

Improving outcomes for young people transitioning from out-of-home care in Victoria

Interim Report

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Introduction

Young people in out-of-home care (OoHC) may experience a range of health, educational and social inequities due to childhood adversity and experiences within the OoHC system. When young people transition from OoHC at 18 years of age, it is recognised that their experience of disadvantage is compounded, with care leavers at risk of poor outcomes post-transition. While governments, Community Service Organisations (CSOs), and Aboriginal Community Controlled Organisations (ACCOs) support young people to plan to leave OoHC, this transition to independence occurs significantly earlier and with less support than in the general population. While government guidelines exist to guide successful transitions from care (i.e., housing, education engagement, life skills, cultural connections), the prevalence of adverse outcomes for young people leaving OoHC indicates the guidelines are not being implemented consistently.

This study was conducted in the State of Victoria, Australia and was supported by an Australian Research Council Linkage Grant (LP210300791). This study was led by the Department of Social Work and the Health and Social Care Unit (HSCU), Monash University in collaboration with the Victorian Aboriginal Child and Community Agency (VACCA), MacKillop Family Services, Anglicare Victoria, Baptcare, the Department of Families, Fairness, and Housing (DFFH) and the Centre for Excellence in Child and Family Welfare. The project aimed to generate new knowledge to inform the development and implementation of evidence-based innovations for young people as they transition from OoHC. This study was approved by the Monash University Human Research Ethics Committee (39433).

The aims of the study were to:

- identify the factors that enable smooth transitions from care;
- assess the quality of transition planning documentation used in current practice; and
- explore the barriers and enablers to the successful implementation of transition planning from the perspective of OoHC staff, carers, and young people.

To date, four components of this project have been undertaken:

- scholarly literature review;
- grey-literature review;
- assessment by researchers of the quality of Transition Plans in OoHC; and
- an exploration of the implementation barriers and enablers from the experiences of staff, carers, and young people.

This interim report presents the findings from these components.

Scholarly literature review

A scoping review of the international scholarly literature was conducted to identify factors enabling smooth transitions from care¹. Empirical literature published in English was

¹ Grage-Moore, S., Newton, D., Mendes, P., Wainwright, H., & Skouteris, H. A scoping review of international scholarly literature on factors enabling smooth transitions from out-of-home care. Submitted to peer reviewed journal, June 2025.

included with 32 studies included in the final review. This review identified nine key factors that contribute to smooth transitions from OoHC: social support; professional worker characteristics; mental health support; development of independent living skills; extended post-care support; culturally relevant support for Aboriginal and/or Torres Strait Islander young people; meaningful participation of young people; service characteristics; and access to education. The findings suggest that care leavers benefit from a range of targeted, wraparound supports from both formal and informal sources when transitioning from care.

Grey literature review

A scoping review of the Australian and international empirical grey literature (non-commercial or academic publications) was conducted with the aim of identifying the key factors that enable smooth transitions from OoHC, including for Indigenous populations². The search strategy involved (1) targeted searches on Google and child welfare organisation websites, (2) a child welfare database and (3) consultation with content experts. Following the screening process, 45 grey literature studies were included in the review.

The following 17 themes emerged in relation to factors enabling smooth transitions from OoHC as described in the grey literature. Themes common to all care leavers (both Aboriginal and non-Aboriginal) included: tailored, long-term and comprehensive case management; active and meaningful involvement of young people; access to affordable housing; supportive social relationships; supportive relationships with professionals; access to post-care support; cross-sector collaboration; system factors; extended care in line with social norms; OoHC policy; individual strengths of young people; quality and stability of placements; and education and employment. Themes unique to Aboriginal and/or Torres Strait Islander care leavers included: culturally appropriate support; Aboriginal-led services; connection to culture; and suitable placement location. The findings of this review have implications for research, policy and practice and provide guidance for the advancement of effective transition pathways for young people living in OoHC.

Assessment of the quality of transition plans in OoHC

The quality of Transition Plans developed for young people and associated demographic factors were assessed across three CSOs (Baptcare, Anglicare Victoria and MacKillop Family Services) and one ACCO (VACCA) in Victoria, Australia³. A Transition Plan Quality Assessment Tool was developed by the research team and applied to 196 plans. Quantitative analyses explored the quality and associated factors, while qualitative content analyses explored how well young people's needs were addressed. Most plans were of moderate quality, with significant variation by placement type (i.e., residential, kinship and foster care), age, length of placement, Aboriginal and/or Torres Strait Islander identity, young people's involvement

² Grage-Moore, S., Wainwright, H., Newton, D., Mendes, P., & Skouteris, H. (2025). Factors enabling smooth transitions from out-of-home care: A scoping review. *Children Australia*, 47(1), 3026. doi.org/10.61605/cha_3026

³ Wainwright, H., Savaglio, M., Morris, S., Newton, D., Devery, A., Luke, J., Grage-Moore, S., Gonsalves, S., Halfpenny, N., Nyblom, C., James, C., Mendes, P., & Skouteris, H. Assessing the Quality of Transition Plans in Out-of-Home Care. Submitted to peer reviewed journal, May 2025.

and who authored the Transition Plan. Quality varied across assessment domains with notable gaps in housing, post-care supports, and cultural considerations for Aboriginal and/or Torres Strait Islander young people.

Qualitative Interviews - Staff, carers, and young people

Method

This study applied an implementation approach to examine why transition planning, as outlined in government guidelines, is not consistently achieving intended outcomes and how its delivery can be strengthened. As implementation is shaped by conditions across multiple layers, the study identified barriers and enablers from an ecological perspective, considering factors at the system level, within placement settings, transition planning practice design, and the characteristics of individuals involved (i.e., young people, staff, and carers). Exploring and identifying the environmental conditions (i.e., placement setting) that shape transition planning mitigates individual responsibility and enables the design of sustainable strategies and solutions.

Data collection included 80 interviews:

- 46 interviews with CSO staff in various roles across residential care, foster care (home-based care), and kinship care (home-based care) (i.e., kinship practitioners, house coordinators, residential carers, senior practitioners, case managers, program managers, and team leaders),
- six interviews with carers (two with foster carers, four with kinship carers), and
- 28 interviews with young people (22 who had recently transitioned from care and 6 who were preparing to transition).

The key topics discussed aligned with the aims of the study and included the process of transition planning, documents used as part of the transition planning process, young people's involvement in transition planning, and barriers and enablers to the successful implementation of transition planning.

Interviews were also conducted at an ACCO (VACCA), but these data are not included in this report as it will be published in a standalone report. A summary of the findings derived from interviews with staff at CSOs, and children and young people supported by CSOs is presented below.

1. Findings – Staff & Carers

Themes from the staff and carer interviews are presented across multiple levels of the implementation context – the systemic and structural level, placement setting, practice and the individual.

1.1. System level (i.e., legislation, policy, cross-sector partnerships, funding)

1.1.1. Role clarity and care-team collaboration

Transition planning in residential care involves a broad network of professionals across care teams, residential homes, Child Protection, and external services such as Better Futures.

While this diversity of roles offers potential for comprehensive support, staff reported that fragmented responsibilities and poor coordination created significant implementation barriers. Responsibility for transition planning was perceived to sit with OoHC case managers and Child Protection - despite their limited day-to-day contact with young people. Despite their daily involvement and strong relational connections with young people, residential carers were typically excluded from formal planning processes as they were not seen as responsible for developing the Transition Plan nor making referrals to required services. Their input was often relayed indirectly, and they had little influence over key decisions, limiting alignment between day-to-day care and transition goals.

Young people's participation in transition planning was also shaped by the structure and culture of the care team environment. Many staff reported that while care team meetings are a key mechanism to hear young people's voices, the meetings are not youth-friendly or psychologically safe for young people to attend. This was due to formal meeting formats, unfamiliar care team members, and adult-centric language, which made it difficult for young people to engage meaningfully in transition planning conversations. Additional barriers arose when young people were absent from placement or at school when meetings occurred. These dynamics reinforced a system-led approach, where transition planning meetings were conducted about young people rather than *with* them.

Additionally, foster carers reported that young people had minimal contact with their case managers and staff from other programs and systems. This was further compounded by high turnover of staff within care agencies and staff who are perceived to be overloaded with administrative burdens. Ideally, they would like case managers to have a stronger relationship with young people under their care.

Several enablers supported more collaborative and inclusive planning. These included integrating transition planning into regular care team meetings, assigning a consistent facilitator, and promoting shared accountability across all team members. Engagement improved when staff holding the strongest relationships with young people were present in meetings and able to advocate for their needs and preferences. Transparent processes, relational consistency, and inclusive communication were all key to fostering youth-centred collaboration.

For Aboriginal and/or Torres Strait Islander young people, involvement of Aboriginal-led organisations and cultural experts was viewed as essential to ensure culturally safe and meaningful planning. While Aboriginal and/or Torres Strait Islander staff may work within mainstream CSOs, many young people are supported by non-Aboriginal workers. Staff emphasised the importance of involving ACCOs in care-team meetings as well as Aboriginal and/or Torres Strait Islander Practice Leaders, Elders, and community mentors to maintain cultural identity at the centre of planning and promote young people's engagement. However, under-resourcing of ACCOs often limited their ability to participate consistently, leading to missed opportunities for culturally guided support.

Lastly, a key barrier for kinship carers was a sense of isolation and lack of formal recognition within the care system during the transition period. Connecting with other kinship carers

through peer support groups (when accessible) was valued as spaces for emotional grounding, shared learning, and mutual encouragement during the transition process. These opportunities helped carers feel less alone and more confident in their caregiving journey. Strengthening and expanding access to such peer networks during the transition period could play a key role in reducing carer burnout and enhancing overall wellbeing.

1.1.2. Placement instability undermines relationships and planning

Staff reported that repeated placement changes were common for young people in residential care and had significant negative impacts on their wellbeing, relationships, and engagement in transition planning. Moves were often driven by crisis or behavioural escalation, but also by the pressures of limited placement options. While placement matching was recognised as an important principle, staff noted that in practice it often resulted in young people being moved multiple times, with continuity and connection repeatedly disrupted. One staff member described this experience as *“moving young people around like chess pieces,”* highlighting the tension between positive intentions and the realities of system capacity.

Staff reported this instability eroded young people’s trust in adults and discouraged them from forming attachments, knowing that relationships would be temporary. Disconnection from familiar staff and peers frequently led to emotional withdrawal and behavioural challenges. Staff observed that when transition planning was introduced during these periods of instability, some young people would *“vote with their feet”* by going missing from placement, to protect themselves from the emotional impact of losing another relationship.

Placement instability also contributed to delays in initiating transition planning. Staff consistently reported that planning often occurred later than ideal, particularly in residential settings, as energy was focused on managing crises and adjusting to new environments. Essential tasks such as securing identification, preparing for housing, and building life skills were often compressed into the final months before a young person exited care. This reduced the opportunity for tailored, developmentally appropriate support and made meaningful engagement more difficult.

Communication breakdowns further compounded these challenges. Both staff and young people were frequently excluded from decision-making and informed of placement changes with minimal notice. These experiences reinforced feelings of powerlessness and made it more difficult to sustain the stability and trust required for youth-centred planning.

1.1.3. System pressures and age-based transitions

Staff consistently identified the legislative requirement that young people leave residential care at age 18 as a major barrier to effective transition planning.

The fixed age threshold meant that some young people were required to exit care before they had secured stable housing or developed the skills and supports needed for independence. The limited timeframe also reduced opportunities for meaningful participation in planning. As one staff member reflected, *“you’ve got time pressures to get it done, and if they’re not engaging, you just do it without them so you can tick your box.”*

Although placement changes and exits occurred within the legislative framework, staff emphasised that this structure prioritised compliance with age-based requirements over developmental readiness. Decisions about readiness were frequently reduced to narrow, task-oriented indicators such as cooking skills or school attendance, while broader social and emotional needs remained unmet. Residential care providers were unable to extend support beyond 18, even where strong and trusted relationships existed, and young people had little control over the timing or conditions of their exit.

Staff also highlighted pressure from Child Protection to manage throughput and create space for others entering care, which often led to young people exiting residential care between the ages of 16 and 17 into semi-independent housing. Structural drivers, such as bed shortages and funding limits, were seen as creating these conditions which leave some young people unprepared for independent living. The assumption that turning 18 equates to readiness for independence was strongly challenged, with staff describing the expectation that young people would function as independent adults immediately after leaving 24/7 care as developmentally inappropriate.

These legislative requirements meant staff were often unable to tailor transition planning to a young person's individual needs. Young people typically had little control over when they exited care, making it difficult to deliver youth-led or developmentally responsive planning. As a result, transition planning was frequently reduced to a procedural task, limiting its impact and relevance. This highlights a fundamental mismatch between the legislative context and the aims of transition planning.

1.1.4. Housing pathways

Securing safe and sustainable housing was described as the primary focus of transition planning, particularly for young people in residential care. Uncertainty about post-care accommodation often stalled planning efforts and heightened anxiety for young people and staff as they neared the end of their placement. Residential care staff reported that when no housing option was available by a young person's 18th birthday, young people were taken to a homelessness service.

Multiple barriers limited access to housing that could support a stable and developmentally appropriate transition to adulthood. Staff reported that housing options, such as family reunification, semi-independent placements, independent living, and supported accommodation, often did not align with young people's preferences and needs. These challenges were compounded by the limited availability of affordable and appropriate housing in the general community, which further constrained options and undermined planning efforts. Housing decisions were frequently driven by available resources in the system rather than suitability, resulting in housing outcomes that lacked safety, consistency, or connection to community. This lack of appropriate housing pathways had significant implications for the quality and individualisation of transition planning. While staff described efforts to tailor plans to each young person, planning could only go so far when suitable post-care options simply did not exist. The absence of viable housing limited young people's choices and undermined the responsiveness of the planning process, regardless of how well it was delivered.

Family reunification was considered a positive pathway when it was safe and aligned with the young person's wishes. However, when driven by a lack of alternatives, and contrary to the young person's preferences, it was viewed as an unsafe and inappropriate outcome. Staff also noted a systemic contradiction. Some staff reported that throughout a young person's placement, reunification was often actively discouraged due to assessed risks. Yet, as they neared the end of care, returning home was considered a viable option, even when circumstances had not meaningfully changed.

Independent housing, such as public housing or private rentals, required young people to live entirely on their own without ongoing support from OoHC case managers. While this is aligned with current guidelines and legislation, staff felt they were "*setting young people up to fail*," as the level of autonomy was often developmentally inappropriate.

Access to housing was further hindered by common barriers to obtaining the identification documents (ID) necessary for housing applications. Staff described administrative processes as incompatible with the lived experience of many young people in care. For example, applying for a photo ID often requires a birth certificate, yet many young people did not have access to one. Obtaining a birth certificate, in turn, typically required other forms of ID or supporting documents, which were also frequently missing. These circular requirements created delays and frustration, often stalling housing applications and undermining timely transitions from care.

Staff emphasised that while early planning is critical, it is not always possible. Many young people enter care as older adolescents, leaving little time to navigate complex administrative processes. Even when planning began early, systemic barriers such as identification requirements could still prevent timely access to housing. This underscores the need for streamlined processes that reflect the lived experience of young people in OoHC and for processes to commence earlier.

Semi-independent housing was seen as a valuable pathway for young people to gradually build the skills needed for independent living while still receiving support from Child Protection and OoHC case managers. These models offered a transitional step with reduced oversight, allowing young people to gain confidence and capability. However, all were short term, with an expectation to move on by age 18 or, in rare cases, 19. Access to semi-independent housing was also limited by rigid eligibility criteria. Young people engaged in education or perceived as less complex were more likely to be prioritised, while those with more complex needs were often excluded, leaving those most in need of stable accommodation at greatest risk of homelessness upon leaving care.

While disability-specific housing was seen as an important enabler for young people with a National Disability Insurance Scheme (NDIS) package, offering stable housing and tailored support, staff reported that due to NDIS processes, disability housing outcomes were commonly not determined until after the young person turns 18. As a result, workers often needed to explore and prepare two housing options: one temporary and one longer-term.

Despite these barriers, staff identified several promising models that supported gradual and appropriate transitions. These included studio units placed in carers' backyards (Kids Under Cover), co-located units with on-site mentoring (Village 21 model), flexible rooms within residential care (zipper rooms), trial apartments (taster flats), residential models with

wraparound supports (Keep Embracing Your Success (KEYS) program), and integrated housing-first programs (Haven Home Safe). These models provided stability, relational continuity, and opportunities for skill-building. However, they were not widely available, and access varied across locations.

Staff emphasised the need for improved coordination between Child Protection and Housing department staff to increase the amount of appropriate housing options specifically for young people transitioning from care. In addition, they emphasised the need to expand age-based eligibility beyond 18 years, so young people are not moved into both semi- and independent housing before they feel ready. Addressing these gaps was seen as essential to support safe, timely, and sustainable transitions from care.

Foster carers similarly expressed frustration about the lack of safe, stable, and affordable accommodation available to young people when they transitioned from care, particularly in regional areas. Participants reported that young males encountered greater barriers to accessing accommodation compared to young women. Competition in the private rental market means that young people are always going to struggle to find accommodation without references and without sufficient income to afford properties. Housing programs such as Kids Under Cover that provide carers with the funding to install bungalow accommodation on their properties make for a smooth and well-supported transition, particularly for young people with disabilities.

1.1.5. Transition-from-care supports

Early referrals to, and engagement with Better Futures are key components of the broader transition planning process, as it is designed to provide transition-from-care support from 15 years and 9 months to 21 years old. Staff described several barriers that undermined the effectiveness of post-care support. Delayed introductions were common, with Better Futures workers often becoming involved only in the final stages of care. This limited opportunities to build trust and reduced young people's engagement with support after leaving care. The voluntary nature of the program was said to further compound this barrier. Staff described Better Futures workers as placing the onus on young people to demonstrate engagement and maintain contact with workers, even though prior to turning 18 they are not expected to independently navigate services. This reported expectation was viewed as developmentally inappropriate for many young people.

In addition, high caseloads of Better Futures teams and demand exceeding program capacity was reported as hindering young people receiving adequate levels of support. Staff also reported that supports such as casework and flexible funding were inconsistently available or poorly integrated into care teams, particularly for young people exiting care before age 18. Greater integration of Better Futures within broader care teams was seen as essential to ensure support is cohesive, timely, and responsive to young people's needs.

Despite these challenges, staff identified several enablers that strengthened the impact of post-care support. Early engagement by Better Futures workers, particularly when initiated well before a young person's 18th birthday, was viewed as critical for building trust and increasing the likelihood that support would be accepted. Consistent, face-to-face contact

over time enabled workers to form relationships, understand individual needs, and provide continuity throughout the transition.

Coordinated approaches, such as joint handovers and planning meetings involving case managers, residential staff, and Better Futures workers, were also described as effective in smoothing transitions and maintaining relational connections. In one organisation, in addition to Better Futures, one organisation also had a dedicated Youth Worker that was allocated to support young people from the start of transition planning through to post-care, providing a consistent point of contact, higher support levels and no fixed service period. This model was seen as a best-practice example of how relational continuity and timing can enhance the effectiveness of post-care services.

Foster carers similarly expressed frustration with some Better Futures workers who made promises to young people that they did not keep. One carer described a 17-year-old girl in her care who was pregnant and had been told she would receive a public housing unit for herself and her baby but was instead placed in a 12-month housing option, with the expectation she would later secure a private rental as a young, single parent. Foster carers felt that Better Futures become involved too late in the leaving care process and they preferred workers to engage with young people earlier. While they felt that the program provides important financial support, carers would like Better Futures workers to also prioritise forming a relationship with young people and providing them with face-to-face support until 21 years of age.

1.1.6. Policy tensions

Staff and young people described how a perceived system-wide focus on risk management often limited opportunities for young people to build independence and experience everyday life. Residential care staff felt constrained in teaching natural consequences due to restrictive policies, while young people missed basic developmental experiences including holding house keys, attending sleepovers, or managing their own medical appointments.

Child Protection protocols were often seen as overly risk-averse and disempowering, for example, issuing police warrants when young people are out beyond curfew. This overprotection left some young people unprepared for adulthood, particularly as they transitioned abruptly from controlled environments to independent living at 18. Balancing safety with opportunities for autonomy and growth was seen as essential to ensure young people are not only protected but genuinely prepared to leave care.

1.1.7. Information technology systems

Key information technology (IT) systems - both government mandated systems and agency specific client management systems - were reported to enable more coordinated and consistent transition planning. Staff highlighted the value of features including built-in templates, automated alerts at key milestones, and the capacity to generate reports that supported visibility and cross-team collaboration. These functions were viewed as important enablers of timely and equitable planning.

However, limitations were also reported. Information was often duplicated across government-mandated and agency-specific systems or stored offline, restricting continuity and collaboration. Platforms were described as difficult to navigate, and prone to data loss, while planning alerts could be obscured by competing prompts. In some cases, plans were completed outside the mandated systems, reducing visibility and undermining consistency. Staff emphasised the need for more integrated and user-friendly systems to strengthen collaboration and reduce administrative burden.

1.2. Placement level (i.e., residential care home-based care provider)

1.2.1. Relational stability and supportive relationships

Trusted, consistent relationships were described as essential to enable effective transition planning and support. Staff emphasised that when young people felt emotionally safe and connected to those supporting them, they were more likely to engage in planning, set goals, and build the skills needed for independence. Strong relationships enabled staff to personalise planning based on their knowledge of the young person's interests, readiness, and needs. Staff reported that planning worked best when integrated into these relational routines rather than treated as a formal or separate process.

However, continuity was often disrupted by staff turnover, placement changes, and reliance on casual or agency staff, making it difficult to sustain the trust needed for meaningful engagement. High Child Protection caseloads further limited regular involvement. While contracted case management meant that CSOs were primarily responsible for day-to-day relational engagement, participants stressed that connections with Child Protection also remained crucial. Regardless of contracted arrangements, Child Protection was described as the "corporate parent" and retained statutory responsibility for decisions about leaving care. As the corporate parent, Child Protection practitioners were seen to hold a responsibility to help young people rebuild trust, confidence, and self-worth, yet they were frequently described as inaccessible or disengaged. Relational stability across both care and statutory roles was viewed as a vital foundation for effective transition planning; without it, planning was more likely to feel procedural than youth-led and personalised.

Relational and placement stability was also reported by kinship carers. Kinship carers reported providing a stable placement for young people during the transition period, with many continuing well into adulthood. This consistency and familial connection meant that formal transition planning was sometimes overlooked, or initialised later than ideal, as it was assumed the young person would remain in the carer's home. In the absence of structured or formal transition processes, kinship carers described having to naturally taking the lead in preparing young people for adulthood and beyond, supporting them with education, housing, mental health, and life skills. Kinship carer commitment, placement stability and the relationship with the young person in their care, facilitated the transition process despite limited formal processes and guidance from others.

Kinship carers spoke highly of the support they received from dedicated kinship practitioners from the service provider partners, describing these relationships as a vital source of guidance, advocacy, and support. Practitioners who were consistent, respectful, and proactive made a significant difference - not only for the young people but also for the kinship carers themselves. Kinship carers valued practitioners help to navigate complex

systems, secure funding, and providing emotional and practical support during the transition period. The presence of a trusted worker often transformed the transition experience from one of isolation to one of shared responsibility and support.

1.2.2. Placement environment

Staff described the residential care environment as a barrier to transition planning achieving the intended outcomes. Some staff worked in homes that accommodated up to four young people with complex and diverse needs and reported these were highly dynamic and often unstable settings. Frequent placement changes, rotating staff rosters, and regular critical incidents contributed to a crisis-oriented environment, where immediate safety concerns took priority over future-focused work, and with transition planning and support, including during periods of relative stability, were a low priority. These conditions made it difficult to build trusting relationships or engage young people consistently in planning activities, including the development of basic life skills.

Despite these challenges, staff noted several environmental factors that enabled more meaningful planning. Smaller homes, particularly two-bedroom models, were perceived as more stable and conducive to stronger relationships. With fewer residents, the environment felt calmer and allowed staff to provide more individualised support for transition-related tasks.

Staff capacity to prioritise transition planning was limited by competing demands. Responsibilities such as managing risk, responding to incidents, and meeting administrative requirements often took precedence. When young people entered care late or experienced placement breakdowns, transition planning was frequently rushed or delayed, as the young person's safety and relational engagement must be prioritised. Nonetheless, in these cases, staff described scrambling to complete minimum requirements, reinforcing the perception that transition planning was more about meeting compliance than supporting young people's development.

The physical environment also shaped the experience of care. Homes that avoided institutional features, such as visible organisational signage, and instead included personalised elements like young people's artwork or involvement in decorating their space, helped foster a sense of belonging. Involving young people in everyday tasks, such as cooking and household routines, not only created a more homelike atmosphere but also supported the development of practical life skills. These conditions were seen as important for creating the stability and relational connection required for effective transition planning.

1.3. Practice (i.e., transition planning practice design)

1.3.1. Conceptualisation of transition planning

There was a shared understanding among staff that transition planning is a task-oriented process focused on preparing young people to leave care. This typically centred on identifying alternative housing, establishing formal and informal support networks, developing independent living skills, and securing income. For those in residential care, this meant planning towards an exit by age 18, as remaining beyond this age is not permitted. In contrast, young people in home-based care (foster or kinship care) had the option of remaining in situ until 21 under the extended care initiative, although this was not

guaranteed in practice. Staff noted that this distinction shaped both the timeframe and approach to transition planning across care types.

There was also general agreement that transition planning should commence as early as possible and actively involve young people. Staff described initiating planning at varying ages, including 15, 16, or 17. Some began informal discussions around age 15, using this time to support skill-building and development, such as exploring part-time work or gradually increasing responsibilities. Others introduced more structured planning tools at age 16, aligning with formal service expectations. Staff described early and gradual planning as more effective, particularly when embedded in a youth-centred, relational approach that could adapt to each young person's pace and readiness. However, staff also noted that when young people entered care in later adolescence, there was often limited time to prepare for leaving. In these circumstances, transition planning was described as compressed and more difficult to deliver in a youth-centred way, with less opportunity to build skills and relationships over time.

Despite this agreement, staff differed in how holistically they conceptualised transition planning, as well as when young people should become aware of and involved in the process. Some described transition planning as a broad developmental journey involving emotional readiness, identity formation, and cultural connection. Others framed it more narrowly as a practical and logistical process, focused primarily on securing housing. Similarly, while some staff advocated for early transparency and youth involvement, others were hesitant to involve young people too soon, citing uncertainty around service access or referral outcomes. They preferred to wait until plans were more concrete before engaging young people, to avoid setting expectations that might not be met.

These differences in conceptualisation and timing may contribute to inconsistencies in how transition planning is delivered across contexts. While government guidelines provide a framework to guide practice, the results indicated a lack of consistent knowledge about the key components, and how to operationalise them in practice.

1.3.2. Appropriateness of transition planning

Staff made a clear distinction between the formal Transition Plan document and the broader transition planning process. The formal plan was generally perceived to have limited value for young people and was primarily described as a compliance-driven tool used to meet system mandates. It was frequently treated as a "*tick-box exercise*," completed by OoHC case managers to satisfy external requirements and rarely revisited in day-to-day work. In many settings, the Transition Plan was not well integrated into regular care team practice or shared with key staff involved in transition planning, such as residential carers, home-based carers, Better Futures workers, or Targeted Care Package case managers, limiting its potential as a coordinated support tool.

Engagement with the Transition Plan was often low. Staff reported they rarely provided young people with a copy and attributed this either to discomfort with the Transition Plan's contents or to young people's limited interest in reading or keeping it. The Transition Plan (and accompanying documents i.e., Assessment and Progress Record) was widely criticised for being lengthy, wordy, and difficult to navigate. Its standardised format lacks flexibility to accommodate young people's communication styles, neurodiversity, cultural identities

(Aboriginal and/or Torres Strait Islander and culturally diverse young people), or developmental stages. This complexity made the document inaccessible and unengaging for most young people.

For Aboriginal and/or Torres Strait Islander young people, staff noted that cultural responsiveness was often lacking in both the design and delivery of transition planning. Cultural Support Plans, which are developed through a separate process from transition planning and were not routinely referenced or integrated into it. This may limit the ability to embed cultural identity, community connection, and practices such as return to Country into transition supports. When well developed and actively integrated, these plans were seen as valuable tools for guiding culturally relevant and safe transition supports. Strengthening this integration was viewed as critical to improving the cultural appropriateness of planning for Aboriginal and/or Torres Strait Islander young people.

The Transition Plan document was also criticised for failing to comprehensively address all key transition domains, particularly housing and transition-from-care services, and for including generic goals with little emphasis on measurable outcomes. In response to these limitations, some organisations and teams have developed alternative tools, including checklists that better align with young people's needs. Staff adapted the planning process in several ways, including introducing transition planning in indirect and casual settings (i.e., driving lessons). These strategies aimed to reduce overwhelm and make the process more accessible to young people. However, staff were still required to complete the standard Transition Plan for compliance purposes, which contributed to an administrative burden.

Beyond issues of format and complexity, staff also described tensions when young people's goals were viewed by adults as unrealistic or unsafe. These conflicts created challenges in supporting youth autonomy while adhering to perceived system constraints or professional responsibilities. While transition planning is intended to be centred on young people's preferences and readiness, in practice it was often shaped by organisational pressures, leading to their disengagement, or presented with pre-filled documents to approve rather than being supported to shape the content themselves.

Despite these challenges, the formal plan was seen to have value in some contexts. When led by staff who valued its purpose and used it to capture the outcomes of youth-led conversations, the Transition Plan could prompt attention to important life domains, support continuity across services, and help young people articulate and prioritise their goals. However, these benefits were only realised when the Transition Plan was embedded within a broader, relational approach to planning that was grounded in trust, youth agency, and developmental fit.

1.4. Individual characteristics and needs

Transition planning is most effective when it aligns with young people's motivation, readiness, and complexity of need. However, staff reported that transition planning practices are often inflexible, rushed, and poorly adapted to the realities young people face, particularly those with higher needs, Aboriginal and/or Torres Strait Islander young people and multicultural and multifaith young people.

1.4.1. Motivation and anxiety

Staff described how young people's engagement in planning varies widely. Some are motivated and eager to leave care, actively participating in planning and pursuing goals. However, many approach the process with fear or avoidance, driven by anxiety about leaving the care system and losing the support it provides. This anxiety was especially acute among young people with complex needs, including disability, neurodiversity, mental health challenges, or criminal justice involvement, who often felt unprepared for independent living. Without emotional readiness and clear, trusted support, many young people disengaged or resisted planning altogether.

1.4.2. Diverse needs

Staff reported that a high proportion of young people in care had disability, neurodiversity, complex trauma histories, mental health needs, or criminal justice involvement, which added layers of complexity to their transitions. Standardised plan templates and timelines were described as barriers to accommodating diverse needs. Staff also highlighted the absence of accessible, age-appropriate materials to help young people understand what transition planning involved and what supports were available. In contrast, tailored approaches such as visual aids or 'social stories' were identified as key enablers, making planning more meaningful and responsive to individual needs.

Additional barriers to a successful transition from care for young people with disability included access to NDIS services, attributed to late referrals to specialist disability services, late identification of disability, lengthy waitlists within the NDIS and "skewed" assessment of disability needs. Staff emphasised that effective transition planning depended on timely service access; without it, young people with disability were at heightened risk of entering independent living without adequate support, financial assistance, and appropriate housing.

Cultural needs were also frequently overlooked for Aboriginal and/or Torres Strait Islander and multicultural and young people. For Aboriginal and/or Torres Strait Islander young people, staff highlighted the importance of connection to culture, their mob, family and community, and opportunities to return to Country. These needs were not always reflected in planning, even when young people had been in care for extended periods. One key barrier was that Cultural Support Plans were a separate process from the Transition Plans. Staff also noted they were not "*cultural experts*" and that the process of providing proof of Aboriginality created additional barriers to accessing culturally specific services, particularly when documentation was unavailable or delayed.

Multicultural and multifaith young people faced additional challenges, including visa and immigration processes, limited English language proficiency and reduced eligibility for services based on immigration status. Some required legal support to resolve visa or citizenship matters, which directly affected their access to housing, healthcare, and education. Staff also noted the importance of supporting young people to connect with their cultural or religious communities.

The capability of staff and carers to support young people leaving care was identified as a critical factor influencing the success of transition planning. This included case managers, Child Protection workers, residential care staff, foster carers, and cross-sector partners. However, participants described variation in skills, knowledge, and confidence across roles and settings, often shaped by individual experience rather than consistent training or supervision. Many staff reported receiving little to no formal training in transition planning and instead learned through informal means such as trial and error, observing colleagues, or copying existing plans. This reliance on informal learning contributed to inconsistent practices and limited understanding of key processes. Staff commonly described a lack of awareness around critical supports, particularly in areas like housing, disability services, financial entitlements, and post-care pathways. Some were unfamiliar with key planning tools such as the Transition Plan or unsure how to complete them in a meaningful and youth-centred way. These gaps are pronounced for inexperienced staff, agency workers, and carers, who often lacked access to training and were not formally included in planning conversations.

Staff also reflected on their limited capability to provide culturally appropriate support for Aboriginal and/or Torres Strait Islander young people. Some staff acknowledged feeling uncertain or ill-equipped to engage meaningfully, due to a lack of cultural knowledge or experience working with Aboriginal and/or Torres Strait Islander young people. This highlights the need to build staff capability and integrate cultural experts (i.e., Aboriginal staff within CSOs, ACCOs and Elders) into transition planning processes.

Despite these challenges, several enablers were identified. Staff spoke positively about learning from peers, engaging in role-modelling, and drawing on other organisational training. Some organisations offered targeted training and support through Better Futures⁴ consultations, which helped staff feel more confident in their role. Staff emphasised the importance of ongoing, practical training tailored to distinct roles. Several participants recommended the introduction of a dedicated transition support role within CSOs to help coordinate planning, guide teams, and ensure continuity of support for young people. Strengthening workforce capacity across all roles is therefore essential to improving the consistency and effectiveness of transition planning in OoHC.

Kinship carers reported feeling unprepared to support the young people in their care during the transition period and reflected on difficulties in addressing the needs of young people experiencing trauma, disability, or behavioural challenges. They also described feeling disempowered and overwhelmed by navigating the OoHC system, reported frequent Child Protection caseworker turnover, and contradictory information or misinformation regarding funding entitlements or service eligibility. Therefore, kinship carers identified the need for targeted transition planning training, encompassing trauma-informed care, adolescent development, and systems navigation. Carers frequently resorted to self-education or paid for private courses to fill these gaps, underscoring the urgent need for accessible training and education to support them in the transition process.

⁴ Better Futures is a transition from care service, which provides funding and casework support up to the age of 21 years old.

2. Findings – Young People

2.1. Inadequate transition planning

Transition planning and support was widely experienced by young people as inconsistent, last-minute, and disempowering. Many young people reported feeling excluded from meaningful involvement in their own planning processes and described a lack of genuine choice in their transition planning. They felt decisions were often experienced as being made for them by Child Protection practitioners they did not know, leaving them feeling like “bystanders” rather than active participants. Young people felt more included and better prepared when they were involved in decisions throughout the entire process.

2.2. Lack of preparation for independence

Young people consistently described feeling underprepared for adulthood. Rather than being supported through a gradual developmental process, young people reported that they were often expected to achieve independence based on age-based mandates that failed to reflect their individual readiness. For some young people, leaving care was associated with increased motivation, confidence, and a sense of anticipation about independence. For others, readiness was undermined by nerves, uncertainty, or feeling unprepared. Several described the feeling of being pressured to begin before they were ready. Specifically, multiple young people from residential care reported knowing that they were being transitioned out of care prior to turning 18 so that other young people could move in.

Several young people described the lack of an incremental build-up of skills, as they moved abruptly from having everything done for them to being self-sufficient overnight. Gaps in life skills education left many young people unable to manage basic responsibilities, such as budgeting or household maintenance. This contributed directly to housing instability, with some young people exiting care into homelessness, or unsafe living arrangements. Further, young people reported that their physical and mental health care needs were often similarly unmet while they were in care. Many reported experiencing isolation, anxiety, and unresolved trauma during their transition from care, compounded by limited access to therapeutic or mental health support. This was compounded for young people with a disability, who reported additional challenges due to transition planning not being accessible for their additional needs and unrealistic expectations for self-management.

Carer’s capability and dedication, alongside trusting and consistent carer-child relationships, were central to young people’s preparation for independence. Most young people reported not being shown essential tasks such as managing household responsibilities and similarly were not involved in arranging medical appointments, which left them without the knowledge to schedule appointments, navigate referrals, or obtain prescriptions after leaving care. In contrast, some young people, particularly those from home-based care, described having carers who actively supported skill development. Young people valued being coached through cooking, budgeting, scheduling doctor appointments or being guided through the process of obtaining a learner driver permit.

2.3. Gaps in information sharing and transition support

A lack of accessible, youth-friendly, and trauma-informed information about transition planning further undermined young people's agency. Planning was often reduced to a compliance task, where workers distributed generic materials with little explanation or engagement. Not being kept informed throughout the process also created a sense of rushed transitions, with some young people only told where they were moving once arrangements were finalised. In other cases, planning was raised once and then not revisited, or information was not provided in ways young people could understand. Further, young people described care team meetings for transition planning as not always accessible or meaningful. Meetings were sometimes scheduled during school hours, limiting young people's ability to attend. Others described the meetings as "*clinical*" and focused on their deficits, while others did not know they could attend. Young people called for the co-design of clear, accessible transition planning resources tailored to diverse communication styles. Young people also recommended stronger care team accountability in guiding and supporting them through the transition process.

2.4. Placement environment

Young people described how their placement environment shaped the conditions necessary for them to actively participate in transition planning and to build readiness for leaving care. Residential care was overwhelmingly described as a chaotic and unsafe environment, characterised by instability, high staff turnover, and distrust. This limited opportunities for young people to form the supportive connections needed for transition planning. In contrast, placement environments that fostered a sense of stability and home enabled successful transition planning. Smaller homes, positive household dynamics (i.e., living with peers of a similar age) and having stable, positive and trusted relationships with their carer, contributed to a more supportive and manageable environment that facilitated and prioritised transition planning.

3. Recommendations

Based on the findings from the studies, numerous policy recommendations were identified to enhance the implementation of transition planning. The recommendations aim to address multi-level barriers and enablers that shape how it is embedded into practice. Key recommendations relate to workforce capability building; adapting transition planning tools; clarifying roles and responsibilities for transition planning; and strengthening transition-from-care supports.

3.1. Workforce capability building for transition planning

- Provide evidence-informed training to all staff and carers - including agency staff - on delivering effective transition planning. Training should include core elements such as building trust and engagement, setting achievable goals, using developmentally appropriate communication, strengths-based and inclusive practice, involving young people in decision-making, and aligning planning with their strengths, interests, and cultural identity.

- Embed ongoing coaching and reflective practice opportunities that are focused on transition planning, led by internal staff with experience in delivering transition planning, navigating cross-sector processes (i.e., housing, NDIS, education), and supporting collaboration between care teams and external services.
- Integrate transition planning training into staff onboarding and ensure refresher training is delivered when staff begin their first planning process with a young person.
- Strengthen workforce capability to support culturally safe transition planning for Aboriginal and/or Torres Strait Islander young people by providing ongoing, practical training delivered by ACCOs and ensuring staff have the skills and partnerships needed to implement cultural goals.

3.2. Transition planning tools

- Replace the current 15+ Care and Transition Plan with a co-designed (with practitioners, carers, and young people) tool that is youth-friendly, flexible, accessible, and responsive to young people's communication styles, cultural identities, and developmental stages.
- For Aboriginal and/or Torres Strait Islander and multicultural young people, incorporate cultural planning prompts into the Transition Plan to streamline planning for these cohorts. It is recommended to co-design a solution in partnership with end users of each plan.
- Develop adaptable guidance and tools that support personalised, tailored, and developmentally appropriate transition planning.
- Strengthen the integration of transition planning tools into day-to-day practice to ensure documents are consistently co-produced and shared with all care team members and residential care staff.
- Ensure timely, transparent communication with young people and staff and actively involve them in planning to preserve trust, reduce disruption, and maintain engagement in transition preparation.
- Commence transition planning processes such as legal documentation, NDIS assessments and visas earlier.

3.3. Transition planning roles and responsibilities

- Develop and implement clear guidance for transition planning, that clarifies roles and responsibilities for all care team members.
- Ensure transition planning care team meetings actively include young people, with formats adapted to their comfort, communication needs, and developmental stage.
- Clarify and share responsibility for transition planning across the care team, involving those with the strongest relationships with young people in planning and decision-making.
- Embed consistent facilitation and shared accountability in care team processes to strengthen collaboration and support continuity of care.

3.4. Transition-from-care supports and continuity

- Fund dedicated transition practitioners within OoHC providers to support continuity and guide young people through planning and service navigation.
- Increase the Better Futures workforce to decrease their caseloads and enable early and long-term engagement from age 15 years and 9 months.
- Increase Better Futures workforce capacity to provide more casework support whilst young people are still in care, and to support assertive outreach to young people who are unlikely to engage in help-seeking behaviour.
- Increase OoHC workforce knowledge of Better Futures, Disability Support Advisers and NDIS processes to promote earlier and equitable referrals.
- Ensure timely, transparent communication with young people and staff about placement changes, and actively involve them in planning to preserve trust, enhance continuity, and maintain engagement in transition preparation.

3.5. Systemic (longer term)

The study identified that systemic conditions shaped by legislation indirectly pose a barrier to the successful implementation of transition planning. A successful transition from care cannot be achieved purely within the bounds of the OoHC service system. It relies on cross-sector partnerships and is shaped by intersecting policy contexts and resources of other service systems (i.e., housing, NDIS, education). Therefore, there is a need for longer term policy reform, as identified by the following recommendations, in tandem with the shorter-term solutions to improve implementation.

- Strengthen placement stability by prioritising continuity in residential care by avoiding reactive moves driven by system pressures and embedding relational and therapeutic approaches to reduce crisis-driven placement breakdowns.
- Delay transitions from residential care or semi-independent housing until the young person is developmentally ready (i.e., not pressured to leave before 18), based on their needs and preferences.
- Reduce policies that restrict young people's ability to incrementally build independence (i.e., medication management, house keys).
- Expand access to safe, appropriate housing linked with community and support services and extend eligibility to age 25 to align with broader youth definitions.
- Scale up transitional housing programs across regions, with extended tenancies and staged support to enable stable, goal-aligned transitions from care.
- Improve coordination between Child Protection and Housing systems, removing eligibility barriers, and embedding models that support relational continuity and readiness.
- Address misaligned policy timelines between Child Protection and NDIS that hinder seamless transitions into disability housing by age 18.
- Align planning processes with young people's definition of readiness and goals, rather than legislative or compliance requirements. Ensure planning is embedded in ongoing, relational work and tailored to individual preferences and pace.

- Tailor planning to each young person’s developmental stage and capacity, focusing on readiness rather than legislative requirements.
- Increase the pool of two-bedroom residential homes and decommission four-bedroom models to create more stable, relationally attuned environments.
- Prioritise small-scale, home-like care settings that avoid institutional features and foster a sense of stability, safety, and ownership for young people.
- Reduce reliance on casual staff by investing in consistent staffing models, recruitment, training, and retention strategies to support trusting relationships.
- Modernise information sharing systems to reduce duplication (i.e., paper-based forms and duplicate data entry) and promote accurate inter-team communication.
- Improve system functionality and usability to promote equitable referrals to external services and support more consistent use of built-in features such as reminders.
- Develop a digital solution that allows young people to securely access their Transition Plans and records, addressing concerns about losing physical copies.