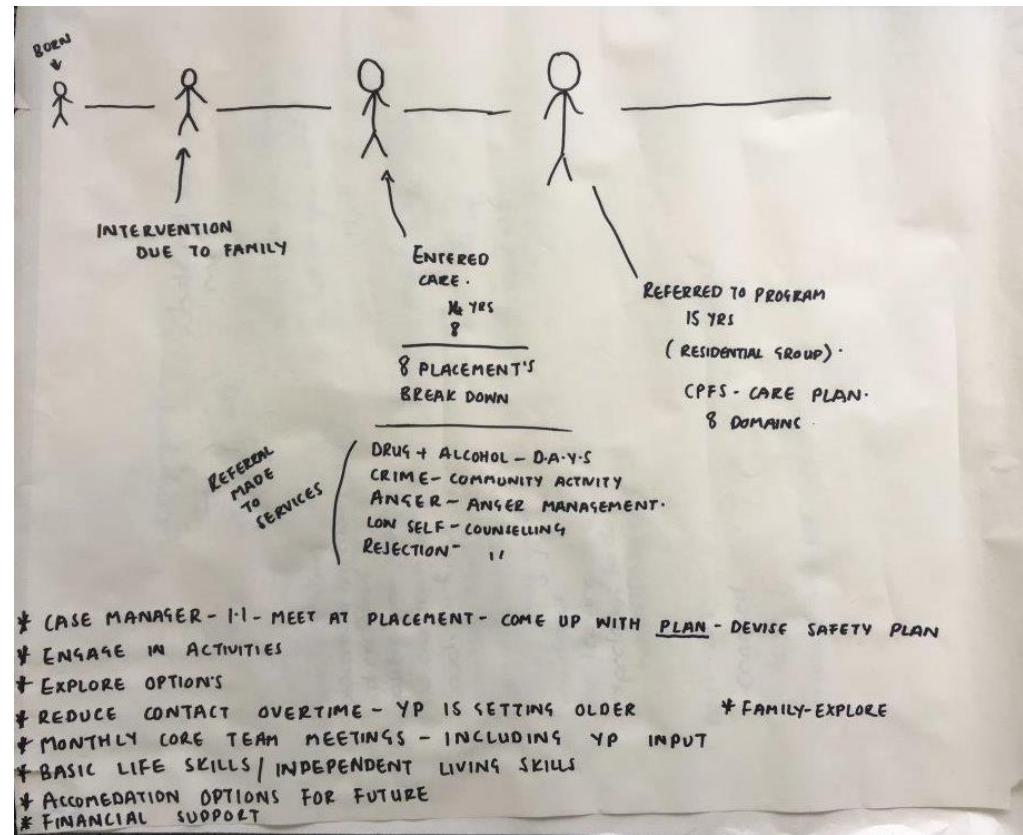
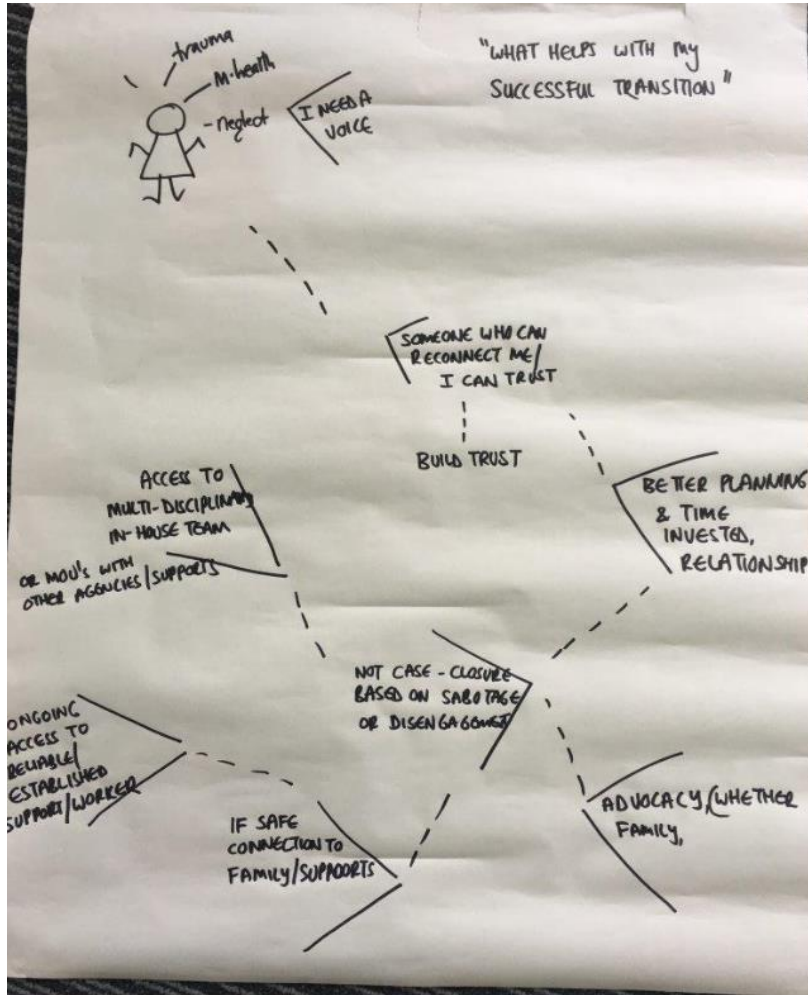


Transition to Adulthood – Consultation & Co-design Workshop with CSO's 30th August 2017

Describe what success looks like for a young person who has successfully transitioned from care to adulthood

- Young person having a voice and having input into plans
- Young person included in goal setting (informed consent)
- Continuity – always having someone there
- Connection with a range of service – streamlining of referrals
- High level of care coordination – health, mental health
- Knowledge of how to access supports and services
- Nurturing support
- Long term housing
- Access to resources
- Developed sense of identity, safety, stability and functionality
- Safe connection to family and supports, trusting relationships
- Have people to emotionally support them – feel loved, sense of belonging
- Sense of purpose in life
- Young person has survival / self-care skills (home management, budgeting, cooking etc)
- Employment/career and education goals
- School leaver with adequate literacy and numeracy
- Cultural identity and connection
- Financial independence

Activity – The young person’s journey – trajectory through transition Use an example of a young person leaving care you are / were most worried about. Groups to draw a picture illustrating what would be their journey if they had access to this process – focus on interventions that lead to change.



Entry/Assessment/Referral

Entry criteria	Assessment	Process for referral
<ul style="list-style-type: none"> - Age: 15 to 24 years - YP with care experience (at any age) - YP that have left care who have high needs - Level 4-5 Needs Assessment Tool - Beyond capacity of Dept. to case manage - Multi agency involvement / care coordination required - Low skill level for independent living - Vulnerable to homelessness - Lack of planning and preparation - Breakdown of previous placements - Lack of support / family connection - Complex trauma impacting behaviour and decision making (mental health, drug use, FASD, disability etc) - Disengagement from education and community employment - High level criminal / anti-social behaviour - YP commitment and choice to engage with service <p>Consideration made to:</p> <ul style="list-style-type: none"> - Location – availability of services to access - Linked with / access to other intensive support services (Disability support, Justice) - How will the entry criteria and assessment/referral process differ for YP 18+ - Dept. may not have current up to date information, no NAT 	<ul style="list-style-type: none"> - Common assessment and criteria that is consistent across the state - Comprehensive assessment covering all dimensions of care - Psycho social assessment - Framework for matching and measuring progress of YP - Use a scoring system (measure 3 months) look at domains – connection to community, family/identity health, mental health, housing, life skills, safety, target behaviour, self-regulation skills - Coordinated interagency approach between all agencies, collaborative process <p>Agency right of refusal due to:</p> <ul style="list-style-type: none"> - Capacity - Matching - Certain level of disability - Risk assessment – too high - Support services unavailable in area (eg mental health services, limited housing options, disability services) 	<ul style="list-style-type: none"> - Dept. / District referral - Dept. to assess referrals - Decision making to be done by Dept. - Self-referral (over 18 years) or referral by other services / agencies - Coordinated integrated state-wide referral – collaborative process - Open referral process – who is best to provide service - Engagement level of YP – prior to accepting referral agency meets with YP - Informed consent of YP - Flexibility <p>Process for prioritising referrals for:</p> <ul style="list-style-type: none"> - 15-18 year olds (case management provided by the Dept.) - 18-24 year olds (not eligible to receive case management by the Dept.) <p>Documents:</p> <ul style="list-style-type: none"> - NAT, trauma profile (provided by CPFS) - NAT analysis provided to form part of referral – information to include input from YP care team – consideration made to practice & quality of NAT reports currently not reflective of YP needs - Risk assessment - Genogram / eco mapping - Life story book, words and pictures (why in care) - Care Plan document

Case Management Plan (Care Team Approach)

<i>Who should be involved?</i>	<i>What is their role?</i>
Young person	Driver Identify & communicate their needs/aspirations/wishes
Family – as identified by young person Extended family Support network – other significant people Peers	Voice for the young person, voice of non-professional network Identify supports for young person Maintain connections for/with young person Help young person reach goals – each person offers what they can
Case Manager (Dept.) + others as required Aboriginal or CALD worker	<u>15-18yrs</u> Hold case management responsibilities – parental guardianship Responsibility of ensuring continuity of care and planning between the Dept. and CSO, oversight of service provided to YP by CSO Identifying and engaging extended family/support network/significant others to connect young person to (Family Finding, rebuilding of relationships, building safety within family) Words & pictures (life story – mapping of history) Financial support and assistance <u>18+ years</u> Provide information re young person’s care history
Case Manager (CSO) + others as required	Preparing the young person to advocate their needs and understand the leaving care planning process Communication between all relevant parties Conveying and communicating the young person’s needs Helping young person achieve their goals Provides advocacy for young person, walking alongside/empowering
Other agency staff Service professionals eg doctors, psychologists, allied health	Consistency / continuity of supports and services Input into plan

Characteristics of 'good' Case Manager:

Finding someone with willingness to assist with ANY practical tasks – hurdle help (cooking, cleaning etc)	Knowledge of resources, funding and services relevant to YP	Organisational skills / time management skills
Resilient worker with the right skills	Professional	Authentic, genuine
Advocacy for YP	Non judgemental	Good self-care
Empowers YP to complete tasks	Capacity/ability to build strong relationship with Dept.	Ability to engage YP that others may not (challenging behaviours)
Walk alongside not working with	Healthy role modelling for YP	Youth Work / Social Work qualification
Clear in their purpose	Innovative	Proactive – doing what they say they're going to do
Child centred	Supportive agency to support workers innovation	Planning and goal setting, outcomes focused
Culturally competent	Trauma informed	High level of emotional intelligence
Invests time into relationship with YP, builds trusting relationship	Skills in restorative approaches to behaviour management	

Challenges of case management:

- Time limited support services
- Time constraints / caseload management
- Allocation of resources, resources not based on need
- Cannot rely on the availability of the Dept. CPW

What is 'intensive' case management – how is it different from other case management

- Time – 'chunks' – allowing relationship to build, planning with young person
- Daily (regular) contact – a consistent worker/team
- Flexibility due unpredictable nature of needs, complex needs of young person
- YP disconnected – 1 or all dimensions
- Non crisis driven work
- Intensive engagement with the end goal of re-engagement
- Accessing a range services where required
- Smaller caseload

What works well:

- Allocated Dept. Officer (example re LIFT Program Becky Anderson)
- LIFT Program – CPW and CSO worker – weekly meetings, mutual agreement on completing tasks, TL and CSO Manager regular review meetings to track progress
- Collaborated and regular meetings with Dept. and CSO with both present Review processes in place with regular meetings including input from young person.
- Separate Dept. CW and Co-ordinator. Co-ordinator manages and arranges practical issues to plan and hold meetings
- Care Team Approach / Village Approach – look at who can offer what (strengths based)
- Open communication to identify and resolves barriers

Role of young person in planning – involvement in planning

- Planning to occur with YP in the room, led by YP
- YP involved in reviewing care plan
- Action plan with YP prioritising goals and identifying needs
- Preparation and informing YP of process and purpose of planning meetings
- Simple and flexible to encourage engagement (how meetings occur, when, where, who attends etc)
- Allowing YP to choose support person to attend outside of professional network

Putting the plan into action – making sure it is effective. What does intensive case management do (actions) with YP?

Action	
Obtaining and maintaining the young person's commitment to the plan	Ensuring it is the young person's plan, making the goals with young people – mutual exchange and ownership User friendly – appeal to their interests Authenticity Using language of young people Consistent, regular communication from CW to YP Rewards of participation
Communicating the elements of the plan to relevant agencies/services and others Monitoring the plan and progress of young person Ensuring identified actions are carried out Reviewing and revising the plan	All Care Team members regular communication and review mechanisms Checking in – regular review of plans and goals Celebrating small wins with young person Goals to be achievable – breaking down of goals, setting small tasks Emphasis on positive Accountability Flexibility in terms of time frames and communication options (direct/phone/email) Revise goals – achievable, relevant, easily identifiable to young person Working well / worries and next steps to be explored Culture shift – transparency – agreement at initial round table with all key people Planning to clearly define roles so there is no duplication
Reporting	Legislative: Care Plan – annual review of 8 dimensions Quarterly Care Report – individual Care Arrangements – carer annual review Critical incident reporting Safety planning Monitoring – Dept. various roles within District / Care Teams Regular meetings with Care Team (Permanency Planning meetings) Contractual Reporting – 6 monthly progress reports from CSO Streamlining Reporting Outcomes Framework - alignment Measures used for outcomes can be used for a variety of reporting requirements

Transition and exit from service

Indicators/criteria for exit:

- Young person is stabilised with supports in place to maintain for the future
- Handover to adult services
- Exiting service due to disengagement – unplanned exit
- Self-select out
- If young person moves from metro to regional and cannot access supports

Transition / exit planning:

- Need to be clear with young person from beginning around exit planning, effects of non-engagement etc
- Informed consent process with young person
- Communication with young person (ongoing) on what service will look like, what 'step down' model may look like
- Reducing contact / intensity of contact by CSO over period of time to transition out
- Step down approach includes nominated members of care team maintaining the relationship (case by case, person by person)
- Individualised planning – will vary based on young person's circumstances – developing a plan that will sustain itself
- Triage system for ongoing supports / any new crisis once young person has exited the program
- Once priority area goals have been met, responsibility back to the Dept. to provide supports required post exit
- No case closure based on sabotage or disengagement

Non negotiables for best practice models

- Early start to planning
- Flexibility of services within an individual agency approach and multi-agency approach
- Young person at centre – flexible planning
- Collaboration with Dept. and other agencies, between all members of the Care Team – working in partnership
- 75% of care team = naturally occurring supports
- Outreach case management model
- Exclusionary processes relating to referrals – agency right of refusal due to capacity and match, availability of services in particular locations, risk assessments too high – but rare
- Capacity for re-entry to the service (direct to service with no waitlist) built into the model
- Flexible exit and transition process
- Informed consent from young person to service
- Service meets with the young person to explain what the service will look like – informed consent
- Young person can engage with service at any stage regardless of refusing service initially
- If young person disengages they can self-refer back
- Comprehensive information provided to service by the Dept. at point of referral (assessment of needs, history, trauma profile)
- Trauma profiles – to be provided if there is one
- Child should be eligible for the service even if they are in a care arrangement with a CSO
- Staff to client ratio – service providers to determine in their model
- Ongoing support available for young people who need intensive case management on a long term basis
- No referral panel
- Information sharing – what's needed? MOU's to enable information sharing to be easier between CSO's and gov Dept. These should be formalised (service agreements). Section 23 of legislation enables Dept. to share information.

Questions:

What happens if young people need to re-engage with the service?

- Will a re-referral be required or for the yp to be put on a waitlist? Consideration to a time limited (ie 3 months) support period to assist with what they need
- What if young person does not want to engage or return to the Dept. for support? YP may want to access the person/people they have a relationship with.
- What level of support could the care team continue to offer?
- Flexibility for young people who re-engage with service
- Some of this cohort will require long term support

What would it look like if young person moves from the Metro to a regional area?

- How to provide intensive case management in a statewide service?
- If different areas are covered by more than 1 agency, how could this work?
- What flexibility is there around design?

Large gaps of service that will fall back onto the Dept. to provide/meet the needs of YP leaving care

- Dept. needs to be following the leaving care policy which may reduce the needs of a small number of YP requiring the intensive case management service.
- Consideration to be made whereby YP are disconnected from the Dept. yet will connect with other services/agencies
- Continued concern around the number 76 YP – prioritising referrals, keeping track of reaching 76, turning YP away from the service, avoiding a long wait list for YP who require intensive and immediate supports.
- Dept. to continue providing leaving care funds as per current process (accommodation, dental, counselling, TAFE, driving lessons etc)

What is the Dept. responsible for?

- Care Planning
- Funding (required to support the YP's needs)
- Leaving Care Funds (legislation identifies eligibility)
- Case Support Costs for children & YP in the CEO's care (up to 25 years). Could include drivers licence funding for TAFE, education tools such as books. This is additional to brokerage.
- Funding for counselling? Costs are projected and factored into the Leaving Care Plan. These funds can be accessed by the YP up to 25 years of age. If the YP has left the CEO's care, if a need arises, up to 25 years old, the need can be funded ie if YP would like counselling post leaving care they are able to return to Dept. for funding of cost to receive counselling.

Young person's emotional wellbeing / relationship needs - how do you transfer relationship with yp would have with the intensive case manager/worker?