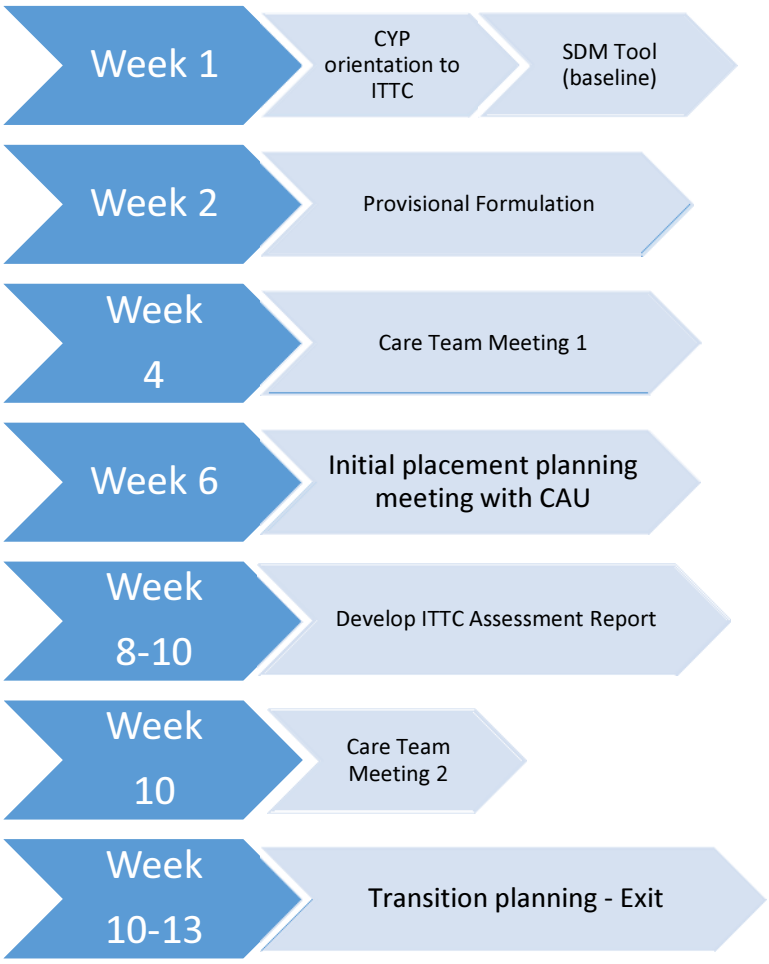
House Managers work in close partnership with Therapeutic Specialists, the direct care team and the MDST to ensure delivery of the Therapeutic Care approach in ITTC. The Therapeutic Specialist guides and enables staff whilst the House Manager leads and manages staff.

The House Manager has a significant role in:

- supporting entry for children and young people into ITTC
- day to day care for children and young people
- managing and supervising direct care staff
- implementing evidence informed assessment and strategies
- supporting direct care staff to integrate recommendations by translating them into actions/activities and staff interactions
- supporting the practical operations for the unit, including coordinating routines and staff rosters, and
- facilitating reflective practice with direct care staff.

4 Key milestones

Outlined below is an overview of key timeframes and milestones that map a child or young person's pathway through ITTC. The milestones are intended as a guide only.



5 Referral and intake

To maintain congruency across the ITC system, the CAU is responsible for overseeing entries, transitions within and exits from ITC. The CAU assesses and determines the eligibility and suitability of a child or young person for ITC and safeguards against unsuitable placements.

The CAU determines referrals to ITTC homes following completion of CAU's Suitability Assessment. The CAU Suitability Assessment identifies children and young people that meet the criteria and suitability for entry to ITTC. This assessment is informed by information gathered from the Client Information Form (CIF) Part A and Part B, Child Assessment Tool, supporting documentation provided by the CFDU/casework team, suitability discussion meeting, and any clarifying information from the casework team.

The CAU will work with the ITTC provider to:

- gather information from the referring provider
- provide the ITTC provider will the child or young person's:
    - Child Assessment Tool (CAT)
    - Client Information Form Part A and B
    - CAU Suitability Assessment and Psychological Review

ITTC providers' intake processes should be inclusive of the House Manager, Therapeutic Specialist, and other managers as deemed appropriate.

Once a referral is accepted by the ITTC Service Provider a Transition Planning Meeting will need to occur. The meeting should be scheduled as soon as possible once the referral has been accepted. More information about Transition Planning is in Section 7.

6 Case Management responsibility

The CAU is responsible for determining which agency should retain case management while a child or young person is in ITTC. The decision is based on which agency is best placed to support the child or young person to achieve their case plan goal while in ITTC, acknowledging the short-term nature of the placement and that progressing case plan goals continues in ITTC.

The overarching principle is that the referring agency into ITTC retains case management responsibility to provide continuity of care, especially when a change in casework team would have an adverse impact on the child or young person.

6.1 Case management transfer

The CAU can assist in determining the most appropriate date for case management transfer to the receiving provider (at exit from ITTC). Case management should transfer in accordance with the needs of the child or young person.

Regardless of the date of case management transfer ITTC providers should support and facilitate early engagement with the child or young person's receiving provider. , at the same time giving consideration for any enduring relationship the child or young person may have with their existing case manager.

6.2 Roles and responsibilities

Agency with primary case management responsibility	ITTC Provider
• determines Case Plan goal and responsible for ongoing case plan activities (during ITTC placement case plan goal may change based on ITTC assessment outcomes) • participates in Formulation and Care Team Meetings in ITTC • weekly visits with child or young person • funding of sundry items • regular communication with ITTC case manager • facilitate, transport and supervise family time • attendance to ongoing or pre-existing medical or other appointments • legal obligations, including informing birth parents that the child is in the ITTC[2] • facilitates Family Group Conferencing and Alternative Dispute Resolution processes • manages placement breakdown incidents • notifies OOHC Health Coordinator of child's 'new placement' details	• Formulation • supports identification of potential step-down arrangements • communication and feedback with case managing agency about any arising issues that impact on case plan • supports integration of child or young person's case plan into day to day care • Therapeutic Specialists will need to work closely with both the case managing agency and ITTC case manager to ensure activities associated with the child's case plan and Formulation (including the Assessment Plan) are coordinated.

[2] This is a Statutory requirement, as per section 163(1) of the *Children and Young Persons (Care and Protection) Act 1998.*

• notifies child or young person's current school of 'new placement' details If applicable, seeks 'Exemption' from school attendance during ITTC placement.	

6.3 OOHC Education and Health Pathway

6.3.1 Educational needs while in ITTC

Children and young people should be supported to attend school wherever this is possible. Decisions about a child or young person's school attendance while in ITTC will need to be made in partnership with the child or young person, their current school, the agency with case management responsibility, and the ITTC provider guided by what is in the child's best interests.

In circumstances where it is not in the child or young person's best interests to attend school, the agency with case management responsibility will need to formally request from the child's current school Principal, an 'Exemption' for the duration of the child or young person's stay in ITTC.

Regardless of a child or young person's personalised learning and support plan, the case managing agency will need to:

- notify the school Principal or delegate to inform them of the change of placement
- complete a Change of Details Advice form that includes details of the ITTC provider, details and contact person for the school (this may continue to be the case manager and/or a contact within ITTC) and placement type (ITTC) and send to Department of Education's mailbox and the school principal (if Catholic or Independent school).
- introduce the ITTC provider and the school to discuss the child or young person's educational goals while in ITTC

Case managing agencies should also consider engaging the OOHC Education Coordinator, OOHC teachers and/or Network Specialist Facilitators for all children and young people in ITTC, especially when school attendance and engagement is an identified issue. Access to these supports is via the child's school Principal.

6.3.2 OOHC Health Pathway Programs

All children and young people that entered statutory OOHC after 2010 are eligible to participate in the OOHC Health Pathway Program. Participation on the Pathway enables children and young people to receive screening, assessment, intervention, monitoring and review of their health needs.

The OOHC Health Pathway is supported by an OOHC Health Coordinator in each Local Health District. The Coordinator is responsible for ensuring the development of a Health Management Plan for children and young people within 90 days of their entry into care. All children and young people over the age of five should have their Health Management Plan reviewed at least annually.

A caseworker's guide on the OOHC Health Pathway is available on DCJ's website.

At the end of the ITTC placement, the case managing agency in partnership with the ITTC provider should consider what assessment outcomes can be shared with the OOHC Health Coordinator to ensure that the child's or young person's health needs and recommended interventions are captured in their Health Management Plan. For children aged over 14 years, consent for sharing information with Health is required.

The case managing agency will also need to ensure that at entry to and exit from ITTC, the OOHC Health Coordinator from the child's district of origin is notified of the change of circumstances. This can be done by providing the OOHC Health Coordinator with a copy of the Change of Detail Advice Form for a child or young person.

Details for the OOHC Health Coordinator and their specific local Health District are available on the DCJ website.

7 Transition planning – Entry to ITTC

7.1 Transition plan meeting

Transition planning provides children and young people with opportunity for their individual needs and views to be considered during the transition process to ensure supported entry and orientation to ITTC. Case managers will need to provide children and young people with sufficient information about ITTC prior to the Transition Plan meeting so that their views can be captured and shared at the meeting.

> Appendix 14 has examples of questions and answers that can be adapted by providers for sharing with children and young people once the referral for entry to ITTC has been accepted. Providers can consider including photos of the ITTC unit and information about house routines.

For service providers, transition planning provides the receiving ITTC provider with enough information to plan a child or young person's entry into the home. In addition to standardised information that providers are given to understand a child or young person's needs, transition planning includes:

- identifying the transition date and if possible any pre-transition visits to ITTC
- identifying case management responsibility and key stakeholders
- setting out how the child or young person will be transported to the placement and introduced to the environment, staff, and other children and young people
- capturing the child or young person's feedback about transition
- identifying any staff/training needs to support entry, particularly when the child or young person has a Behaviour Support Plan in place
- considering any planning required to support the following aspects of the child or young person's life such as family contact, health (attendance at appointments), education, social and recreational commitments/activities

- medication requirements, if applicable
- confirming that the case managing agency will:
  - inform the child or young person's birth family
  - notify OOHC Health Coordinator about the child or young person's 'Change of Circumstances' (new placement)
  - notify child or young person's school and the OOHC Education Coordinator of change of placement (see Section 6.3 for further details)
- developing a risk management plan that outlines current risk issues and response strategies
- exploring exit pathway from ITTC.

An ITTC Transition Plan template has been developed (See Appendix 14) to support consistency across all ITC providers referring in to ITTC and is the agreed[3] format for recording the Transition Plan. The plan is completed by the current casework team and is saved to ChildStory. For children case managed by a FSP the Child and Family District Unit is responsible for saving the plan to ChildStory (if case managed by DCJ then this would be done by the DCJ caseworker).

ITTC providers will need to be provided a copy of the Transition Plan.

7.2 Who attends the transition planning meeting

The CAU facilitates the ITTC Transition Planning meeting between the referring casework team and the receiving ITTC home. If appropriate, the meeting can occur at the ITTC home.

At a minimum the following key people should attend the transition plan meeting:

- CAU caseworker (Therapeutic Coordination)
- Therapeutic Specialist (ITTC provider)
- Child or young person's current case manager
- ITTC House manager

7.3 Timeframes

As outlined at the referral and intake stage, Transition Plan meetings should be scheduled as soon as possible once the referral is formally accepted by the ITTC provider. The meeting may be facilitated via a teleconference.

7.4 Supporting documentation

Information that will be reviewed and considered as part of the Transition Plan meeting including the child or young person's:

- Child or young person's current Case Plan
- Behaviour Support Plan
- Restrictive Practices Authorisations
- Risk management and/or Safety Plans, if available
- Medication approvals and/or prescriptions
- Current orders, if applicable (for example, AVO, bail conditions)

[3] The ITTC Working Group designed the Transition Plan template.

7.5 Safety and Risk

The Transition Plan identifies any known risks for the child or young person and strategies to minimise or respond to those risks for the transition period. Safety and risk planning should be guided by the child or young person's Behaviour Support Plan and any approved Restrictive Practices Authorisations (RPA).

For children and young people that do not have an approved Behaviour Support Plan, the risk assessment outcome will need to be clearly recorded in the Transition Plan.

7.6 Initial Placement planning meeting with CAU

Placement planning remains an ongoing consideration for children and young people from the time of entry to ITTC. At entry to ITTC, placement planning may include discussing anticipated exit pathways and setting a meeting date for Week 6 to discuss referrals that the CAU should consider. For some children and young people where foster care or kinship/relative care is part of the plan, DCJ Child and Family District Units should be invited to this meeting.

At Week 6, a formal placement planning meeting is convened and where there is a clear exit plan, CAU will commence sourcing the child or young person's next placement. Once the next placement provider is confirmed, the provider will be invited to participate in ongoing Transition Planning, where appropriate. In circumstances when a referral for foster care is required, the Child and Family District Unit should be involved in the Week 6 planning meeting.

8 Formulation

8.1 Purpose

Formulation is a process of building a narrative of the child or young person and identifying the challenges and potential hypotheses to understand their presentation. The narrative is set across a series of domains including:

- diagnoses
- trauma/ attachment
- culture/identity
- placement – including history and future pathways
- family
- health
- education
- emotional and behavioural presentation
- relationships
- legal

Formulation is an opportunity for clinicians to be curious about the child or young person, consider their history relevant to each domain, and discuss current challenges and/or hypotheses for those challenges. Through this process, clinicians will identify the assessment priorities that correlate with what is hypothesised to be driving the challenges the child or young person is presenting with.

Formulation in ITTC has a focus on assessment and is intended to:

- identify the assessment needs of the child or young person, in addition to the minimum set of standardised assessments (See Section 8 for detail)
- establish a plan to undertake identified assessments, that is who will undertake which assessments and the timeframe
- develop the assessment plan for ITTC and inform future therapeutic needs for the child or young person (following transition from ITTC).

8.2 Roles and responsibilities

The Therapeutic Specialist leads Formulation in close partnership with the ITTC multidisciplinary team, House Manager, casework team, CAU Psychologist, and where practicable the CAU caseworker. All staff involved have a role in contributing assessment and analysis information about the child or young person.

Outlined below are other discrete responsibilities for each role in Formulation:

Therapeutic Specialist	- Leads and organises the Formulation Meeting - Identifies therapeutic interventions or assessments to be undertaken in ITTC - Records/documents Formulation meeting (or delegates to other ITTC staff) on agreed template - Coordinates the collation of multiple sources of data (observations, interviews with past carers, external professionals who know the young person, previous reports, interviews with young person and family members, standardised measures)
Multidisciplinary Specialist Team	- Identifies therapeutic interventions or assessments to be undertaken in ITTC
House Manager	- Identifies supports, including direct care staff supports and logistical considerations to be implemented to complement the Assessment Plan -
Case management team (agency with primary case management responsibility)	- Provides historical narrative
CAU Psychologist **Note: Initial/provisional Formulation only, as required**	- Provides clinical interpretation of CAU's Suitability Assessment and clinical file review - Supports initial formulation development - Can provide feedback for Therapeutic Specialist

CAU Therapeutic Coordinator (Caseworker) **Note: Initial/provisional Formulation only**	- Provides input regarding CAU's Suitability Assessment - Ensures transfer of information and analysis gathered through the Suitability Assessment process

8.3 Information considered

Information discussed at the provisional or initial Formulation meeting should include (but not limited to):

- CAU Suitability and Psychological Review assessments (initial only)
- Previous psychological, allied health or other relevant assessments
- Health Management Plan and health assessments undertaken through as part of the child or young person's participation in the OOHC Health Pathway process
- Current case plan
- Current day to day functioning

OOHC Health Coordinators can provide information about previous assessments and planning already undertaken for a child or young person since they have been in out-of-home care. This may avoid duplication, especially if the child or young person has already had assessments or there are plans in place to undertake assessments.

8.4 Formulation template

A Formulation Template (See Appendix 14) has been developed and is the agreed recording tool for documenting Formulation. The template includes prompts for the Therapeutic Specialist and participants to consider during Formulation and outlines the Assessment Plan.

8.5 Timeframes

Formulation should be reviewed throughout the child or young person's assessment period to adjust the assessment plan and goals as more information is understood. As a guide:

- Provisional formulation should occur at Week 2 so that clinicians, the House Manager and caseworker can identify early in the placement the assessment plan and priorities for the child or young person while in ITTC. CAU participates at this provisional formulation to share insights from CAU's Suitability Assessment and Psychological Review report.

- A further mid-placement Formulation should be undertaken by Week 6 to review the provisional formulation and the outcomes of completed assessments identified in the assessment plan. CAU does not need to attend the mid-placement Formulation however should be provided with the completed Formulation template.

9 Standardised Assessments

Standardised assessments have been identified for use within ITTC which provides further opportunity for congruency across the ITC system and shared understanding of children and young people. Assessments provide further information to support Formulation and future assessment, including what therapeutic supports the child or young person is likely to require once they transition from ITTC.

Following completion of assessments by the ITTC, the ITTC will facilitate the coordination of the most appropriate service system response for the child or young person. This will be captured in the ITTC Assessment Report.

At a minimum, the following standardised assessments should be undertaken at entry and prior to exit from ITTC for all children and young people:

9.1 Child and Adolescent Needs and Strengths (CANS)

The Child and Adolescent Needs and Strengths (CANS) is multi-purpose tool for children that is designed to be used for decision support (including level of care and service planning) and outcomes management. This measure facilitates linkage between assessment and the young person's individual plan. It has individualised assessment modules, including a trauma module.

9.2 Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a brief behavioural screening questionnaire for 3-16 year olds. It is suitable for pre and post measurement, can identify domains for assessment and can be a psychiatric screener if a multi-informant approach is taken.

Note: This tool is also administered as part of the OOHC Health Pathway for the child or young person's initial assessment. The SDQ is also provided to the child's carer at the time to complete.

9.3 The Brief Assessment Checklist measures

The Assessment Checklist series provides standardised care-giver report measures of a range of attachment and trauma related mental health difficulties experienced among children growing up in foster, adoptive, kinship and residential care.

- Assessment Checklist for Children (ACC)
- Assessment Checklist for Adolescents (ACA)

9.4 Other assessments that may be undertaken

- Independent Living Skills checklist for young people aged 16 years and over.

10 Care Team Meetings in ITTC

Care team meetings provide key stakeholders (including staff and people important to the child or young person) with an opportunity to monitor, plan and review a child or young person's passage through ITTC. This is done through:

- sharing insights and data collected by the care team
- reviewing assessment results
- considering variations for the child or young person's case plan

Care Team meetings are separate from internal ITTC clinician meetings (which are at the discretion of the ITTC provider).

10.1 Participation of child or young person and their family

The child, young person, their carer and/or family should be invited to actively participate in Care Team Meetings. If they do not wish to attend in person, or partially attend the meeting, the case managing agency should capture any views prior to the meeting.

The table below sets out the functions of ITTC Care Team meetings and Case Plan Meetings:

	Care Team Meetings	***Case Plan Meetings***
Purpose	Review and monitor progress of Assessment Plan actions Review and make variations to the case plan and exit goals (in partnership with case managing agency) Consider exit plan/strategy for child or young person	Develop or review case plan goal (permanency direction)
Output	Meeting minutes with agreed actions	Case Plan - primary case management tool for progressing child or young person's permanency goals
Any changes to the Case Plan as a result of ITTC Care Team meetings will be made by the case managing agency.		
Attendance	**Week 4** – CAU, Therapeutic Specialist, MDST, Case managing agency **Week 10** – Therapeutic Specialist, MDST, case managing agency, family and child or young person	Case managing agency, family, other service providers supporting the child and family.
Facilitator	Therapeutic Specialist	Case managing agency

10.2 Timing

ITTC providers can determine the frequency and triggers for Care Team meetings however at a minimum meetings should be held at Week 4 and Week 10.

10.2.1 Week 4 - Care Team Meetings

Care Team Meetings held at Week 4 are focused on:

- updating progress with Formulation and Assessment Plan
- reviewing and making variations to case plan and exit goals in the context of information being collated by ITTC
- reviewing child or young person's arrangements such as family contact time, education, general functioning
- discussing feedback and/or data collected from direct care about child or young person's daily functioning
- identify exit plan/strategy

10.2.2 Week 10 – Care Team Meetings

Care Team Meetings held at Week 10 are focused on:

- reviewing and making variations to case plan and exit goals in the context of information being collated by ITTC
- discussing feedback and/or data collected from direct care about child or young person's daily functioning
- planning transition from ITTC. This meeting may be used as the formal Transition Plan meeting (exit from ITTC)
- reviewing Formulation and assessment results (identified in the ITTC Therapeutic Assessment Report)
- identifying what the child or young person's needs are going forward in relation to ongoing referrals, family and contact, education

If the CAU is not available, the case managing agency should forward minutes of the meeting to the CAU.

11 ITTC Assessment Report

The final ITTC Assessment Report is the guiding assessment document that captures the outcomes of all assessments undertaken for children and young people while in ITTC.

The assessment report should form the communication between the ITTC and the receving provider to communicate what is formulated about the child following the period of assessment. It includes extensive recommendations about the child's needs for their next placement that will inform the development of environment specific behaviour support plans and therapeutic care plans.

The ITTC Assessment Report template is available at Appendix 14. The template includes guidance notes and prompts for completing each section.

11.1 Assessment domains

The ITTC Assessment Report will cover the following areas:

- Young person's views and hopes/aspirations
- Background information
- Current Assessment
- Final formulation and analysis
- Recommendations
- Appendices of reports, completed standardised assessments, and daily functioning data

11.2 Information sharing

The ITTC Assessment Report is intended for use by the case managing agency, Care Team for the child or young person and receiving placement provider.

11.3 Timeframe for ITTC Assessment Report

The final ITTC Assessment Report will need to be completed by Week 10 (or at the time of the final Care Team Meeting). This is to ensure that appropriate planning and supports can be integrated for the child or young person's transition to their next placement.

12 Transition Planning – Exit from ITTC

The aim of transition planning (exiting from ITTC) is to ensure that updated information and understanding about the child or young person is transferred to their new placement. The Transition Plan meeting may also occur at the same time as the final Care Team meeting and involve the new service provider.

The aim of the Transition Plan meeting is to set out the most appropriate supports and strategies required to minimise the impact of transition on the young person. Considerations for the meeting include:

- exit timeframe or date
- how information about the child or young person will be transferred between the ITTC provider and receiving agency
- identifying supports required to transition to new placement
- confirming date of case management transfer
- other logistical considerations
- notification or engagement with child or young person's school
- confirming that the agency with case management will complete necessary notifications to family, education and OOHC Health Coordinator.

12.1 Attendees

Exit or Transition Planning from ITTC should include the following people at a minimum:

- Child or young person and family, if appropriate
- Therapeutic Specialist from both ITTC and the new service agency (if ITC)
- Current caseworker and new service provider's relevant staff (for example caseworker or manager)
- ITTC House Manager
- CAU caseworker and where necessary CAU Psychologist

- Other relevant staff

12.2 Timing

Transition Planning should commence as soon as practicable once the child or young person's next placement is identified.

13 Data collection and reporting

As outlined in the ITC Service Overview, DCJ is introducing mandated data collection and reporting. Data will include information on safety, permanency and wellbeing to align with the outcomes of the Quality Assurance Framework (QAF).

Service Providers must use a web based tool to record daily observations of client level data to support Reflective Practice, Care Team Meetings and the formulation of Case Plans. It is expected that data collection should align with the domains of the Quality Assurance Framework. This daily observation data is part of the child's record and therefore the web based system should integrate with ChildStory.

The data must be made available to other Service Providers when a child or young person transitions to another service and upon request by DCJ. This data could be shared with the Intermediary Organisation to assist development of therapeutic care for individuals. At an aggregate level the data may assist DCJ identify practice trends, outcomes for children and young people and will also ensure the integrity of the DCJ ITC system. The data set may develop as the ITC Intermediary Organisation is established and ITC matures.

14 Appendix

14.1 Transition Plan

TRANSITION PLAN

Name	
DoB/ Age	
Child Story Number	
Cultural Background	
Current Placement Agency	
New Placement Agency	
Case Management	
Date of Plan	
Date of Transition to New Placement	

Attendees:

Name	Organisation	Role

Key Area	Tasks	Responsibility	Date to be completed	Completion Y/N
Introduction to placement *Information to YP, photos etc., visits, transporting, supports, who to meet.*				
Family *Contact arrangements, mode of communication, information for families, important people.*				
Health *Health conditions, medication, prescriptions, handover of medication, important immediate health needs*				

Key Area	Tasks	Responsibility	Date to be completed	Completion Y/N
Education *School location, distance- ed needs, transport needs*				
Legal *Current legal matters bail conditions, pending court dates.*				
Current behavioural supports *Existing behaviour support plans, effective behavioural or regulation strategies in place*				

Key Area	Tasks	Responsibility	Date to be completed	Completion Y/N
Cultural Considerations *Identification, particular needs, observances or rituals*				
Previous Placement *Details of carers, strategies, routines in place, setting.*				

Key Area	Tasks	Responsibility	Date to be completed	Completion Y/N
Young Person's Belongings *Where are they, how will they be transported, significant items*				
Young Person's views *Thoughts about the placement, concerns*				

Key Area	Tasks	Responsibility	Date to be completed	Completion Y/N
Consultation with other Young People				

Transition Plan – Risk Considerations

Risk *Absconding, sexualised behaviour, previous sexual harm/vulnerabilities, AOD use, violence…*	**Indicators/ Triggers**	**Strategy to Minimise or Respond**

Prepared By: _____ (Case Manager)

Signature

Date: _____

Approved for Distribution: _____ (Manager)

Signature

Date: _____

14.2 Formulation Template

PROVISIONAL FORMULATION - ITTC

Name	
DoB/ Age	
Child Story Number	
Cultural Background	
Current Placement Agency	
Case Management	
Admission date	
Formulation date	

Attendees :

Name	Organisation	Role

Client profile	Relevant History	Current challenges / hypotheses	Assessment Priorities
Diagnoses *Known or queried, who has made it, when, last reviewed.*			
Trauma Load/Attachments *Significant events and persons including identified impacts, as well as persons known to have strong seeking out of or attachments with. Specific trauma and attachment disruptions*			

Client profile	Relevant History	Current challenges / hypotheses	Assessment Priorities
Culture/Identity *Include current attitudes, engagement, hobbies and other interests. Significant rituals or activities associated.*			
Placement *Placement history (how many, who, environment, triggers for breakdown), future **placement** pathways*			
Family *Dynamics, concerns, aims, contact, meaning.*			

Client profile	Relevant History	Current challenges / hypotheses	Assessment Priorities
Health *Ongoing conditions, temporary conditions, optical, dental, OOHC Health Screen, other needs. Medication, last medical/ paediatric review.*			
Education *Current, school history. Cognitive functioning, learning needs. Tutoring, incidental learning and amenability Specific programs, school reports.*			

Client profile	Relevant History	Current challenges / hypotheses	Assessment Priorities
Emotional presentation *Variability, consistent states, patterns or particular states that are context/ trigger dependent (mood and affect); Any MSE information that may be helpful.*			
Behavioural Presentation *Presenting areas of concern, including risk, decision making vs impulse control, successful strategies to date, history, precipitating factors, maintaining factors (beliefs, contextual, triggers, responding)*			

Client profile	Relevant History	Current challenges / hypotheses	Assessment Priorities
Relationships *Peers, family or intimate - comments on status, noteworthy trends, expressed wishes, social skills.*			
Legal *Current or historical legal matters such as patterns of CJP contact, current legal issues, care orders etc., bail conditions.*			

Clinical Assessment Plan

Provisional Formulation statement:
Current Assessment Plan (including who is responsible, by when):
Example: Complete CANS - Trauma Assessment - LEAD MDST by 1st April 2020.
Treatment Plan (Future treatment recommendations post-ITTC to build into Transition Plan):

14.3 ITTC Assessment Report template

Intensive Transitional Therapeutic Care (ITTC) Assessment Report

Name of Young Person:
Preferred name:
Date of Birth:
Age:
Child Story No:
Gender: (M/F/Oth)
Preferred Pronoun:
Cultural Background:
Date of Entry to ITTC:
Weeks of stay:
Current Case management agency:
ITTC Agency:
Transition to:
Therapeutic Specialist:
Date of report:

This assessment report outlines the results of the assessments, observations and strategies undertaken and developed whilst the above named young person was in the ITTC. This report is intended for use by the Casework and Care team of the young person that is the subject of the report and is inclusive of the views of the young person and their families. The report should not be used for other purposes. The details of the assessments are true at the time of writing the report, constitute a culmination of the work of several professionals , and care team staff of the ITTC and is informed by multiple sources of information. The recommendations found in this report do not replace the need for development of a Case Plan and Behaviour Support Plan for a young person but are for the purpose of supporting the young on exit from the ITTC and should form the basis of their case and behaviour support plans.

Intensive Transitional Therapeutic Care (ITTC)

ITTC is a program up to 13 weeks guided by an overarching philosophy of Therapeutic Care.

The primary objectives of the ITTC are to provide a safe and child friendly environment where baseline behaviours can be established in order to:

- accurately assess needs
- review existing assessments and/or complete comprehensive assessments
- determine future needs and the most suitable transition pathway for children and young people
- enable formulation of case planning
- ensure that specialist service referrals have been identified
- identify and treat presenting need
- identify the best placement option, and
- work with the CAU, other Service Providers, case management teams, families and carers to successfully transition the child or young person.

Assessments in the ITTC setting should take a comprehensive approach and include the domains of cognitive development, psychological or mental health, physical/ emotional development and relational functioning.

Reason for Referral:

(Can include brief history of young person's placement request in ITTC, rationale provided by CAU on referral of young person to ITTC, what assessments were identified as required)

Sources of Information:

(Point form, this will include the DCJ CAU suitability assessment, DCJ CAU Psychology Report, any existing professional reports or school reports referred to in the ITTC report or used for assessment, etc)

***Professionals Involved**:*

(MDST team, TS, external providers of assessment, anyone else involved in the production of assessment information about the young person)

Tests/ Assessments administered:

(point form, will include the standardized assessments for ITTC: SDQ, BAC, CANS and all other assessments administered by the MDST or external providers contracted to assess the young person)

Identity and Culture

Photo with young person (if consent provided)

(describe young person, likes, dislikes, strengths, interests, goals, important relationships, culture, gender, hopes, include the young person's own opinions, desires and goals…they may be involved in developing this part of the report, may include a photo or other unique identifying information….

Describe the young person's unique cultural context, their view of culture, their connection to their culture, what is home to them culturally. In the case of indigenous young people, describe where is their country, if they are on country, where they consider country, cultural obligations and responsibilities, their connection with biological family and kin and if they are getting cultural guidance. Do they have a connection with Aboriginal medical services?)

Young Person's Views / Hopes and Dreams:

Background

Family of Origin:

Trauma History:

Placement History:

Significant Relationships:

Educational History:

Developmental History:

Mental health and Emotional functioning History:

Legal:

Current Assessment

(Refer to specific psychometric data and assessment reports in appendices)

Observations:

(Day to day functioning)

Cognitive and Educational Functioning:

(include formal testing, psychometric results, academic ability, memory, insight, judgement, school attendance and functioning, barriers to school attendance and functioning, learning ability (strengths and deficits or needs), plans for future cognitive and academic functioning)

Emotional Functioning:

(presentation, triggers, observations, strategies attempted and findings. include any formal testing eg: cans, sdq; include clinical interviews, progress through stay, important formulation around emotional functioning, should take a trauma lens perspective and include connection to the young persons experience)

Behavioural Functioning:

*(presentation, concerns, triggers, observations, strategies tried and what is effective; any formal testing of behaviours including psychometric measures administered, differences in various settings, **functional analysis**… what is the behaviour communicating, should take the perspective of the young persons trauma experience and developmental status)*

Social Functioning:

(interpersonal presentation, friendships, social skills, patterns of social response, include any formal assessment, observations or clinical interview, include different settings and context, extra curricular activities)

Developmental Functioning:

(speech and language assessment, occupational therapy assessment including sensory and motor function, any other paediatric developmental assessment, include formal assessments, informal assessment and observations)

Health:

(include any health professional assessments, health conditions, management of health, needs related to health conditions, sleep, growth, appetite, allergies etc)
(health record in appendix)

Mental health:

(include formal diagnoses, mental health professionals involved, discharge summary information, assessment information, observations, ongoing mental health needs)

Medications:
(for both physical and mental health, state reason for taking them) and prescriber

Independent Living:
(This section would be appropriate for young people over 15 where independent living skills can be identified as well as areas for development. For the 15 and 16 year olds this may then form recommendations for preparation to enter independent living arrangements prior to 18 and for the older cohort may assess the suitability for an independent living setting either prior to 18 or for leaving care.)

Risk Assessment:
(Formal assessment, observations, self-harm, suicidality, protective factors, vulnerabilities)
(include safety plan in appendix)

Final Formulation and Analysis

(This could include a narrative formulation or in point form relating the understandings of who the young person is, what they need, what they respond to, what they are affected by, what they have been affected by and their interpersonal and social world, Should be an evolution of the original provisional formulation done in week 2 that has developed as a result of the extensive assessment and observations undertaken. Should be a statement that incorporates the shared understanding of the professionals and carers that have worked with the young person)

Recommendations

This should be a detailed section that draws out how to support the young person in light of the assessment information in the body of the report as well as the final formulation and analysis. The recommendations should be multi-disciplinary, specific and a rationale provided. Incorporation of the recommendations developed by the MDST and the external providers of assessment happens here. The recommendations represent an incorporation of the professionals separate recommendations in areas such as:

Placement Recommendations:
Placement
Therapeutic Care (caring for the young person in their care context, including what strategies the young person responds to, environment, other young people, emotional and physical needs etc)

Therapeutic recommendations:
Behavioural Support
Emotional Supports
Educational needs
Family Relationships
Social Needs

Developmental needs (language, sensory, physical disability supports)
Referrals
Future Assessment Priorities

Appendices

(clearly titled, labelled)

1/ Transition plan (from ITTC to receiving provider)
2/ Standardised assessment data (SDQ, BAC, CANS)
3/ Other psychometric measures data administered
4/ Developmental Assessment Reports (Cognitive, Speech, Occupational Therapy, Paediatrician, medical, health etc)
5/ Significant observational notes / relevant Casework notes
6/ Independent Living Checklist
7/ Psychological/ Mental Health Assessment Reports
8/ Daily function data (school attendance, incidents etc)
9/ Behaviour Support Plan
10/Safety Plan
11/ NDIS authority, eligibility, approval, plan

14.5 Sample information sheet for children and young people

Intensive Therapeutic Transitional Care

What is Intensive Therapeutic Transitional Care (ITTC)?
Intensive Therapeutic Transitional Care (ITTC) is a home where you will be cared for by a team of staff that may include care (youth) workers, psychologists, counsellors and teachers. It is a home where you will live for about 13 weeks with up to 3 or 5 other children and young people.

What will happen when I move to an ITTC home?
While living at the ITTC home the team will work with you to find out what you need now and for the future to help meet your goals. When you and the team have worked out what you need, a plan will be made and you will be supported with that plan. It might include having one on one appointments with a counsellor, psychologist or other team member.

Where will I live?
Your caseworker will tell you where the ITTC home is and introduce you to staff that work there and other children and young people who live there. You will have your own bedroom and there will be an outdoor space and other recreational areas in the home.

Will I have to change school?
It will depend on where you move. Your caseworker will listen carefully to what you want and there will always be people to help you decide what you want regarding school.

Where will I go after 13 weeks?
The team will work with you to plan and support your move to your next home. When you do move, you will have support from the team and will always have somewhere to live. Your safety and wellbeing are the most important things.

Will I still get to see my family and friends?
If you already have regular plans to see your family and friends your caseworker will work with you and the ITTC team to continue with those plans. Your caseworker will talk to you if any of your plans need to change while you are living at the ITTC home.

Who can I talk to if I have any questions or I'm worried about anything?
You can always ask to talk to your caseworker or someone you trust. There will also be staff at the ITTC home 24 hours a day.