**Intensive Therapeutic Transitional Care (ITTC) Outreach**

This factsheet has been developed for use by Department of Communities and Justice (DCJ) staff as part of the referral process for outreach services from Intensive Therapeutic Transitional Care (ITTC) units. It is intended as a guide only to assist staff understand the different levels of service provision when making referrals to ITTC units.

The factsheet should be read in conjunction with the following documents:

* ITTC Outreach Practice Guide (include link once published)
* [Business Rules: Eligibility Criteria for PSP Service Packages](https://www.facs.nsw.gov.au/__data/assets/pdf_file/0004/648841/Business-Rules-for-Eligibility-of-PSP-Service-Packages-FC,-ITC-Feb-19.pdf)
* [Permanency Case Management Policy - Policy Statement](https://www.facs.nsw.gov.au/__data/assets/pdf_file/0007/595195/PSP-PCMP-Policy-Statement-2020.pdf)
* [Permanency Support Program Appendix 5: Service Overview - Intensive Therapeutic Care (ITC)](https://www.facs.nsw.gov.au/__data/assets/pdf_file/0009/437733/ITC-RFT-Volume-5-Appendix-5-Service-Overview-ITC.pdf)
* [PSP Program Level Agreement](file:///H:\Chrome%20Downloads\PSP-Changes-to-PSP-contracts-effective-1-July-2019%20(1).pdf)
* [NSW Therapeutic Care Framework](https://www.facs.nsw.gov.au/about/reforms/NSWPF/nsw-therapeutic-care)

## ITTC Outreach:

ITTC Outreach is a service provided by a DCJ funded Intensive Therapeutic Care (ITC) Service Provider through an Intensive Therapeutic Transitional Care Unit (ITTC) unit.

ITTC Outreach is not prescriptive so it does not limit its capacity for innovation and creative service provision, however has the intention of providing short term support based on specific, measureable, achievable, realistic and time-limited (SMART) goals. These will be included in the ITTC Outreach Plan.

Areas where support may be provided will depend on the availability of specialists by the provider in that location. This could extend to providers undertaking brokerage to deliver services.

Services could include behavioural assessment and support (but not drafting BSPs), developmental assessments including but not limited to occupational and speech therapy, mental health, alcohol and/or drugs, education, independent living skills, carer / parent support, placement support, and risk management.

This will be achieved through providing the necessary assessments and interventions identified on a case by case basis for each child, young person and/or their carer, family or direct care staff referred to ITTC outreach.

## Primary goals:

## ITTC Outreach has the primary goal of promoting the safety, welfare and wellbeing of children and young people in PSP with the main objectives to:

* prevent placement breakdown
* prevent entry into ITC
* assist transition where children and young people require a placement change, or
* assist transition where children and young people require support to move to step down models of care

## Key outcomes:

The key outcomes of ITTC Outreach are that:

* children and young people remain in their current placement, if appropriate
* children and young people receive the support they need to preserve their placements
* children and young people do not enter ITC, unless in their best interests
* children and young people who need to transition to new placements receive the assessments and intervention they need to ensure its success
* foster carers, family or direct carers receive the support they need to maintain placements.

## Services provided:

The Intensive Therapeutic Transitional Care (ITTC) Unit has been established as part of the ITC service system and facilitates the delivery of a suite of evidence informed, tailored assessments and interventions.

The ITTC Unit performs two distinct functions, to:

1. provide time limited (up to 13 weeks) direct care supported by a highly skilled multidisciplinary team in home-like and child-centred environment (for children and young people aged 12 years and over with a CAT score of high); and to
2. provide outreach support to children and young people that require increased support and assistance

The focus of this factsheet will however be **ITTC Outreach only**.

As each ITTC unit is operated by different SP and the Multi-disciplinary Specialist Team (MDST) services may be either provided in-house, purchased from other agencies or individuals, or a combination of both depending on the individual needs of the children and young people, service provision will vary by unit and location.

## Services not provided

The following services are not provided by an ITTC outreach model:

* early intervention services
* placement in an ITTC unit.

## Minimum requirements:

The ITTC unit as part of outreach must provide services:

* + - * for up to 24 children and young people per quarter,
      * for a period of up to 13 weeks in duration,
      * that develop and monitor outreach plans,
      * conduct monthly care team meetings, and
      * complete an exit summary on services provided and outcomes achieved.

After consultation with service providers the following forms have been agreed for use:

* ITTC Outreach Referral Form
* ITTC Outreach Plan, and
* ITTC Outreach Exit Summary.

It is an expectation that referrals and ITTC service provision comply with these forms and processes.

## Service delivery:

ITTC Outreach will be expected to meet the requirements outlined in the Permanency Support Program and the Ten Essential Elements as part of the Intensive Therapeutic Care Framework.

ITTC Outreach will provide support to children and young people by a highly skilled and multi-disciplinary specialist team (MDST), qualified staff with experience in (but not limited to) behavioural assessment, therapy, psychology or allied health services led by a Therapeutic Specialist.

Service provision will be for a period of up to13 weeks, with an option to extend for a further 13 weeks in circumstances where the intended outcomes cannot be achieved in a shorter time frame.

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 determined by the local Child and Family District Unit (CFDU) and will be dependent on the capacity of the ITTC Unit at that time.

ITTC Outreach will provide support to the PSP service system in the following ITTC geographically based locations:

* + - * Blacktown
      * Gosford
      * Lismore
      * Liverpool (yet to be established)
      * Newcastle
      * Orange
      * Queanbeyan
      * Tamworth (yet to be established)
      * Wollongong (yet to be established).

NB: Service provision will only be provided within a 2 hour radius of the ITTC unit.

## Client group:

The target group for ITTC Outreach is children and young people with high and/or complex needs placed in:

* foster care that require increased support and assistance to prevent entry into ITC[[1]](#footnote-1)
* ITC and need further assessment and assistance to transition to, or settle in to a new placement
* alternate care arrangements (ACAs) and require support to transition to an ITC placement or more appropriate placement
* the interim care model who require support to transition to a more permanent care arrangement.

## Referral process:

Referrals can be made by PSP or ITC service provider (SP), or Department of Communities and Justice (DCJ) caseworker as per eligibility criteria.

### Pre-screening (Suitability Consult)

In some districts, prior to a referral being made the referring agency (DCJ or a service provider), may contact their permanency support coordinator (PC) to determine whether ITTC outreach would be beneficial for a child, young person, or their carer, or whether another service would be more appropriate based on their needs.

### Referral pathway

Referrals for ITTC Outreach can be made by completing the ITTC Outreach Referral Formand emailing it to the local agreed mailbox in the district.

If the referral meets the eligibility criteria the District sends it to the Therapeutic Specialist and Multidisciplinary Team at the ITTC unit.

The Therapeutic Specialist assesses the referral based on capacity (taking in to consideration current ITTC placements and outreach support) and completes the ‘Referral Outcome’ section of the referral form (including reasons for non-acceptance).

If the referral is accepted the Therapeutic Specialist immediately contacts the allocated caseworker and commences development of an ITTC Outreach Plan. This could include bringing together all the relevant stakeholders in the child or young person’s life through a care team meeting.

If the ITTC Unit declines the referral CFDU will pass on the outcome to the caseworker, who could consult with the Permanency Support Coordinator for support.

## Referrals when an ITTC unit covers more than one CFDU

In some ITTC locations the unit may cover more than one CFDU. To ensure a consistent process there should be a lead CFDU identified for the location. The following steps should be followed by the local CFDU once a referral is received.

The local CFDU assesses the referral against the eligibility criteria and sends it to the lead CFDU.

The CFDU in the lead district assesses the referral based on the capacity of the unit and forwards the referral to the ITTC unit.

The ITTC unit (as per referral process) assess their capacity to provide outreach and advise the CFDU in the lead district of the outcome.

The CFDU in the lead district informs the local CFDU of the outcome. The local CFDU contact the referring agency to inform them of the referral outcome.

## Care Team Meetings:

Care Team Meetings can be arranged and facilitated by the ITTC service provider to develop an outreach plan through the course of the engagement of services.

A review of the plan, its implementation and progress should be conducted at each care team meeting, which could include the caseworker with primary case responsibility.

## Monitoring:

Whilst further work is being progressed on monitoring mechanisms, Districts may wish to consider monitoring referrals in consultation with contract managers.

## Case responsibility during ITTC outreach:

Under PSP, children and young people are placed with a non-government service provider who has primary case responsibility. The service provider receives funding via PSP packages to cover the cost of providing case management as well as services and supports to address the needs of children and young people in their care.

When a referral is accepted for ITTC outreach primary case responsibility remains with the referring agency whether that is DCJ or a SP. Case co-ordination of outreach services will however be provided by the ITTC Unit.

Whilst the ITTC multi-disciplinary team will assist in making referrals, and reviewing and making recommendations to guide case plan goals, their role does not include tasks associated with primary case responsibility.

## Exiting process:

During the course of outreach ITTC service providers should provide District staff with copies of Outreach Plans and advise when support is close to completion.

## At cessation of service provision the Therapeutic Specialist (ITTC) should complete the ITTC Outreach Exit Summary, including any recommendations for future supports or intervention. The report should be discussed with the caseworker with primary case responsibility, with a copy sent to the district mailbox.

## Support and advice:

## For more information contact [OOHCRecontracting@facs.nsw.gov.au](mailto:OOHCRecontracting@facs.nsw.gov.au)

1. This includes children and young people placed with PSP funded SP [↑](#footnote-ref-1)