Schedule 1 – Permanency Support Program – Service Requirements

Service Provider Name	«Provider_Name»
PLA ID	«PLA_ID»
Program	Permanency Support Program

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1 Purpose

(a) The purpose of this Schedule is to set out in detail the Service Provider's obligations in respect of the Service Requirements. The Department of Communities and Justice (DCJ) roles and responsibilities, in supporting Service Providers to deliver against these requirements, are detailed in the Permanency Case Management Policy referenced in Schedule 4.

(b) The following table correlates Services with sections of this Schedule 1.

Section	Description	Applicable Service Provider
1	**Purpose**	All Service Providers: • Foster Care • Aboriginal Foster Care • Intensive Therapeutic Care (including Significant Disability) Providers • Interim Care Providers • Supported Independent Living Providers
2	**Definitions**	
3	**Permanency Support Program**	
4	**Foster Care**	Foster Care Service Providers Aboriginal Foster Care Service Providers
5	**Interim Care**	Interim Care Providers
6	**Supported Independent Living**	Supported Independent Living Providers
7 & 8	**Intensive Therapeutic Care**	All Intensive Therapeutic Care Service Providers including: • Intensive Therapeutic Transitional Care (ITTC) • Intensive Therapeutic Care Homes (ITCH) • Therapeutic Sibling Option Placement (TSOP) • Therapeutic Supported Independent Living (TSIL) • Therapeutic Home Based Care (THBC) • Intensive Therapeutic Care Significant Disability (ITC SD)

2 Definitions

In this Agreement, unless the context requires, all defined terms will have the meanings set out in Schedule 5 – Definitions

3 Permanency Support Program

3.1 Client Group

All Children and Young People entering the Permanency Support Program. As such, all Service Providers must adhere to the Service Requirements detailed in this section 3 of Schedule 1.

3.2 Key objectives

The Permanency Support Program aims to:

(a) maintain more Children and Young People at home safely with their birth parents, minimising entries and re-entries into care

(b) find permanent homes for Children and Young People currently in care by increasing the number of Children and Young People either being restored to their family, moving into guardianship, or adopted within two years of placement

(c) invest in higher quality support for Children and Young People in care, with their safety and wellbeing being the paramount objectives

(d) provide support to diverse client groups to address and meet specific needs through targeted services addressing individual needs, and

(e) address the over representation of Aboriginal Children and Young People in care.

3.3 Service Requirements

3.3.1 Permanency Goals

The Service Provider must:

(a) achieve permanency outcomes for Children and Young People as soon as possible, and within two years of entering care or setting the case plan goal, including:

i. providing flexible intensive and culturally responsive wrap around supports to Children and Young People and their families, and delivering casework to support parents to increase their parenting capacity to enable children to return home as quickly as possible (for new entries to care)

ii. developing positive working relationships with Children and Young People's birth parents, families and kin; and between parents/family and carers

iii. supporting carers work towards permanency outcomes

iv. using evidence based programs and assessments to support families and carers

(b) collaborating with DCJ to identify the most suitable permanency goal for all Children and Young People who enter care within six months for children under 2 years, and twelve months for children over 2 years

(c) support and implement the Permanent Placement Principles and Aboriginal and Torres Strait Islander Child Placement Principles during everyday casework, including reviewing a Child or Young Persons case plan goal to actively consider opportunities for permanency at least annually

(d) build Children and Young People's networks of support to foster lifelong connections

(e) support Children and Young People to develop and maintain strong cultural identity, and cultural connections to family and culture

(f) support Children and Young People, and their families to recover from and heal from trauma

(g) actively support carers to improve a Child or Young Persons care experience

(h) prioritise permanency casework to actively decrease the time Children and Young People spend in out-of-home care

(i) achieve lasting permanency outcomes for Children and Young People to minimise re-entries into out-of-home care

(j) deliver a holistic approach across the care continuum integrating, assessment, intervention, pathways to permanency, and post Out of Home Care services

(k) have policies and procedures in place that prioritise permanency casework and enable achievement of permanency outcomes for Children and Young People within required timeframes.

3.3.2 Participation and Rights of Children and Young People

The Service Provider must:

(a) inform Children, Young People and their families and carers of their rights (in a manner and language they can understand) and support them to participate in decision making about their lives in accordance with the NSW Child Safe Standards for Permanent Care, United Nations Convention on the Rights of the Child (Article 12), and the Children and Young Persons (Care and Protection) Act 1998

(b) ensure that the privacy of Children and Young People and their families is respected and adhered to in accordance with all relevant laws and clause 15 (privacy) of the Funding Deed

(c) ensure that confidentiality is maintained and information is collected and exchanged in accordance with the Care Act and clause 14 (Confidentiality, information sharing and information security) of the Funding Deed.

(d) have policies and procedures in place to appropriately process complaints and appeals by Children, Young People and their families and carers within clearly stated timeframes.

3.3.3 Working with Birth Families and the Community

Consistent with any applicable court orders, the Service Provider must:

(a) deliver family-centred practice and support Children and Young People to maintain their identity and culture including:

i. planning, facilitating and supporting family time (contact) with people important to the child including parents, siblings, extended family/kin and significant others (including friendships and community members significant to the child or family) as an integral part of Case Planning

ii. coordination of timely alternative dispute resolution when family time (contact) disagreements arise that cannot be resolved through everyday casework in order to prevent escalation of disputes on matters (such as contact to the NSW Children's Court)

iii. ensuring Children and Young People are provided with opportunities to participate in activities and experiences which help develop, maintain and support their cultural identity, language, spirituality and religion, connection and sense of belonging to family, community and, for Aboriginal Children and Young People, Country

(b) conduct family finding and genealogy to build Children and Young People's networks of support to:

i. support birth parents, siblings, family/kin and community to develop or strengthen

relationships with the Child or Young Person, regardless of Case Plan Goal to promote lifelong connections

ii. identify suitable potential relative/kin carers immediately after entry into out-of-home care

iii. determine the Child or Young Persons Aboriginality or cultural heritage as soon as practicable

(c) seeks to confirm the paternity of a Child or Young Person as soon as possible after entry into out-of-home care

(d) comply with requirements relating to identity and working with birth families and the community as outlined and detailed in the Permanency Case Management Policy, Aboriginal Case Management Policy, and other relevant DCJ policies and procedures in Schedule 4.

3.3.4 Case Management and Casework

The Service Provider must:

(a) meet minimum standards for Case Planning and review as per the Office of the Children's Guardian's (OCG) NSW Child Safe Standards for Permanent Care

(b) comply with case management requirements as outlined and detailed in the Permanency Case Management Policy including accepting primary case responsibility upon placement unless otherwise approved by DCJ

(c) comply with requirements as outlined and detailed in the Aboriginal Case Management Policy and other relevant DCJ policies and procedures in Schedule 4

(d) engage in thorough pre-placement planning for children, including the development of a Transition Plan between the Child or Young Person and their prospective caregivers, and provision of adequate information prior to planned placement changes

(e) provide initial support and referral to a Child or Young Person who may be a victim of crime, including a referral to and supporting the Child or Young Person in interaction with NSW Victims Services and Support if applicable

(f) focus on strengths-based and family-centred practice, including the active involvement and participation of Children and Young People and their Authorised Carers (if applicable), and families

(g) ensure case management is responsive to the cultural beliefs and immediate needs of the Child or Young Person and their family and the community they belong to, especially for Aboriginal and CALD Children and Young People

(h) apply the Aboriginal and Torres Strait Islander Child Placement Principles and its intended result areas for Aboriginal Children and Young People, including greater self-determination, participation, preservation and cultural planning

(i) as part of the Case Plan, develop and implement a quality cultural support plan, strategies and practices to support Aboriginal and CALD Children and Young People to maintain their culture and identity, including opportunities to participate in relevant activities and experiences that meaningfully build or maintain a sense of belonging and identity with support provided by community controlled organisations to ensure cultural connections. The Plan should contain all the information that is known about the Child's culture and must be developed in consultation with relatives, kin and communities and must be reviewed as appropriate, but as a minimum as part of regular Case Plan reviews

(j) carry out casework with the Child's birth family and significant others, consistent with any applicable court orders and regardless of the Case Plan Goal, including contact, facilitation of positive connections between birth parents and Authorised Carers/prospective adoptive parents

(k) record and monitor case plan goals, objectives and tasks to ensure their continued

relevance to each individual Child or Young Person

(l) conduct regular reviews of a Child or Young Persons Out-of-Home Care Case Plan, which include an assessment of the Child or Young Person's changing needs and Case Plan Goals. Case Plan Reviews must occur at a minimum annually.

(m) develop, and conduct ninety day reviews of a Child or Young Persons Family Action Plan for Change where the case plan goal is Restoration

(n) participate in and contribute to 6 monthly permanency progress reviews for children with case plan goals of restoration, guardianship or adoption in collaboration with DCJ

(o) provide timely and accurate reporting on all Case Plans and Case Plan Reviews required in accordance with the timeframes outlined at 3.3.4.m of this Schedule and as per the requirements in Schedule 2 (Performance and Outcomes Data Reporting) via the ChildStory Partner Portal

(p) address the needs of the individual Child or Young Person and support their ongoing development to build toward their long term goals and aspirations including after care

(q) achieve continuity of support, carers and caseworkers through appropriate referral, transition and follow up

(r) ensure that all caregivers are provided with opportunities to attend relevant training

(s) provide Case Coordination for up to six months for Restoration cases (or eligible Guardianship/Adoption cases) if approved by DCJ to prevent the 'breakdown' of the permanency outcome and to ensure that the Case Plan Goal is achieved

(t) if the service provider is a QAF trial site, the service provider must review the data to assist with decision making including case review and planning

(u) comply with casework requirements as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4

(v) must comply with the requirements of clause 3.11 (Cooperation and assistance) of the Funding Deed.

Specific casework elements – such as Aboriginal Care and Leaving/After Care Planning – are addressed in Sections 3.3.13 and 3.3.14 (respectively) of this Schedule 1.

3.3.4.1 Case management also involving services from Youth Justice

The Service Provider must:

(a) use best endeavours to prevent placement on remand of Children and Young People for whom they have case management responsibility, including in circumstances where the Child or Young Person's supports have broken down immediately prior to, or during their involvement with, Youth Justice.

3.3.4.2 Adoption applications

If the Service Provider is or becomes an Accredited Adoption Service Provider (AASP), it must:

(a) assume the primary responsibility for making adoption applications in the Supreme Court of New South Wales in its capacity as an AASP

(b) as and when required, direct its Principal Officer to assume the care and conduct of, prepare for and file applications for adoption orders in the Supreme Court of New South Wales in its capacity as an AASP

(c) in the event that an adoption application is contested follow policies and procedures in place by DCJ to access the contested adoption fund

(d) at all times, meet all relevant obligations pursuant to the permanency planning principles and any further obligations imposed on the Service Provider by virtue of its status as an AASP.

3.3.5 Safety and Physical Environment

The Service Provider must:

(a) have systems, policies and processes in place to meet the Child Safe Standards

(b) ensure safe and protective environments for all Children and Young People

(c) ensure a culturally safe environment for Aboriginal or CALD Children or Young People

(d) support carers to ensure Children and Young People are provided with a nurturing, predictable, home like environment that promotes a sense of normality and fosters a sense of safety for Children and Young People

(e) promote and provide Children and Young People the opportunity to provide feedback about their physical environment and sense of safety.

3.3.6 Health and Education

The Service Provider must:

(a) improve health, cultural and spiritual wellbeing, education, overall wellbeing and quality of life outcomes for Children and Young People

(b) ensure all Children are enrolled in and attend a preschool program for 15 hours / two days per week in the two years prior to starting school, in line with the National Partnership Agreement on Universal Access to Early Childhood Education

(c) ensure all Children and Young People in care participate in the OOHC Education and Pathways Program. This includes:

i. organising and participating in a meeting with the school within 30 days of Child or Young person entering OOHC to undertake Personalised Learning and Support Planning (PlaSP)

ii. working with the Child or Young Person, their carers and birth parents (where appropriate) to implement PlaSP strategies. Note all Aboriginal children attending a Department of Education School must have a Personalised and Learning and Pathway (PLP) Plan developed

iii. ensuring that the Child or Young person's educational needs are reviewed

- at least once per semester with the school
- after any significant change to the child's life, for example change in placement

iv. ensuring relevant education records including communication about assessments, school reports, PlaSP documentation and reviews are saved.

v. ensuring that NSW Education and for Catholic or Independent Schools that the Principal is advised when a Child or Young Person's circumstances, including their placement, carers or legal status, changes as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4

(d) ensure Children and Young People in care receive appropriate medical care

(e) ensure all Children and Young People participate in the OOHC Health Pathway Program. This includes:

i. supporting the Child or Young Person and their carers to attend required health assessments

ii. working with the Child or Young Person, carers and birth parents (where appropriate) to implement the Health Management Plan developed for the Child or Young person by the OOHC Health Coordinator or their team

iii. ensuring that the Child or Young person's Health Management Plan is kept up to date and reviewed by the OOHC Health Coordinator or their team

- every six months for children under five years
- annually for children aged five years and over

iv. ensuring relevant Pathway records including communication about assessments, reports, Health Management Plans and reviews are saved

v. ensuring that the OOHC Health Coordinator or their team is advised when child's circumstances including their placement, carers or legal status changes outlined and detailed in the relevant DCJ policies and procedures in Schedule 4.

3.3.7 Trauma Related Services

The Service Provider must:

(a) provide evidence based holistic, individualised, team-based approaches to address the complex impacts of trauma, abuse, neglect, separation from families and significant others; and other forms of severe adversity

(b) provide support and referral to a Child or Young Person who may be a victim of crime

(c) deliver trauma-informed casework and care to each Child and Young Person

(d) train all carers and staff who work with Children and Young People in evidence- based trauma-informed practice

(e) have policies and procedures in place to demonstrate Organisation-Wide commitment to Best Practice in trauma- informed casework and care.

3.3.8 Disability Related Services

The Service Provider must:

(a) embed consideration of disability or developmental delay into casework practice and everyday engagement with Children, Young People and carers

(b) ensure a young person eligible for the NDIS has an appropriate plan, and that the supports in that plan are utilised fully

(c) actively monitor NDIS plans to identify when the level of disability support may not be meeting the Child or Young Person's needs, to help avoid breakdown of placement

(d) ensure early childhood access for children under 7 years of age

(e) support access to mainstream supports including Health and Education

(f) act as the Child's Representative for the purposes of the NDIS including undertaking pre-planning, planning and monitoring and review process which are described in the Operational Guidelines of the National Disability Insurance Agency

(g) facilitate active participation by the Child or Young Person and their carer in all discussions and decisions relating to the NDIS

(h) ensure the Child or Young Person and carer are involved at all stages of the NDIS planning lifecycle

(i) for care leavers, ensure the Young Person's disability support is targeting this transition, make sure the Young Person's goals and aspirations in their NDIS plan focus on transitioning to independence and life beyond 18

(j) comply with requirements relating to services for Children and Young People with disabilities as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4.

3.3.9 Positive Behaviour Support

The Service Provider must:

(a) have a positive behaviour management policy outlining behaviour support and management practice including transport in line with Clause 45 (2)(d) of the *Children and Young Persons (Care and Protection) Regulation 2012*

(b) develop, review and approve a positive behaviour support plan where a Child is prescribed psychotropic medication (as required by law) and provide the relevant Child or Young Person the additional supports in accordance with the plan. The Principal Officer must be aware of and approve the use of psychotropic medication for any Child or Young Person as per Clause 25 (2) of the *Children and Young Persons (Care and Protection) Regulation 2021*

(c) implement a behaviour support plan in consultation with the case managing agency where the service provider is contracted to provide residential accommodation and does not hold case management (where they have supervisory responsibility)

(d) provide the behaviour support plan to the agency who has supervisory responsibility for implementation where a service provider holds case management for a child but the child is in residential accommodation supervised by another agency

(e) review behaviour support plans as appropriate, at a minimum 12 monthly or in line with Case Plan Reviews

(f) ensure positive behaviour support plans are developed in consultation with the Child or Young Person and their carer and where necessary, in consultation with a relevant behaviour support expert such as a psychologist, psychiatrist, education or health professional or equivalent professional with specialist training and expertise in behaviour support

(g) comply with requirements relating to services and reporting for Children and Young People with behavioural issues as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4 and OOHC Reporting Requirements in Schedule 2

(h) comply with additional requirements for NDIS participants under the *National Disability Insurance Scheme Act 2013 and its associated Rules, as well as the NSW Restrictive Practices Authorisation Policy (RPA Policy).*

3.3.10 Children's Court

Service Providers must support Children's Court proceedings, specifically:

(a) conduct assessments or casework in a timely manner as required by the Children's Court (or any other Court)

(b) provide affidavits and reports on the placement, casework including assessment and family time (contact) and other information on the Child or Young Person as required

(c) giving evidence in the Children's Court (or any other Court) when affidavit material is filed

(d) report writers to give evidence in Children's Court (or any other Court) when required

(e) arrange for affidavit/report authors to give evidence in the Children's Court as required

(f) implement a decision regarding drug and alcohol or DNA testing of birth parents

(g) contribute to and collaborate in the care plan development

(h) comply with any Children's Court orders that may be in place, including preparation of timely section 82 reports or 76 reports for supervision orders

(i) organise respite care in accordance with court orders

(j) implement the permanency plan approved by the Children's Court

(k) comply with all other requirements for designated agencies as outlined in the *Children and Young Person's (Care and Protection) Act 1998* and the model litigant policy.

3.3.11 Service Partnerships

The Service Provider must:

(a) promote and reinforce integrated service delivery with both mainstream and specialist agencies by establishing and maintaining service delivery partnerships or access pathways. Critical partnerships include:

i. Health

ii. Mental Health

iii. Education

iv. Restoration services

v. Disability Service Providers

vi. Drug and alcohol support providers

vii. Police

viii. Youth Justice

ix. DCJ.

3.3.12 Culturally Appropriate Care

The Service Provider must:

(a) provide culturally competent care for Aboriginal and CALD Children and Young People

(b) provide access to accredited interpreter or language services

(c) place Aboriginal and CALD Children and Young People (where possible) with Authorised Carers of the same cultural background and employ active efforts to identify and find family or kin through the use of Family Finding or family connection casework

(d) ensure Children and Young People are immersed in their culture through connection and meaningful relationships to family/kin, community and Country and that this be embedded in meaningful Cultural Support Plans

(e) work with the Child or Young Person, their family and kin to develop and/or review Cultural Support Plans at a minimum, annually alongside the Child or Young Person's Case Plan

(f) develop strategic relationships with Aboriginal and CALD organisations and community leaders for support across the continuum of services; including taking active steps to build connections with ACCOs to promote the transfer of Aboriginal children

(g) ensure staff and Authorised Carers increase their cultural capability and receive ongoing cultural competency training

(h) actively recruit authorised caregivers, caseworkers and applicable staff from Aboriginal and CALD backgrounds

(i) ensure their organisational characteristics (including strategic frameworks, policies and procedures) underpin the consistent delivery of culturally competent care to Children and Young People from Aboriginal and CALD backgrounds

(j) comply with requirements relating to culturally appropriate care as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4.

3.3.13 Care of Aboriginal Children and Young People

The Aboriginal Case Management Policy promotes an integrated case management approach that is tailored to the needs of Aboriginal children, young people and families. The Aboriginal Case Management Policy, Practice Rules and Guidance identify four key enablers required to improve the service system to achieve better safety and wellbeing outcomes for Aboriginal children. These are:

(a) Aboriginal community controlled mechanisms

(b) Aboriginal family-led assessment

(c) Aboriginal family-led decision making

(d) Proactive efforts

The Service Provider must:

(a) deliver culturally sensitive and family-led casework to Aboriginal families in line with the requirements set out in the Aboriginal Case Management Policy and associated Practice Rules and Guidance in Schedule 4

(b) ensure every Aboriginal Child and Young Person entering or in the Permanency Support Program:

i. is supported to be connected to family, kin, culture, country and community

ii. receives active casework efforts towards restoration to their parent/s as a priority, with appropriate step down supports

iii. has decisions made about their care and protection in a timely manner and consistent with the Aboriginal and Torres Strait Islander Child Placement Principles, and the Aboriginal participation in decision-making requirement within the *Children and Young Peoples (Care and Protection) Act 1998*.

iv. decisions made about Children or Young People are family led, and involve the child, parents, family, kin and community. Aboriginal family and kin, as culturally recognised, must be engaged in the decision making process in accordance with the Aboriginal Case Management Policy to determine the best way to keep Aboriginal Children and Young People safe

v. receives appropriate support to ensure stability in care, ensuring their needs are met in a culturally rich environment regardless of the Case Plan Goal

vi. receives tailored, Child and family-centred, holistic support as needed to achieve improved lifelong wellbeing outcomes (cognitive functioning, physical health and development, mental health, social functioning and cultural and spiritual identity). Including meaningful connections to their Aboriginal community(ies)

vii. is supported to be placed with their siblings, on Country, or with kin in accordance with the *Children and Young Persons (Care and Protection) Act 1998*

(c) ensure Aboriginal Children and families have timely access to culturally appropriate services, through ACCOs and mainstream organisations, in accordance with the Aboriginal and Torres Strait Islander Child Placement Principles as outlined in section two part 11-14 of the Care Act

(d) explore support environments for Aboriginal Children and Young People, in following order:

i. exploration of support with a member of the Child or Young Person's extended family or kinship group

ii. exploration of support within the Aboriginal community

iii. exploration of a member of some other Aboriginal family residing in the vicinity of the Child or Young Person's usual place of residence

iv. If these options are not practicable, or it would be detrimental to the safety, welfare

and wellbeing of the Child, placement with a suitable Person approved by the Secretary can be considered. This can only occur after consultation with members of the Child's extended family of kinship group and suitable Aboriginal organisations as are appropriate to the Child or Young Person. This is the least preferred option

(e) form a professional working relationship with an Aboriginal Service Provider or organisation able to provide specific services to Aboriginal Children and Young People (applicable to non-Aboriginal Service Providers)

(f) provide the tools, training and support required to implement Cultural Care Plans and Cultural Support Plans for staff and carers working with Aboriginal Children and Young People.

(g) embeds the requirements of Aboriginal Case Management Policy and associated Rules and Practice Guidance in Schedule 4 into organisational policies.

3.3.14 Leaving and After Care Planning

The Service Provider must:

(a) develop a comprehensive person-centred Leaving Care Plan for each Young Person 15 years old or over to support their transition to independent living, that is consistent with relevant DCJ policies and procedures outlined in Schedule 4.

(b) address key life domains consistent with the DCJ *Guidelines for the provision of assistance after leaving out-of-home care* including accommodation, physical and mental health, education, training and employment, culture and identity including family and social relationships, legal matters and independent living skills including financial management

(c) annually review and if required update the Leaving Care Plan to ensure it incorporates all available opportunities such as education scholarships and addresses the needs of the Young Person, especially those that can / should be met before leaving care e.g. dental work, obtaining a provisional driver's licence, permanent residence, elimination of any fine debt and other legal matters

(d) ensure that Post Care Education Financial Support (PCEFS) is part of the Leaving Care Plan for a Young Person who turns 18 while completing the HSC

(e) support eligible carers to access the Teenage Education Payment

(f) ensure the Transition to Independent Living Allowance (TILA) is discussed with the young person and included in the preparation of the Leaving Care Plan for access at 18 years or beyond, depending on the wishes of the young person and their current and future needs – TILA is available up to age 25

(g) submit financial plans for after care assistance to DCJ with sufficient time for approval before a Young Person turns 18 to ensure that financial assistance is available when needed (i.e at least 3 months before the transition from care)

(h) submit a Leaving Care letter and relevant information to DCJ using the appropriate template with sufficient time for approval before a Young Person turns 18

(i) provide after care support at regular intervals for Young People who were placed with the provider for 12 months or more, until the Young Person turns 25, including advocacy, assistance, advice and referral to appropriate services

(j) promote lifelong connection (to carers, caseworkers and community) for Young People who have left care as a result of turning 18 as required up until the age of 25

(k) comply with requirements relating to leaving and after care planning as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4.

3.3.15 Placement and Placement Changes

Service Providers must address planned and unplanned placement changes and:

(a) advise DCJ of changes to placements within 5 business days and record on the ChildStory Partner Portal in line with the OOHC Reporting Requirements in Schedule 2

(b) cooperate in transition planning with other Service Providers (including DCJ where appropriate) and support services to ensure the Child or Young Person continues to receive the support they need to achieve their permanency goal

(c) ensure adequate risk management strategies are developed, including wrap around supports to manage setbacks and prevent placement breakdown

(d) provide DCJ with copies of any relevant risk management plans, or plans for alternative placements in the event of likely placement breakdown. DCJ Child Protection Helpline will liaise with Service Provider providers as required.

(e) implement 'Step Down' supports which are:

(f) determined based on the needs of the Child or Young Person and the adults responsible for the ongoing day-to-day care of the Child or Young Person

(g) provided to families for an agreed duration to ensure stability and safety, acknowledging that setbacks are likely and require thoughtful support rather than judgement

(h) manage appropriate alternative placement arrangements in the event where placements break down

(i) comply with requirements relating to placement changes as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4.

3.3.16 Information exchange

(a) In relation to record keeping, the Service Provider must comply with clause 11 of the Funding Deed (Records and Intellectual Property Rights) and must:

i. have a secure record management system in accordance with clause 14.4 of the Funding Deed (Information Security)

ii. exchange data about Children and Young People electronically through ChildStory and/or other relevant secure file sharing systems agreed between DCJ and the Service Provider or otherwise as determined by DCJ

iii. maintain accurate and comprehensive Person-centred records for each Child or Young Person including their social and medical history, development and identity and all Case Planning decisions

iv. update required person details and case plans through the ChildStory Partner Portal

v. provide Children and Young People supported access to their records, when requested

vi. comply with relevant legislation and policies related to electronic and paper record keeping, retention, transfer and disposal of records for Children and Young People, including the requirements of cl 11 of the Funding Deed and any requirements in Schedule 4

(b) An organisation funded by DCJ that ceases operations or no longer continues to be funded by DCJ, must liaise with DCJ to ensure the client records are maintained in keeping with legislation. Records sent to DCJ following the closure of a funded organisation will become the management responsibility of DCJ. The organisation must identify which paper files relate to clients:

i. that are closed because they no longer receive a service

ii. that are to remain open because they receive ongoing case management support that are open and under review.

3.3.17 Carer Supports

The Service Provider must:

(a) comply with minimum qualifications and training levels for Authorised Carers and staff – these qualification levels will be specified in future DCJ policies, reflecting allowances that have been made in the prices reflected in Schedule 3 of the Program Level Agreement

(b) provide mandatory training for all new carers and optional training for existing Authorised Carers the nature of the mandatory training will be specified in future DCJ policies, reflecting allowances that have been made in the prices reflected in Schedule 3h

(c) provide adequate support levels for Authorised Carers, including access to up to 24 nights of respite per year applied flexibly and based on the assessed needs of the Child or Young Person, their family and carers

(d) comply with carer support requirements as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4.

3.3.18 Reportable Conduct

The Service Provider must comply with all relevant Laws and the Notification Requirements as outlined in clause 3.4 (Notification Requirements) of the Funding Deed.

4 Foster Care

4.1 Client Group

The client group for Foster Care will be as determined by DCJ based on individual circumstances. The Service Provider will have an obligation to accept referrals for Immediate Placements.

4.2 Key objectives

The key objective is to achieve the permanency, safety, wellbeing, education and health outcomes for each Child and Young Person in Foster Care.

4.3 Foster Care Service Requirements

In addition to the Service Requirements detailed in section 3 of this Schedule 1, the Service Provider must:

(a) provide placements that are matched to a Child or a Young Person's needs and circumstances, including immediate placements and appropriate placements for Children and Young People stepping down from Intensive Therapeutic Care (ITC) services. DCJ will provide information about Children and Young People to facilitate this process

(b) comply with Foster Care Service Requirements as outlined and detailed in the relevant DCJ policies and procedures in Schedule 4.

4.3.1 Placement Referral Acceptance

The Service Provider will be required, upon notification by DCJ, to accept Placement Referrals (Broadcasts) up to its number of Actual Vacancies via the ChildStory Partner Portal.

Service Providers:

(a) will at any given point in time be expected to accept Immediate Placements

(b) should have procedures in place to consider and respond to Placement Referrals within timeframes specified in this Schedule.

(c) following receipt of a Placement Referral must reply to DCJ confirming Placement Referral Acceptance or Placement Referral Decline

(d) following receipt of a Placement Referral for an Immediate Placement must reply to DCJ confirming Placement Referral Acceptance or Placement Referral Decline within 4 hours

(e) that have Actual Vacancies and accept an Immediate Placement, will have a Placement Referral Acceptance recorded

(f) who fail to confirm Acceptance or Decline of a Placement Referral for an Immediate Placement within the specified timeframe will be recorded as a Placement Referral Decline

(g) must provider a clear rationale for declining a Placement Referral. Legitimate reasons would include, but not be limited to circumstances where:

i. placing the Child or Young Person in the available placement would not be in their best interests and place their safety, welfare or wellbeing at risk

ii. placing the Child or Young Person in the available placement would result in inappropriate placement matching due to the Child or Young Person's:

1) Cultural identity

2) Religion

3) Disability needs

4) Medical needs

5) Behavioural needs

iii. there is a contracted vacancy but no available authorised carer

iv. the Service Provider is an Aboriginal provider, the Immediate Placement request was for someone other than an Aboriginal Child or Young Person or a sibling of an Aboriginal Child or Young Person, and there are non-Aboriginal Service Providers in the geographical area.

(h) DCJ reserves the right to resubmit a declined Placement Referral, including an Immediate Placement Referral as a Placement Referral.

4.3.2 Recruitment of Carers

The Service Provider must:

(a) have additional Authorised Carers who can accept immediate placements

(b) seek to recruit carers from a Child or Young Person's family and kinship network; including working with DCJ to undertake provisional or full authorisation assessments of suitable family members

(c) attract potential carers/guardians/adoptive parents to support short term, restoration supports, or to become guardians or prospective adoptive parents

(d) implement Family Finding and Family Group Conferencing to identify/recruit/support potential carers, potential respite carers and/or significant others for each Child or Young Person, in line with Case Plan Goals

(e) recruit carers who can care for Children and Young People stepping down from Intensive Therapeutic Care (ITC) to family-based placements

(f) coordinate general community awareness-raising activities with local targeted recruitment campaigns; and work with My Forever Family and DCJ where appropriate

(g) maintain a thorough knowledge of local demand and supply and stay up to date with recruitment marketing research to better target recruitment campaigns and initiatives

(h) ensure response to online and telephone enquiries are handled in a timely way and responded to with a good customer service practice

(i) target couples or individuals with the competencies required to effectively care for Children and Young People and work towards permanency outcomes

(j) target prospective carers from relevant backgrounds with competencies to meet the diverse needs of Children and Young People requiring placement

(k) support Authorised Carers to be active in positive 'word-of-mouth' recruitment

(l) identify skills and competencies required and provide regular and timely access to training, support and networking opportunities

(m) support carer mobility across Service Providers where required and in the best interests of the Child or Young Person.

4.3.3 Assessment and Authorisation of Carers

The Service Provider must:

(a) support DCJ to place a Child or Young Person with an authorised relative or kinship carer in the first instance, by conducting Child-specific recruitment of relative/kinship carers as part of Family Finding

(b) develop and implement intake and assessment processes that facilitate the matching of Children and Young People with suitable carers/prospective adoptive parents, and promote the successful establishment of the placement and achievement of permanency and Case Plan Goals

(c) undertake thorough assessments of prospective carers, guardians and prospective adoptive parents, utilising an assessment format (such as the Step by Step assessment package) that focuses on carers' competencies. Assessment packages should be tailored for use with prospective carers from Aboriginal and culturally and linguistically diverse backgrounds

(d) authorise carers, guardians and prospective adoptive parents in accordance with the *Care Act and the Children and Young Persons (Care and Protection) Regulation 2012*

(e) conduct genuine, ongoing consultation and facilitate participation of prospective carers, guardians and prospective adoptive parents in decision-making processes

(f) provide prospective carers with information about the permanency planning principles and the prioritisation of permanent care options over long term Foster Care from the application/recruitment stage

(g) conduct a series of probity and suitability checks before authorising a prospective foster, relative or kinship carer or prospective adoptive parent in line with legislative requirements. These are outlined in Schedule 2 (Performance and Outcomes Data Reporting) and the Children and Young Persons (Care and Protection) Regulation 2012

(h) authorise carers in accordance with DCJ policies and procedures in Schedule 4

(i) record information about those who apply to be Authorised Carers and the outcome of their probity and suitability checks on the NSW Carers Register.

4.3.4 Matching of Children and Young People to Carers

The Service Provider must:

(a) support DCJ to place a Child or Young Person with an authorised relative or kinship carer in the first instance, by conducting Child-specific recruitment of relative/kinship carers as part of Family Finding

(b) support DCJ with matching activities through case management, casework and information exchange

(c) conduct matching in a way that enables:

i. timely decision-making and permanency planning

ii. carer support for the Child and the Case Plan Goal

iii. compliance with the Aboriginal and Torres Strait Islander Child Placement Principles when matching Aboriginal Children and Young People to carers.

4.3.5 Carer training

The Service Provider must:

(a) train prospective carers in accordance with the *Children and Young Persons (Care and Protection) Regulation 2012*

(b) provide mandatory ongoing, sector-wide standardised training for all prospective carers, guardians and prospective adoptive parents, and optional training for existing Authorised Carers that equips them to care for a Child at any need level

(c) conduct entry level training based on Shared Stories, Shared Lives

(d) provide culturally appropriate training and support to Aboriginal and CALD carers to ensure cultural sensitivity of all carers caring for Aboriginal and CALD Children and Young People

(e) ensure training for relative and kin carers takes into account their existing relationship with the Child and their birth parents and the difficulties and complications that could arise

(f) provide prospective and Authorised Carers with information and training about the guidelines relating to abuse in care allegations

(g) provide training on culturally appropriate care and cross-cultural communication for Children from CALD backgrounds and Aboriginal Children and Young People

(h) provide mandatory ongoing training for Authorised Carers to consolidate their knowledge, build on their skills, promote their wellbeing and to address identified issues as they arise.

4.3.6 Support for Carers

The Service Provider must:

(a) provide minimum support levels for Authorised Carers, prospective guardians and prospective adoptive parents, including up to 24 nights of respite per year applied flexibly and based on the assessed needs of the Child or Young Person, their family and carers

(b) access the need for Authorised Carers to receive regular planned respite care as stipulated in Care Plan Goals

(c) offer the carer the opportunity to explore what type of support they will require in terms of self-care and maintaining placement stability

(d) pass on the Standard Care Allowance subject to the child's age at a minimum, published annually by DCJ and allowed within the prices reflected in Schedule 3, to Authorised Carers – no portion is to be retained by the Service Provider

(e) provide caseworker support for Authorised Carers and prospective adoptive parents which varies in regularity according to individual needs and which may take the form of phone contact, personal visits and e-mails

(f) ensure Authorised Carers/prospective adoptive parents have the necessary information about the Child or Young Person to meet their daily care responsibilities for that Child or Young Person

(g) arrange or provide specialist support and advice to Authorised Carers/prospective adoptive parents to assist them in their role (for example, support from a psychologist, speech pathologist, medical specialist or case worker with language or cultural skills)

(h) provide or arrange support to Authorised Carers through the process that occurs following abuse in care allegations, at the same time ensuring the wellbeing of the Child or Young

Person

(i) encourage Authorised Carers to develop and participate in peer support/network groups and care events locally and online, including Carer reference Groups where appropriate

(j) recognise that tailored supports are different for each carer and carer types and ensure insights/feedback from carers continue to inform practice of support

(k) provide annual correspondence to Carers using the template provided by DCJ that includes:

i. a list of allowances and rates paid to the Carer at that point in time for each Child and Young Person in their care

ii. an itemised list of all PSP packages that Children and Young People in their care are receiving and the associated package rates at that point in time

iii. access to information about supports and funding packages that are automatically available to Carers, Children and Young People under the PSP

iv. access to a list of additional services and supports that can be requested, including supports from independent agencies

v. details of all available complaint mechanisms.

4.3.7 Supervision of Authorised Carers/prospective adoptive parents

The Service Provider must:

(a) monitor Authorised Carers' compliance with the Ministerial Code of Conduct for Authorised Foster, Relative and Kinship Carers

(b) conduct a review of a newly Authorised Carer within 60 days of their first Child placement

(c) regularly (as appropriate, but as a minimum, in line with Case Plan reviews) conduct reviews of Authorised Carer's strengths and needs particularly when significant changes affect the household (e.g. Child or Young Person starting school, placement breakdown)

(d) conduct annual reviews of Authorised Carers

(e) conduct a five yearly review of the carer's authorisation

(f) comply with DCJ's requirements for the procedures/inclusions for the reviews listed above. These requirements are outlined and detailed in the Permanency Support Program Description and other relevant DCJ policies and procedures.

4.4 Foster Care Service Requirements for Aboriginal Children and Young People

4.4.1 Aboriginal Transition Support Plan

(a) A Service Provider who is not an Aboriginal Community Controlled Organisation is required to develop an Aboriginal Transition Plan by 30 June 2023.

i. An Aboriginal Transition Plan is to be developed in partnership with Aboriginal Community Controlled Organisations (ACCO), and DCJ.

ii. Aboriginal Transition Plans set out the ways the Service Provider will partner with ACCOs to transition Aboriginal children and young people in its case management to an ACCO.

iii. In accordance with clause 4.4.1.a. the Service Provider works collaboratively with other Service Providers to ensure plans are realistic, and do not place unnecessary burden on ACCOs.

iv. The Service Provider must review its Aboriginal Transition Plan at least annually, in collaboration with DCJ and ACCOs.

(b) A Service Provider who is an Aboriginal Community Controlled Organisation is required to develop an Aboriginal Transition Support Plan by 30 June 2023 1. The plan should be focussed on sustainable growth, in line with DCJs Strategic Plan for the Transition of Aboriginal Children and Young People to ACCOs.

i. An Aboriginal Transition Plan is to be developed in partnership with DCJ.

ii. In accordance with clause 4.4.1.a. the Service Provider works collaboratively with non-Aboriginal Service Providers to ensure plans are realistic.

iii. The Aboriginal Transition Plan set out the ways the Service Provider will partner with non-Aboriginal Service Providers to transition Aboriginal children and young people to its case management.

iv. The Service Provider must review its Aboriginal Transition Plan at least annually, in collaboration with DCJ.

4.4.2 Service Requirements for Aboriginal and Non-Aboriginal Service Providers

In addition to the requirements for Foster Care in section 5.3 and requirements set out in section 3 (particularly Section 3.3.13) of this Schedule 1, Aboriginal Service Providers and Non-Aboriginal Service Providers must:

(a) be responsive to the immediate needs of Aboriginal Children and Young People in need of care through the recruitment of emergency and short-term Aboriginal carers that will contribute to an Aboriginal carer network to provide immediate placements and respite

(b) continue to provide support using a step-down approach once a permanency goal (Restoration or Guardianship) is achieved

(c) ensure appropriate levels of staff are Aboriginal

(d) ensure all staff respect and understand cultural rights and the impact of inter-generational trauma affecting Aboriginal communities

(e) ensure compliance with the requirements set out in the Aboriginal Case Management Policy and associated Rules and Practice Guidance in line with Schedule 4.

4.4.3 Non-Aboriginal Service Providers

All carers of Aboriginal Children and Young People will be transferred over time to Aboriginal Community Controlled Organisations.

In addition to the requirements in Section 3 (particularly Section 3.3.13), 5.3 and 5.4 of this Schedule 1, Non-Aboriginal Service Providers must:

(a) work with Aboriginal families and build relationships with local Aboriginal communities and Aboriginal Community Controlled Organisations to support their work with Aboriginal Children and families. This work is to include:

i. improved family and community participation through Aboriginal family led decision making

ii. meaningful cultural and social connection and

iii. supportive relationships with individuals and organisations to achieve safe and permanent homes and promote lifelong wellbeing for Aboriginal Children and Young People

(b) identify and establish linkages with trusted Aboriginal People, groups or Aboriginal Community Controlled Organisations to build greater cultural connection, where there are no existing connections

(c) actively promote and support the transition of Aboriginal children (and their carers) to Aboriginal Community Controlled Organisations to ensure culturally appropriate care and case management

(d) develop relationships with Aboriginal Community Controlled Organisations

(e) transfer the care of Aboriginal Children to another non-Aboriginal agency only where it is in the best interests of the Aboriginal Child and is consistent with the permanency support principles.

(f) recruit, retain and develop Aboriginal staff to support carers in the best interest of the needs of Aboriginal Children and Young People, with the view that Aboriginal Children and Young People, and their carers, will transition to an Aboriginal Service Provider in the future

(g) recruit, retain and develop Aboriginal staff to support Aboriginal Children and Young People in the best interest of the needs of Aboriginal Children and Young People

(h) utilise local Aboriginal decision-making mechanisms to ensure community participation in decisions regarding placement and connection to family/culture; carried through to implementation

(i) ensure all non-Aboriginal staff increase their cultural capability and receive cultural competency training

(j) ensure compliance with the requirements set out in the Aboriginal Case Management Policy and associated Rules and Practice Guidance in line with Schedule 4.

4.4.4 Service requirements specific to Aboriginal Service Provider delivery

Aboriginal Foster Care has been designed to enable Aboriginal Community Controlled Organisations to deliver the following all-encompassing services that extend over and above the standard costs to deliver permanency support services:

(a) Community education that may include, but is not limited to, attendance at domestic violence intervention and education programs, attendance at drug and alcohol education programs and training locals/carers on local Aboriginal matters

(b) Community programs and connections that may include, but are not limited to, community program costs such as running NAIDOC week events, Sorry Day, men's and women's business, healing work and community relationship building programs

(c) Preventative family work such as providing preventative services to Children, Young People and their families requiring managed support.

5 Interim Care

5.1 Client Group

The client group for an Interim Care placement is Children and Young People in the Permanency Support Program who have been assessed as suitable by DCJ. Children and Young People will:

(a) have low and medium support needs

(b) be aged between 9 and 14 years, and

(c) be in or would otherwise be at imminent risk of entering an Alternative Care Arrangement.

DCJ recognises that in some circumstances there may be Children and Young People that are outside of this age range that may be suitable for this service model (including sibling groups). In such circumstances DCJ will determine the appropriateness of an Interim Care placement on a case-by-case basis.

There is a maximum of up to four Children and Young People in an Interim Care home.

5.2 Key Objective

The objective of Interim Care is to support step-down into a permanency arrangement, relative/kinship care, or foster care. Interim Care will provide time-limited placements for up to 3 months to support transition from and/or prevent entry into an Alternative Care Arrangement. In exceptional circumstances, DCJ can approve placements beyond 3 months on a case-by-case basis.

Interim Care will provide:

(a) a safe, child friendly and home-like environment

(b) stability and predictability through consistent appropriately trained direct care staff and/or authorised carers

(c) participation in everyday routines and links to community, cultural and social activities, and

(d) better oversight of placements delivered by contracted and accredited service providers.

(e) collaborative casework practices between the Interim Care provider and provider with primary case responsibility to ensure:

i. integration of supports and case planning into day-to-day routine

ii. transition from Interim Care to permanency arrangements or foster care placements.

Interim Care is complemented by continued intensive casework to transition to permanency arrangements or foster care placements. In most circumstances, primary case responsibility will be retained by the referring agency.

5.3 Service Requirements

In addition to the Service Requirements detailed in section 3.3 of this Schedule, the Service Provider must adhere to the Interim Care Model Service Overview and Interim Care Model Operations Guide.

Service Providers must also ensure that they:

(a) work closely with DCJ and agency with primary case management responsibility to facilitate immediate placements

(b) provide a safe and home-like environment for children and young people that

facilitates the delivery of age-appropriate activities and experiences. This includes communal indoor and outdoor areas

(c) provide opportunities for children to personalise their own space

(d) encourage children to participate in household routines

(e) identify a key primary contact for each child. The primary contact could be, but not limited to, a primary authorised carer, the house parent or case manager. The primary contact should work with the agency with primary case management responsibility to coordinate activities and identify roles and responsibilities on the child's entry into Interim Care. The roles and responsibilities should be reviewed as required

(f) provide day to day care and supervision in line with the young person's case plan, as agreed with the agency with primary case management responsibility

(g) support children to participate in routines and maintain or develop community relationships, including cultural, sport and other social activities, as agreed with the agency with primary case management responsibility

(h) work collaboratively with the agency with primary case management responsibility to support the child or young person's case plan goals, including transitioning to permanency outcomes or foster care placements. This includes providing regular updates to the case managing agency on the child or young person's needs and views

(i) provide stability through a small pool of consistent and appropriately trained staff and/or authorised carers per House who are predictable and reliable

(j) use authorised carers as a preference over direct care staff wherever possible

(k) staff and/or carers are required to provide supervision and support for Children and Young People within business and after hours. Staff and/or carers are also required to provide or arrange transport for Children and Young People when required

(l) ensure staff and/or carers participate in regular house meetings

(m) for models using direct care staff, Interim Care houses must:

i. be staffed during the 'day worker' hours (as defined in the Award) or between the hours of 7am to 9pm with a minimum of two staff when Children and Young People are present in the house. This could include Direct Care staff and the house parent.

ii. have one sleepover staff member with flexibility for this staff member to undertake an awake night shift when required to meet emergency placement and child-related needs

iii. employ one house parent per Interim Care home who will spend the majority of their time on-site. The house parent must have a minimum qualification of a relevant Diploma. A Bachelor's degree or relevant Diploma working towards a Bachelor's degree is preferred. For Aboriginal staff, a qualification is desirable but experience and willingness to participate in training is acceptable.

6 Supported Independent Living

6.1 Client Group

Supported Independent Living (SIL) placements are for Young People aged 16 to 17 years old at entry, assessed as low-medium under the Child Assessment Tool (CAT) who:

(a) are in statutory out-of-home care, or are preparing to transition from statutory out-of-home care to live independently; and

(b) have been assessed by the Child and Family District Units (**CFDU**) as having the capacity to live in a supported independent living program and will have the capacity to live independently after a period of tailored support.

The maximum amount of time a Young Person can remain in the program is 24 months. Ongoing placement for Young Adults over 18 years in SIL is subject to ongoing DCJ monitoring and approval and the service requirements outlined at section 6.4 of this Schedule 1.

6.2 Key Objective

The key objective of SIL is to prepare and support Young People and Young Adults to successfully transition to independent living by acquiring independent living skills through the provision of accommodation, case management and structured and individualised life skills programs.

6.3 Service Requirements (Young People under 18 years)

In addition to the Service Requirements detailed in section 3 of this Schedule 1 the Service Provider must:

(a) provide a caseworker for each Young Person. Casework support is flexible and scaled according to their needs as they move towards independence

(b) provide furnished accommodation that is stable, appropriate and affordable

(c) pay the difference between Young People's contribution towards the rent and the actual rent charged for the property. The Young Person contributes a proportion of their income towards the rent and utilities for their share of costs (aligned with DCJ Charging Rent Policy)

(d) be responsible for any repairs and maintenance of properties but, where appropriate, negotiate the repayment of property damage debts with the Young Person responsible for the damage

(e) ensure carers or volunteers are Authorised Carers provide:

i. living skills training and support which include self-care, home management and budgeting

ii. support the Young Person to negotiate and maximise entitlements under NDIS.

iii. assistance with access to education, training and vocational and employment assistance, to support financial self-sufficiency

iv. a 'stay put' option for Young People exiting the program who have demonstrated the capacity to maintain a tenancy

v. education and support to develop parenting skills, where appropriate

vi. ongoing support after completing the program as required up until the age 25 years.

6.4 Service Requirements (Young Adults over 18 Years)

6.4.1 Definition of Young Adult

In this section 6 of Schedule 1, Young Adult means a person aged 18 years or over who is placed in SIL.

6.4.2 Supporting Independence

The Service Provider must:

(a) provide casework support which is flexible and scaled according to Young Adults' needs as they move toward independence;

(b) provide a casework focus to increase Young Adults' independence within the community to promote successful transitions from SIL;

(c) continue to develop connections to family, peer networks, community and services to enable the Young Adult to take necessary steps to meet their own individual needs as they prepare to transition from the SIL model;

(d) provide advocacy, guidance and support to enable the Young Adult to transition to independence;

(e) collaborate with Young Adults to assist with establishing and pursuing goals contributing to their growth, development and confidence in navigating life independently; and

(f) equip Young Adults to increase independent living skills including but not limited to; budgeting and financial literacy, cooking, meal planning, maintaining the home, accessing local universal health and emotional supports, government supports, NDIS, further education, training and employment.

6.4.3 Accommodation

The Service Provider must:

(a) begin early planning with Young Adults to secure stable accommodation to support transition to independence from SIL model, including a stay put option;

(b) provide furnished accommodation that is stable, appropriate and affordable;

(c) pay the difference between a Young Adult's contribution towards the rent and actual rent charged for the property. The Young Adult contributes a proportion of their income towards the rent and utilities for their share of costs. The amount of the Young Adult's contribution can be scaled according to the Young Adult's income as they move toward independence; and

(d) be responsible for any repairs and maintenance of properties, but where appropriate, negotiate the repayment of property damage debts with the Young Adult responsible for the damage.

6.4.4 After care support

(a) The Service Provider must comply with the requirements relating to after care support as outlined and detailed in section 3.3.14 and the relevant DCJ policies and procedures in Schedule 4 until the Young Adult attains the age of 25 years.

(b) For the purposes of this section 6.4.4., references to 'Young Persons' in section 3.3.14 should be replaced by 'Young Adult' where relevant.

6.4.5 Placement and Placement Changes

(a) The Service Provider must comply with requirements relating to Placement and Placement Changes as outlined and detailed in section 3.3.15(a) – (c) and the relevant DCJ policies and procedures in Schedule 4.

(b) For the purposes of this section 6.4.5, references to ‘Child or Young Person’ in section 3.3.15 should be replaced by ‘Young Adult' where relevant.

6.4.6 Information exchange

(a) The Service Provider must comply with the requirements relating to information exchange as outlined in section 3.3.16 and the relevant DCJ policies and procedures in Schedule 4.

(b) For the purposes of this section 6.4.6, references to ‘Children and Young People’ in section 3.3.16 should be replaced by ‘Young Adults’ where relevant.

7 Intensive Therapeutic Care (ITC)

7.1 Client Group

The client group for Intensive Therapeutic Care (ITC) will be as determined by DCJ on the basis of individual circumstances.

To be eligible for ITC, Children and Young people must be:

(a) in statutory OOHC

(b) aged 12 years or over*

(c) High CAT

*Children under 12 years can be considered for ITC in very limited circumstances. In such circumstances thorough assessments will be considered to determine the appropriateness of and approval by DCJ is required as outlined in the policies in Schedule 4.

Decision making for referrals into ITC will be informed by a needs assessment of the Child or Young Person to assess most suitable placement type options. This assessment will consider, for example:

(a) placement history (past 12 months)

(b) permanency options explored including outcomes from Family Group Conferencing, Restoration and Guardianship considerations

(c) Case Plan Goals and case work activities undertaken in the past 12 months

(d) summary of health, psychological, educational, behaviour support plans, speech and occupational therapy assessments on file

(e) summary of identified gaps in assessment documentation to inform formulation meeting

(f) Child or Young Person's view about Case Plan Goals and placement.

7.2 Key objectives

The key objective of therapeutic care is to provide a holistic, individualised, team-based approach to address the complex impacts of abuse, neglect, separation from families and significant others, and other forms of severe adversity on Children and Young People in the Permanency Support Program.

7.3 Ten Essential Elements

The ITC Framework mandates Ten Essential Elements that must be:

(a) fully incorporated by Service Providers providing any ITC service

(b) consistently applied by Service Providers across the continuum of services within the ITC system.

This section 7 is applicable to Service Providers providing Intensive Therapeutic Transitional Care (ITTC), Intensive Therapeutic Care Homes (ITC Homes), Therapeutic Sibling Option Placement (TSOP), Therapeutic Home Based Care (THBC), Therapeutic Supported Independent Living (TSIL), and/or Intensive Therapeutic Care Significant Disability (ITC SD or SD).

7.3.1 Therapeutic Specialist

The Service Provider must have equivalent Therapeutic Specialist resources for at least one worker to 12 children and young people across ITC services to support the monitoring and formulation of all Case Plans and supports including movement through the service continuum and transition to exit.

The Therapeutic Specialist will:

(a) be primarily responsible for facilitating Care Team Meetings and coordinating the formulation and progression of the therapeutic aspects of Case Plans and work with care teams to ensure robust and timely exit planning

(b) ensure that client level data is collected and distributed to Care Team Meetings to inform Case Plans

(c) provide clinical expertise in therapeutic care

(d) drive therapeutic practice within organisations and across ITC by ensuring application of the Ten Essential Elements of Therapeutic Care

(e) mentor and support the Care Team and facilitate reflective practice

(f) collaborate with the CAU and Service Provider's management to determine client mix

(g) implement innovative multidisciplinary responses to the individual needs of Children and Young People

(h) have a working knowledge of service pathways, networks and initiatives. For ITC Significant Disability, this includes mainstream disability services and NDIS service provision

(i) coordinate preventative strategies to mitigate placement breakdown

(j) maximise access to and use of NDIS funded disability individual supports including engagement in leaving care planning.

7.3.2 Engagement, participation and inclusion of Children and Young People

The Service Provider must:

(a) actively engage the Child or Young Person at the centre of everyday practice and in the formulation and implementation of their Case Plans

(b) involve the Children and Young People in decision-making process about house routines and structures, particularly with regard to: menu planning; community based outings and social events; establishing systems for feedback; and complaints management processes

(c) engage and support Children and Young People to personalise their space (i.e. room)

(d) use communication methods appropriate to the individual needs of Children and Young People to promote active engagement and decision making.

7.3.3 Client Mix

The Service Provider must:

(a) work collaboratively with the referral units, including but not limited to the Central Access Unit (CAU), ITTC (where applicable) and referring agency with case management, when matching and placing Children

(b) match Children and Young People appropriately based on the needs of the Child or Young Person and their shared needs

(c) support decisions on client mix by implementing a well-developed process and through the participation of key staff who bring knowledge and understanding of the Young Person.

(d) consider the application of innovative and person-centred mitigating strategies to manage risks and enable positive placement experience.

7.3.4 Care Team Meetings

The Service Provider must:

(a) facilitate regular Care Team Meetings on a monthly basis, as a minimum, with more formal reviews quarterly and, in addition, in accordance with a Child or Young Person's changing needs

(b) review Care Team composition when there are changes in a Child or Young Person's needs or circumstances or at the following intervals, as a minimum:

i. six monthly for ITC SD

ii. annually for all other ITC service types

(c) determine and engage relevant stakeholders, for individual cases of Children and Young People, to attend Care Team meetings where appropriate. Relevant stakeholders can include but are not limited to critical partners such as Health, Education, and Justice, NDIA and disability service providers

(d) form and review Case Plan documents, critically review interventions and therapeutic approaches used for working with an individual Child or Young Person, their families and caregivers

(e) review client level data and progress towards outcomes with a focus on improving access to mainstream services. For children with a disability (including those in ITC SD) this should include reviewing NDIS plans and utilisation of NDIS plans

(f) link all children and young people to a General Practitioner for medical reviews in line with the OOHC Health Pathway requirements and timeframes, including community based mental health supports.

7.3.5 Physical Environment

The Service Provider must:

(a) provide a safe, well maintained physical environment

(b) provide a nurturing, predictable, home like environment that promotes a sense of normality and fosters a sense of safety for Children and Young People

(c) incorporate NSW Child Safe Standards for Permanent Care in policies, procedures and direct practice

(d) promote and provide Children and Young People the opportunity to provide feedback about their physical environment and sense of safety

(e) provide each Child or Young Person with their own bedroom

(f) ensure the layout of the physical environment is designed/modified to provide appropriate level of supervision and line of sight, where needed

(g) ensure Children and Young People with disability have access to necessary building modifications and equipment

(h) provide adequate common living areas to maintain stability in the home environment, a therapeutic environment and visiting multidisciplinary specialists and family.

7.3.6 Reflective Practice

The Service Provider must:

(a) develop Staff and/or Carers skills and practice by becoming aware of their actions and responses, and their impact on the Children and Young People they are working with

(b) ensure that Staff and/or Carers reflect on the Child or Young Person's actions, interactions and triggers within a framework that attributes meaning to the Child or Young Person's behaviour

(c) hold regular Reflective Practice meetings facilitated by the Therapeutic Specialist, to inform the collation of outcome measures of Children and Young People

(d) undertake active and constructive engagement with interfacing agencies and organisations in relation to maintaining a consistently therapeutic practice

(e) provide interventions in the program which are congruent with the guiding philosophy of care.

7.3.7 Exit Planning and Post Exit Support

The Service Provider must:

(a) Where the child or young person is exiting to another placement or service, work with the agency with primary case responsibility and care team to develop child centred exit plans

(b) develop a comprehensive Leaving Care Plan in consultation with the Child or Young Person. The Leaving Care Plan is to be developed before a Child turns 15, and is to be reviewed annually as part of regular Case Plan reviews

(c) arrange and provide timely and appropriate transitional and/or aftercare services for Young People who exit the ITC placement

(d) identify and develop relationships with potential family, extended family, community links and mentors, and peers prior to exit from care

(e) liaise with the NDIA as necessary to facilitate transition to adult disability services.

7.3.8 Qualified, Trained and Consistent Staff

The Service Provider must ensure all Staff (including casual staff) and carers:

(a) have the qualifications detailed in the table below:

Role	Minimum Qualification
Therapeutic Specialist	• A tertiary qualification in Psychology, Social Work, Occupational Therapy, Mental Health Nursing or related discipline. (candidates that also hold a relevant Postgraduate Qualification will be highly regarded) • Minimum of five years of experience in a therapeutic care setting or working in a clinical environment with Children and Young People in OOHC. • Current registration with the professional body relevant to their qualification. • Therapeutic Specialists working in Intensive Therapeutic Care Significant Disability should have Disability specific experience, including knowledge of service networks and pathways such as NDIS Service Provision

Direct Care staff (including casual and agency staff)	For Intensive Therapeutic Care Services • Diploma in Community Services or related Diploma • For ITC Significant Disability, the Diploma should include electives specialising in children and young people with disability. If a current Diploma is held without electives related to disability, it is the responsibility of the service provider to provide additional disability specific training and to ensure competency in these areas. • For Aboriginal staff, a qualification is desirable but experience and willingness to participate in training is acceptable. Service Providers may request time-limited flexibility in this qualification, via the DCJ Representative and if approved, follow the reporting requirements outlined in Schedule 2. Service Providers must prioritise rostering staff with the minimum qualifications (including when engaging casual and agency staff). Casual and agency staff Service Providers engaging casual and agency staff when required, must continue to focus on stability for children and young people. Reporting on proportion of casual and agency staff will be managed through Service Provider's monthly meetings with the DCJ Representative.
ITC house managers	• A relevant Bachelor's degree or relevant Diploma working towards a Bachelor's degree is preferred • Diploma in Community Services or related Diploma is acceptable, with experience and understanding of trauma-informed practice and Therapeutic Care. • For Aboriginal staff, a qualification is desirable but experience and willingness to participate in training is acceptable.
Caseworkers	• A relevant Bachelor's degree or relevant Diploma working towards a Bachelor's degree. The preferred minimum qualifications are Bachelor of Social Work, Social Welfare, Bachelor of Psychology, Nursing and Mental Health. • For Aboriginal staff, a qualification is desirable but experience and willingness to participate in training is acceptable.
Multidisciplinary Specialist Team/ Allied specialists (Internal/External)	• A recognised tertiary qualification in the allied health field for which the professional is engaged. • Current registration with the relevant Board in Australia. • For Intensive Therapeutic Care Significant Disability a NDIS Registered Provider is preferred.
THBC Carers	• Not used
TSOP Carers	• Not used

(b) are trained in the theoretical principles of Therapeutic Care and competency based requirements, including cultural competency. The minimum training requirements are outlined below.

i. Successful completion of foundational training in Therapeutic Care should be completed as soon as possible within the staff member's employment, preferably prior to commencing direct care work and no later than three months after commencing direct care work

ii. Successful completion of cultural competency training within the first three months of commencing work within ITC system

iii. Successful completion of positive behaviour support planning

iv. Successful completion of the foundational training on the Joint Protocol to reduce the contact of young people in residential OOHC with the criminal justice system

v. Periodically undertaking refresher training.

(c) have access to regular supervision and professional development

(d) attend house meetings and Care Team Meetings.

Intensive Therapeutic Care Significant Disability Staff (including casual staff) must also:

(e) be trained in the theoretical principles of Disability Care and competency- based requirements, and

(f) have undertaken disability care training and competency.

7.3.9 Organisational commitment

The Service Provider must:

(a) ensure all programs and services are underpinned by a therapeutic philosophy of care

(b) ensure that treatment approaches are evidence-informed

(c) ensure staff/carers are appropriately supported by mechanisms such as workforce development strategies and on call management advice/support

(d) establish formal policies and procedures to process complaints/appeals by Children and Young People within clearly stated timeframes.

(e) ensure commitment to access and inclusion for all people with disability.

7.3.10 Governance and Reporting

The Service Provider must:

(a) adhere to the requirements reporting as outlined and detailed in Schedule 2 (Performance and Outcomes Data Reporting) and Schedule 4 (Policies, Guidelines and Regulatory Requirements)

(b) Establish effective partnerships and governance frameworks, where appropriate, with other Service Providers and key stakeholders, including those outlined at 3.3.11.

(c) participate in local hub governance where established.

7.4 Casework

The Service Provider must:

(a) provide casework in line with Section 3 of this Schedule 1 and policies outlined in Schedule 4.

(b) provide intervention and facilitate access to specialist services to address Children and Young People's behavioural, emotional, psychological, cultural, educational and physical health needs

(c) allocate a caseworker for each Child or Young Person, to ensure that their individual needs are integrated into the day to day running of the placement at the following caseloads:

i. 1:6 ratio for ITC Homes, ITC Significant Disability and THBC

ii. 1:8 ratio for TSOP and TSIL.

7.5 Transitions between ITC Services

The Service Provider, in partnership with DCJ, is responsible for transitions of Children and Young People between ITC services, to Foster Care or to permanent placements.

The Service Provider must:

(a) ensure transitions are driven by casework

(b) develop child centred transition plans

(c) incorporate the principles of the DCJ NSW Therapeutic Framework and the essential elements of therapeutic care in the Case Plans, as detailed in the Permanency Support Program Description - referenced in Schedule 4

(d) have a continuum of service options within the ITC and Foster Care systems, either directly or through partnerships with other Service Providers.

7.6 Placement Referral Acceptance

The ITC service system was designed to support timely placements for children and young people. Timely acceptance is essential to maintain the integrity and functioning of the system.

(a) The Service Provider will be required, upon notification by DCJ, to accept referrals up to its number of Actual Vacancies. This includes accepting Immediate Placements.

(b) ITC Service Providers are required to have the capability and capacity to support and group Children and Young People with high and complex support needs. For ITC Significant Disability providers, this includes children and young people with significant, complex and often multiple disabilities.

(c) Service providers should have procedures in place to consider and respond to Placement Referrals within timeframes specified in this Schedule.

(d) Following receipt of a Placement Referral, Service Providers must reply to DCJ confirming Acceptance or Decline within:

   i. 4 hours of notification for Immediate Placements referrals

   ii. 3 business days of notification for Placement referrals

Failure to confirm Acceptance or Decline within the specified timeframes will be recorded as a Placement Referral Decline

(e) Immediate Placements are expected to commence on the same business day. Other new placements are expected to commence within 7 days of notification of the referral.

(f) The Service Provider must provide a clear rationale and evidence for declining a Placement Referral under the following categories:

   i. Placement is not in the child's best interests

   ii. Agency does not have the staffing required for the placement

   iii. Agency unable to mitigate identified risks

   iv. Agency recommends alternative placement within their service

(g) DCJ reserves the right to resubmit a declined Placement Referral, including an Immediate Placement Referral as a Placement Referral.

7.6.1 Mitigating Placement Risk

(a) The Service Provider will consider the referral and all measures that can be put in place to mitigate risks and support Placement Referral Acceptance.

(b) Mitigating strategies may include, but not limited to:

i. management of the weekly activity planner – including school attendance, social engagement

ii. engagement of therapeutic support – including behaviour support/individual mental health supports

iii. house configuration and reasonable adjustments including robust house design

iv. staff configuration and rosters to support individual and group need

v. solution-focused discussions with DCJ to support Placement Referral Acceptance

vi. implementing the Ten Essential Elements – including reflective practice, staff training, predictable safe environments and routines.

7.7 TC locations

ITC services must be located in the following locations to enable strong interface with relevant mainstream and specialist services who can support the therapeutic needs of Children and Young People:

(a) Blacktown

(b) Gosford

(c) Lismore

(d) Liverpool

(e) Mid North Coast

(f) Newcastle

(g) Queanbeyan

(h) Orange

(i) Sydney Metro

(j) Tamworth

(k) Wagga and

(l) Wollongong

These locations may change in response to market need and demand:

ITC Homes, ITC SD Homes, THBC, TSIL and TSOP services must be located in close proximity to ITC locations to support congruence of the model, shared learnings and practice and building of capacity and expertise. These services should be no more than two hours away from regional ITC locations and one hour away from Metropolitan Sydney ITC locations (in average driving times).

8 Intensive Therapeutic Care Service Types

8.1 Intensive Therapeutic Transitional Care (ITTC)

8.1.1 Client Group

The client group for ITTC is Children and Young People eligible for ITC who will benefit from a suite of assessments and evidence-based interventions within a program of intensive therapeutic support.

DCJ recognises that, in extraordinary circumstances, there may be children on Temporary Care Arrangements, that require the intensive level of assessment, care and supervision that the ITTC is designed to provide. In such circumstances thorough assessments will be considered to determine the appropriateness and approval by DCJ is required.

8.1.2 Key Objectives

The key objectives of the ITTC are to provide a strictly time-limited safe and Child friendly environment where baseline behaviours can be established in order to:

(a) accurately assess needs

(b) review existing assessments and/or complete comprehensive assessments

(c) determine future needs

(d) enable formulation of case planning

(e) make specialist service referrals

(f) identify and treat presenting needs

(g) identify the best placement option, and

(h) work with the referral unit, including but not limited to CAU, and other Service Providers

to successfully transition the Child or Young Person to restoration to family or kin, Foster Care, an ITCH, TSIL, TSOP, THBC, ITC SD or SIL.

8.1.3 ITTC Service Requirements

ITTC providers must adhere to the Service Requirements detailed in section 3 and 7 of Schedule 1 and the ITC Service Overview and relevant Operations Guide.

The ITTC Provider must also:

(a) provide accommodation, care and assessment services for up to four (4) Children and Young People at a time, for a period of up to 13 weeks

(b) work closely with the referral unit, including but not limited to CAU, to facilitate the immediate placement of Children and Young People

(c) be staffed 24 hours per day with at least two staff on duty at all times, with two active overnight staff. Direct care staff must provide the day-to-day care and supervision in line with the Child and Young Person's case plan

(d) employ a full time House Manager who will spend the majority of their time on-site in the ITTC

(e) provide care that reflects current best practice standards and research around trauma, attachment, neglect and resilience

(f) holistically address the needs of Children and Young People through the development and delivery of consistent and planned daily interactions and a structured program of activities and interventions

(g) ensure that each Child or Young Person has a dedicated caseworker to support each Child or Young Person through the process of entry, assessment, plan development, implementation and transition

(h) have a Therapeutic Specialist for each ITTC who will:

i. work closely with the referral unit, including but not limited to CAU, to agree on the Children and Young People for referral

ii. lead the ITTC Multidisciplinary Specialist Team

iii. lead an independent clinical assessment of the emotional, psychological, developmental, and educational needs of the Child or Young Person and recommend future placement options and psychological and therapeutic support needs

iv. be required to work with several agencies at any one time, as Children and Young People progress through the ITC service system.

(i) have an ITTC Multidisciplinary Specialist Team which will:

i. be led by the Therapeutic Specialist

ii. consist of qualified specialist staff with experience in (but not limited to) behavioural and developmental assessment. Disciplines should include (but not limited to) speech pathology, occupational therapy, psychology, educational professionals and other allied health services, and should where possible be provided by an in-house team or in circumstances where internal assessment is not possible, can be accessed from the broader agency resources or purchased from other specialist agencies to support timely delivery

(j) The Therapeutic Specialist and ITTC Multidisciplinary Specialist Team will:

i. support entry of Children and Young People into ITTC

ii. conduct assessment planning for Children and Young People

iii. undertake tailored assessments for Children and Young People

iv. jointly prepare and provide a report by week 10 of Child and Young Persons placement detailing assessment outcomes including (but not limited to) behaviour support needs and mental health needs, and provide recommendations regarding ongoing placement and the systemic and individual supports the Child or Young Person will require into the future

v. where appropriate deliver short-term interventions such as safety planning, skills development and emotional regulation

vi. plan, support and facilitate transition of Children and Young People to their next placement

vii. be flexible and responsive to meet the therapeutic needs of the Children and Young People.

8.1.4 ITTC Outreach

The ITTC Service Provider must cater for a target of 10 additional Children and Young People every Quarter in order to support the following situations:

(a) Children and Young People who are in Foster Care but where there is a potential for placement breakdown in order to provide increased support and assistance to prevent their entry into ITC

(b) Children and Young People in ITC who need further support and/or assistance to transition to a new placement

(c) Children and Young People with family or significant others where extra assessment and/or support may assist in sustaining the placement.

These services will vary on a case by case basis and are expected to focus on review, referral and recommendations to guide case plan goals, rather than the delivery of full assessments and associated wraparound services. Referrals will be dependent on the capacity of the ITTC at the time.

8.1.5 Transition from Intensive Therapeutic Transitional Care

The ITTC Service Provider must:

(a) assess the needs of the Child or Young Person and identify the appropriate placement option. The transition of Children and Young People into permanency and less intensive placement options and consistency in service delivery is a priority

(b) work with DCJ, agency with primary case responsibility, and the new Service Provider, which could be Foster Care or ITC, to transfer the Child or Young Person to the care of the new Service Provider, where applicable. This must be done in such a way as to minimise any adverse implications to the Child or Young Person

(c) gain DCJ's approval of the placement option prior to the Child or Young Person transiting from Intensive Therapeutic Transitional Care

(d) enable the Case Plans to progress and develop with the Child or Young Person throughout their journey.

8.2 Intensive Therapeutic Care Homes

8.2.1 Client Group

The client group for an ITC Home placement is Children and Young People is children eligible for ITC. There is a maximum of either two (2) or four (4) Children and Young People in an ITC Home.

8.2.2 Key Objective

To provide a safe and home-like environment, with a dedicated direct care team of qualified and consistent staff within a program that is guided by an overarching philosophy of Therapeutic Care. The key objective of this placement type is to support the Child or Young Person achieve a permanency outcome and/or to transition to a less intensive placement type.

8.2.3 ITC Homes Service Requirements

In addition to the Service Requirements detailed in section 3 and 7 of this Schedule 1 the Service Provider must ensure that the ITC Homes:

(a) provide accommodation and care for two (2) Children and Young People at a time in 2-bed models and four (4) Children and Young People at a time for 4-bed models

(b) deliver a program that holistically addresses the needs of Children and Young People through an intensive, time limited program of integrated individual and group therapeutic interventions, consistent and planned daily routines

(c) is staffed during the 'day worker' hours (as defined in the Award) or between the hours of 7am to 9pm with a minimum of:

i. For 4-bed ITC Homes: two staff when Children and Young People are present in the house.

ii. For 2-bed ITC Homes:

A. one staff when one child is in placement and present in the house
B. two staff when two Children are in placement and present in the house

This could include Direct Care staff, rostered staff, Therapeutic Specialist, caseworkers and the House Manager. Staff are required to provide transport, supervision and support for Children and Young People within business and after hours

(d) has an overnight roster with a minimum of one staff member on a sleepover shift, and on call support available during the night

(e) takes a risk management approach to rostering, with flexibility for an awake night shift when required based on a risk assessment

(f) establishes a Risk Management Plan to determine rostering, including at peak times in the house, and updates the plan when Children and Young People enter or exit the home or as needs change in the home Risk Management Plans are provided to the FACSDCJ representative upon request

(g) employ one full time House Manager per ITC Home who will spend the majority of their time on-site.

8.3 Therapeutic Sibling Option Placement

8.3.1 Client Group

Therapeutic Sibling Option Placements (TSOP) provide for a minimum of three Children and Young People who are part of a sibling/ relative group when at least one or more of the Children or Young People meets the eligibility criteria for ITC. Children under 12 years of age and/or with a Low and Medium CAT can be placed in this program if is required to keep a sibling/relative group together.

8.3.2 Key Objective

The key objective of the TSOP is to successfully support sibling/related groups of Children and Young People to reside together as a family unit, requiring intensive support, to nurture the attachment bond between family and kin.

The aim is to enable Service Providers to develop innovative, tailored responses to Children and Young People's needs to better achieve exit from ITC and improve their safety, permanency and wellbeing outcomes.

8.3.3 TSOP Service Requirements

In addition to the Service Requirements detailed in section 3 and 7 of this Schedule 1 the Service Provider must:

(a) ensure Children and Young People are cared for by permanent live-in carers who provide 24 hour care seven days a week in a home provided and maintained by the Service Provider. Carers:

i. must be Authorised Carers

ii. can be single individuals or a partnered couple, including kinship carers

iii. are consistently available to meet the needs of the Children or Young People

iv. must work with the Care Team to deliver therapeutic services in line with Child or Young Person's Case Plan

(b) provide Carers with:

i. access to the Therapeutic Specialist, specialist support practitioners and services

ii. are provided with training outlined at 4.3.5 and ITC Foundation training to provide the skills and have the relevant experience and competencies to deliver therapeutic care

iii. regular respite - which must be provided by consistent Authorised Carers allowing for the Children and Young People to stay in the home

(c) reimburse Carer expenses.

8.4 Therapeutic Supported Independent Living

8.4.1 Client Group

Therapeutic Supported Independent Living (TSIL) placements are for Young People aged 16 to 17 years old at entry and assessed as High CAT who:

(a) are in statutory out-of-home care, or are preparing to transition from statutory out-of-home care to live independently; and

(b) have been assessed by the Central Access Unit (**CAU**) as having the capacity to be placed in a supported independent living program and will have the capacity to live independently after a period of tailored support.

The maximum amount of time a Young Person can remain in the program is 24 months. Ongoing placement for Young Adults over 18 years in TSIL is subject to ongoing DCJ monitoring and approval and the service requirements outlined at section 8.4.4 of this Schedule 1.

8.4.2 Key Objectives

The key objective of TSIL is to prepare and support Young People and Young Adults to successfully transition to independent living by acquiring independent living skills through the provision of accommodation, case management and structured and individualised life skills programs integrated with therapeutic care and intervention offered within ITC.

8.4.3 TSIL Service Requirements (Young People under 18 years)

In addition to the Service Requirements detailed in section 3 and 7 of this Schedule 1, the Service Provider must:

(a) ensure the Therapeutic Specialist support transition to independence

(b) provide a caseworker for each Young Person that is flexible and scaled according to their needs as they move towards independence

(c) ensure that the caseworker has weekly contact in person, at minimum, with the Young Person

(d) provide furnished accommodation that is stable, appropriate and affordable

(e) pay the difference between Young People's contribution towards the rent and the actual rent charged for the property. The Young Person contributes a proportion of their income towards the rent and utilities for their share of costs (aligned with DCJ Charging Rent Policy)

(f) pay for the repair of deliberate property damage caused by Young People and, where appropriate, negotiate the repayment of property damage debts with the Young Person responsible for the damage

(g) ensure all carers or volunteers are Authorised Carers

(h) provide training and support for:

i. developing living skills which include self-care, home management and budgeting

ii. assistance with access to education, training, vocational and employment assistance to support financial self-sufficiency

iii. a 'stay put' option for Young People exiting the program who have demonstrated the capacity to maintain a tenancy

iv. parenting skills, where appropriate

v. ongoing support after completing the program.

8.4.4 Service Requirements (Young Adults over 18 years)

8.4.4.1 Definition of Young Adult

In this section 8.4.4. Young Adult means a person aged 18 years or over who is placed in TSIL.

8.4.4.2 Supporting Independence

The Service Provider must:

(a) provide casework support which is flexible and scaled according to Young Adults' needs as they move toward independence;

(b) provide a casework focus to increase Young Adults' independence within the community to promote successful transitions from TSIL;

(c) continue to develop connections to family, peer networks, community and services to enable the Young Adult to take necessary steps to meet their own individual needs as they prepare to transition from the TSIL model;

(d) provide advocacy, guidance and support to enable the Young Adult to transition to independence;

(e) collaborate with Young Adults to assist with establishing and pursuing goals contributing to their growth, development and confidence in navigating life independently; and

(f) equip Young Adults to increase independent living skills including but not limited to; budgeting and financial literacy, cooking, meal planning, maintaining the home, accessing local universal health and emotional supports, government supports, NDIS, further education, training and employment.

8.4.4.3 Accommodation

The Service Provider must:

(a) begin early planning with Young Adults to secure stable accommodation to support transition to independence from TSIL model, including a stay put option;

(b) provide furnished accommodation that is stable, appropriate and affordable;

(c) pay the difference between a Young Adult's contribution towards the rent and actual rent charged for the property. The Young Adult contributes a proportion of their income towards the rent and utilities for their share of costs. The amount of the Young Adult's contribution can be scaled according to the Young Adult's income as they move toward independence; and

(d) be responsible for any repairs and maintenance of properties, but where appropriate, negotiate the repayment of property damage debts with the Young Adult responsible for the damage.

8.4.4.4 After care support

(a) The Service Provider must comply with requirements relating to after care support as outlined and detailed in Section 3.3.14 and the relevant DCJ policies and procedures in Schedule 4.

(b) For the purposes of this section 8.4.4.4, references to 'Young Persons' in section 3.3.14 should be replaced by 'Young Adults' where relevant.

8.4.4.5 Placement and Placement Changes

(a) The Service Provider must comply with requirements relating to placement and placement changes as outlined and detailed in Section 3.3.15(a) and the relevant DCJ policies and procedures in Schedule 4.

(b) For the purposes of this section 8.4.4.5 references to 'Child or Young Persons' in section 3.3.15(a) should be replaced with 'Young Adults' where relevant.

8.4.4.6 Information exchange

(a) The Service Provider must comply with requirements relating to information exchange as outlined in Section 3.3.16 and the relevant DCJ policies and procedures in Schedule 4.

(b) For the purposes of this section 8.4.4.6, references to 'Child or Young Persons' in section 3.3.15 should be replaced by 'Young Adults' where relevant.

8.5 Therapeutic Home Based Care

8.5.1 Client Group

Therapeutic Home Based Care (THBC) is for Children and Young People who are assessed as eligible for ITC and can be safely cared for in a home based placement with the provision of therapeutic care services in ITC. THBC is primarily for individual placements (1:1) but in limited circumstances may apply to related groups or kin with a high CAT.

8.5.2 Key Objectives

The key objective of THBC is providing a step-down option from ITTC, ITCH, and individual placements. THBC is a model where care is provided by a volunteer carer. THBC can also be provided as an option to divert Children and Young People away from a more intensive service type and to offer an alternative service type to TSOP and TSIL.

THBC is a flexible service type. Service Providers will be able to develop innovative, tailored responses to Children and Young People's needs to better achieve exit from ITC and improve their safety, permanency and wellbeing outcomes.

8.5.3 THBC Service Requirements

In addition to the Service Requirements detailed in section 3 and 7 of Schedule 1, the Service Provider must ensure that:

(a) THBC is provided by permanent authorised live-in carer/s who is supported by an ITC Service Provider to deliver a therapeutic approach to daily care

(b) THBC is delivered in a carer's home or in a residence provided and maintained by a Service Provider

(c) placement matching (carer with Child or Young Person) includes robust and joint decision making with Children and Young People

(d) an allowance is to be paid in line with the Child or Young Person's needs and care considerations, which are greater than for those children and young people residing in general Foster Care. It is expected that the allowance for the Child or

Young Person in the placement would be paid at a rate of no less than $1,250 per week which would equate to no less than $65,000 over an annual period

(e) THBC carers provide care in line with the service requirements and the Ten Essential Elements. Expectations and requirements for both the carer and service provider must be documented in accordance with the usual practices of individual service providers (for example, embedded within an existing Carer Code of Conduct or standalone Carer Agreement).

(f) THBC carers

i. are Authorised Carers

ii. can be single or partnered, including kinship carers

iii. are consistently available to meet the high and complex needs of these Children or Young People

iv. are provided with training outlined at 5.3.4, ITC Foundation training to provide the skills and have the relevant experience and competencies to deliver therapeutic care

v. must receive training by the Service Provider, tailored to the needs of Children and Young People in their care

vi. must participate in reflective learning and ongoing training as per the Ten Essential Elements

vii. must work collaboratively with Therapeutic Specialist and care teams and take therapeutic direction

viii. will have access to regular respite which must be provided by consistent Authorised Carers. Where possible, and when it is in the child's best interests, respite is to be provided in the child's home

ix. must meet service provider expectations for THBC carers (as outlined in the relevant agency document reflecting same), which includes: participation in care team meetings as required; regularly providing to, and receiving updates from, the care team; and accepting a higher level of active support in the home, for example, more frequent home visits, as a result of caring for a Child or Young Person with high and/or complex needs.

8.6 Intensive Therapeutic Care (ITC) Significant Disability

ITC Significant Disability (SD) is a specialist ITC Service type that has strict eligibility criteria. Having a diagnosed disability does not result in an automatic referral, it is designed for a very limited cohort of Children and Young People who have extremely high support needs related to a disability or multiple disabilities. ITC SD is only suitable where the disability or multiple disabilities have a significant global impact on daily functioning, impacting placement stability and where:

(a) step down from mainstream ITC into a less intensive placement type is extremely unlikely within 24 months

(b) other placement types in ITC are unsuitable as the Child or Young Person requires, intensive supports above the provision offered in mainstream ITC

(c) intensive disability related supports to maintain stability in care arrangements are required

(d) the impact of disabilities will significantly reduce independence; and necessitate specialist health, education and disability services, and

(e) intensive support needs related to disability are likely to continue into adulthood and require adult disability services including accommodation.

8.6.1 Eligibility criteria

Children and Young People must meet criteria in all the categories outlined below.

(a) Children and Young People eligible for ITC SD must be eligible for ITC

AND

Meet the following permanency of disability criteria;

Must have a disability (or multiple disabilities) that are permanent or likely to be permanent which may include:

(b) cognitive, neurological, developmental or intellectual disability (IQ assessed under 70)

(c) physical or sensory disability

(d) diagnosed psychiatric/psychological condition (regular exacerbations)

(e) serious medical conditions, e.g. degenerative conditions, uncontrolled epilepsy

AND

Meet the impact on adaptive functioning domains;

The impairments related to disability (as distinct from developmental norms) will have a significant global impact across adaptive functioning domains requiring ongoing intensive daily supports:

(f) communication - skills needed to communicate own needs and interact with others

(g) self-care - skills needed for personal care

(h) motor skills - fine and gross motor skills

(i) self-direction - skills needed for self-control, decision-making, responsibility and independence

(j) home living – domestic skills needed in the home

(k) community access – skills needed to access and participate in the community

(l) health and safety – skills needed to remain safe and well and for the consideration of the safety of others

(m) leisure – skills to plan and engage in recreational activities/play

(n) social – skills to interact with others and build relationships with others

(o) school/vocational – skills to independently function in school or vocational settings

AND

Meet the following managing and meeting needs criteria:

(p) the Child or Young Person is highly unlikely to step down into a less intensive placement type within 24 months

(q) Children or Young People with disability are not excluded from ITC placements if their needs can be adequately and safely supported in an ITCH with the other children in residence.

8.6.2 Key objectives

ITC SD will ensure care is delivered within a therapeutic environment with disability specific supports. This will be delivered by DCJ-contracted, and Office of the Children's Guardian (OCG) accredited Service Providers.

ITC Significant Disability will have a strong focus on skill and capacity building of Children and Young People to reach their full potential and improve quality of life.

ITC SD will support Children and Young People to:

(a) achieve placement stability

(b) achieve client-centred goals across the following outcome domains:

i. permanency

ii. education and skill

iii. health and wellbeing

iv. economic

v. home and safety

vi. social and community participation, and

vii. personal empowerment

(c) develop and/or maintain relationships with family, kin and community

(d) gain improved access to specialist and mainstream services including disability services

(e) develop and/or maintain life skills, and

(f) benefit from tailored leaving care planning and leaving care preparation within a disability context.

8.6.3 ITC Significant Disability continuum of care

The ITC SD Service type should sit as part of the broader continuum of Services. This does not mean a Service Provider needs to deliver other Permanency Support Program Services. It does mean that Service Providers of ITC SD will need to demonstrate an understanding of both Permanency Support Program Service provision and adult disability service provision. Providers must also develop and maintain relationships with other Service Providers and mainstream services including the NDIS, Health and Education.

The Service Provider must:

(a) have a continuum of Service options within the ITC and Foster Care systems, either directly or through partnerships with other Service Providers, and

(b) have a continuum of service options within the disability sector, either directly or through partnerships with other Service Providers.

8.6.4 ITC Significant Disability Service Requirements

In addition to the Service Requirements detailed in section 3 and 7 of this Schedule 1, the ITC Significant Disability Service Provider must:

(a) provide accommodation and care for two (2) Children and Young People at a time in 2-bed models and four (4) Children and Young People at a time for 4-bed models.

(b) provide person-centred planning and support to Children and Young People, consistent with their life stage and functional needs to achieve goals across outcome domains

(c) staff the ITC SD home during the 'day worker' hours (as defined in the Award), or between the hours of 7am to 9pm, with a minimum of:

i. For 4-bed ITC SD homes: two staff when Children and Young People are present in the house

ii. For 2-bed ITC Homes:

A. one staff when one child is in placement and present in the house
B. two staff when two Children are in placement and present in the house

This could include rostered staff, Caseworkers and the House Manager. Staff are required to provide direct care, supervision and transport for Children and Young People during business and after hours

(d) ensure the staffing roster is flexible to adapt to the intensity of direct care required by Children and Young People in the ITC SD home. The minimum requirement is that each home has an overnight roster with one staff member on a sleepover shift with on call support available during the night, with flexibility for an awake night shift

(e) establish a Risk Management Plan to determine rostering, including overnight and peak times in the home. The Plan should be updated when Children or Young People enter or exit the home, or needs change. Plans are to be provided to the DCJ upon request

(f) employ one full time House Manager who will spend the majority of their time on-site

(g) ensure Direct Care Staff provide day to day care and supervision in line with the Child and Young Person's case plan and behaviour support plan

(h) holistically address the needs of Children and Young People through the development and delivery of consistent and planned daily interactions and a structured program of activities and interventions

(i) provide disability and therapeutic care that reflects current best practice standards and research including aspects related to trauma, attachment, and neglect.

9 Service Provider Declaration

I have read, understood and agree with the Schedule 1 – Service Requirements as it relates to the Program Level Agreement.

Service Provider: «Provider_Name»

Delegated Signatory

Name: _____

Position in Organisation: _____

Date: _____

Signature: _____

Department of Communities and Justice:

Delegated Signatory

Name: _____

Position in Organisation: _____

Date: _____

Signature: _____