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Assessing the Adherence and Quality of Transition Planning in Residential Out-of-Home Care in Australia

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Abstract
Young people transitioning from residential out-of-home care experience inequities across key life domains. To address this, transition planning is implemented for young people aged 15–17 years. This evidence-informed practice aims to prepare them for adulthood by addressing their social, material, and developmental needs. However, the intended health and social outcomes are not consistently realised. Examining indicators of implementation fidelity may help explain these gaps, as lower fidelity is associated with poorer outcomes. Therefore, this study examined two indicators of fidelity: (1) adherence to key components of transition planning; (2) the quality of transition plans. A multi-source design drew on administrative data ($n=77$), a staff adherence survey ($n=102$), and transition plan documents ($n=95$). Findings revealed notable gaps between intended and actual practice. Across the 18 transition planning components, mean adherence was 71.9% ($SD=11.85$), indicating that while most components were delivered, implementation was inconsistent. Administrative data reflected similar gaps, with only 45.5% of young people having a transition plan in progress, and the quality of completed plans was modest (median = 58.3%). Significant differences in adherence and quality were observed across several demographic and contextual factors, indicating that implementation is shaped by the characteristics young people and staff and broader service system contexts. The study highlights the need for organisational and system supports that strengthen capability and promote greater consistency in practice. Further research should examine additional implementation outcomes and identify multilevel enablers and barriers to implementing transition planning in residential out-of-home care.

Keywords Implementation · Transition planning · Residential care · Fidelity · Quality · Care leavers

The transition from out-of-home care for young people in residential care is a complex process associated with inequitable life outcomes both in Australia and internationally (Mendes et al., 2025; Munro et al., 2024). These include homelessness (Chikwava et al., 2022); lower education attainment (Goulet et al., 2024); financial insecurity (Mendes et al., 2023); mental and physical health challenges (Butterworth et al., 2017; Mendes et al., 2023); and social isolation (Purtell et al., 2021). These inequities are particularly pronounced among some cohorts, including Aboriginal and/or Torres Strait Islander young people and those with disabilities (Commission for Children and Young People [CCYP], 2020; Walsh et al., 2023). Ineffective transition planning has been identified as one factor contributing to poorer leaving-care outcomes (CCYP, 2020; Martin et al., 2021).

As of 30 June 2024, 44,868 children and young people were living in out-of-home care nationally, with 20% in the State of Victoria (Australian Institute of Health and Welfare [AIHW], 2025). In Victoria, most children live in home-based care (94%) and residential care is used primarily for older adolescents (5%; $n=454$), over half of whom are aged 15–17 (AIHW, 2025). These placements are funded

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by the Department of Families, Fairness and Housing, typically accommodate two to four young people, and provide 24-hour care delivered by paid residential care staff, referred to as carers or house supervisors. Young people are also supported by staff who work outside the home, including case managers, Child Protection practitioners and specialist roles such as therapeutic practitioners (AIHW, 2021; Vamvakos & Berger, 2024). To support young people leaving State care, the evidence-informed practice of *transition planning* is delivered between ages 15 and 17 to prepare them for independent living by age 18 (Mendes & Snow, 2016).

In Victoria, transition planning is operationalised through the *Looking after Children (LAC) Framework*, which guides the assessment and planning for all children and young people in care (Department of Human Services [DHS], 2012; Department of Families, Fairness and Housing [DFFH], 2021). The *LAC Framework* comprises three core documents: the *Assessment and Progress Record*, the *Essential Information Record*, and the *15+Care and Transition Plan* (transition plan/s hereafter). Collectively, the framework is designed to identify, document, and address the developmental, relational, and material supports required prior to leaving care. This study focuses on the transition plan, which structures planning across seven domains: health; emotional and behavioural development; education, training, and employment; family and social relationships; identity; social presentation; and self-care skills (DHS, 2012). Together, the LAC Framework and Department of Families, Fairness and Housing guidelines outline key components of effective transition planning, including life skills development, early and coordinated planning, housing, engagement in education and employment, active participation, service connection, and links to family, community, and culture (O'Donnell et al., 2020b; Taylor et al., 2024; van Breda & Reuben, 2025).

Victorian policy requires transition planning to commence from age 15, or shortly after entry to care for those placed at an older age, with plans reviewed at least every 6 months until leaving care (DFFH, 2021). Early commencement of transition planning is widely identified as critical to effective practice, allowing sufficient time for coordinated goal setting and enabling the transition plan to guide service coordination and support delivery over time (CCYP, 2020; Grage-Moore et al., 2025). Consistent with best-practice principles, plans are intended to be youth-centred, strengths-based, and tailored to individual needs, with goals that are specific, measurable, actionable, realistic, and timebound (SMART) (CCYP, 2020; Stewart et al., 2024).

Despite policy guidance outlining best-practice transition planning, recent research with the same workforce found substantial variation in how staff conceptualised the practice, with agreement on 18 guideline-derived components ranging from 60.8% to 94.1% (Wainwright et al., 2025). This variation suggests that some components are delivered more consistently than others, limiting the extent to which intended practices reach all young people (Proctor et al., 2011). Moreover, many young people continue to leave care without stable housing, post-care supports, education pathways, or enduring family and community connections (CCYP, 2020; Mendes et al., 2025). The persistence of these outcomes suggests that transition planning may not be implemented as intended, yet empirical evidence on how it is delivered in routine practice remains limited.

One established way to examine this is through implementation fidelity, defined as the extent to which a practice is delivered as intended (Proctor et al., 2011). As transition planning is not a manualised intervention and comprises multiple components delivered over several years, this study examines two indicators of fidelity: adherence, referring to whether key components are delivered to young people, and quality, referring to how well they are implemented (Carroll et al., 2007; Duppong Hurley et al., 2017). Although low fidelity is a recognised barrier to effective practice in residential care and related settings (Galvin et al., 2021, 2022; James et al., 2017), indicators of fidelity have not previously been examined for transition planning. Therefore, to address this gap, the aims of this study were to:

1. Examine staff adherence to key components of transition planning,
2. Assess the quality of transition plans; and
3. Explore whether young person, staff and contextual characteristics were associated with variation in adherence and quality.

Method

Ethics and Reporting Guidelines

Ethics approval for this study was obtained from the Monash University Human Research Ethics Committee (Project ID: 39433). The Good Reporting of a Mixed Method Study (GRAMMS) checklist was used to guide reporting of the findings (O'Cathain et al., 2008) (Supplementary File 1).

Study Design

This study is part of a broader project aimed at improving the implementation of transition planning in residential care. A multi-source design was used to examine implementation fidelity, defined as the extent to which a practice is delivered as intended (Carroll et al., 2007). Because transition planning comprises multiple components and lacks

established fidelity measures, fidelity was examined using two pragmatic indicators: adherence, referring to whether key components are delivered, and quality, referring to how well they are implemented. This approach enabled an initial exploration of how transition planning is delivered in routine practice (Akiba et al., 2022).

Setting

The study was conducted at MacKillop Family Services (MacKillop) in Victoria, Australia. MacKillop is a community services organisation providing child and family services including residential, kinship and foster care in four Australian States and Territories. At the time of data collection, MacKillop operated 48 residential care homes in Victoria, accommodating approximately 126 children (< 15 years old) and young people (> 15 years old). Most residents were aged 15–17 years (61%, $n = 77$). All young people in residential care were assigned a MacKillop case manager, in addition to a Child Protection practitioner. MacKillop case managers held an average caseload of eight young people and were responsible for coordinating care across all stages of a young person's placement. Young people were also supported by residential carers in small homes (two to four bedrooms), who provided day-to-day support and contributed to transition planning as part of their broader role. There were no dedicated transition planning roles; instead, transition planning was embedded within routine case management and residential care practice.

Data Collection

Three data sources addressed the study aims: (1) a staff self-report survey assessing adherence to key transition planning components and staff demographics; (2) transition plan documents assessed using a structured tool to evaluate plan quality; and (3) administrative data used to examine plan commencement and demographic characteristics. Table 1 summarises the measures and research aims addressed by each data source.

Table 1 Research Aims and Data Sources

Research aims	Adherence survey ($n = 102$)	Transition plans ($n = 95$; $n = 61$ young people)	Administrative data ($n = 77$) [A]
1. Examine staff adherence to key components of transition planning	Yes	No	Yes
2. Assess the quality of transition plans	No	Yes	No
3. Explore whether young person, staff and contextual characteristics were associated with variation in adherence and quality	Yes	Yes	Yes

($n =$) refers to the number of young people reported in the administrative data

Data were collected between April and September 2024 and analysed separately before being integrated during interpretation to examine convergence and divergence across sources. This integrated design enabled examination of what is delivered (adherence), how well it is delivered (quality), and the contextual factors shaping implementation. Although data collection occurred concurrently, sample sizes varied because the residential care population fluctuates due to admissions, discharges, and placement changes, and administrative data and transition plan documents were collected at a single point during the study period.

Adherence Survey

To address Aims 1 and 3, MacKillop staff whose roles involved working with young people in residential care were invited to participate in a self-report survey. Purposive sampling was used to target staff with involvement in residential care, rather than all MacKillop employees (Palinkas et al., 2015). Eligible staff were recruited through multiple strategies: distribution to residential care teams via MacKillop leadership, promotion at a residential care governance group meeting, internal team communication channels, and follow-up reminders from leadership. While 102 staff responded to the survey overall, the analyses drew on the subset of 82 respondents who completed the adherence items. Based on available staffing estimates at the time of data collection, this represents a response rate of 13%.

A range of roles were represented, including clinical staff (e.g., therapists who periodically visit residential homes), residential carers and house supervisors who provide day-to-day care, and case management staff responsible for overseeing transition planning and coordinating service referrals (Vamvakos & Berger, 2024, Wainwright et al., 2025). For analysis, roles were grouped as working *in the home* ($n = 70$, 68.6%) or *outside the home* ($n = 32$, 31.4%) due to prior evidence that implementation varies by proximity to young people (Vis & Fossum, 2013; Wainwright et al., 2025). Participant characteristics are reported in Supplementary File 2, Table S1.

The survey was administered electronically via Qualtrics between April and September 2024. To assess adherence, staff were asked to reflect on their typical practice when working with, or supervising staff supporting, young people in residential care. Two questions were used. First, staff were asked, "How often are you able to deliver each transition planning component in practice?" Eighteen components were listed, reflecting expected elements of transition planning. To encourage accurate reporting, the phrasing "able to

deliver" was used to orient responses toward the extent to which transition planning components are enacted in routine practice, rather than compliance. Responses were recorded on a five-point Likert scale: "Don't know/Not applicable," "Never," "Sometimes," "Mostly," and "Always." The scale demonstrated strong internal consistency (Cronbach's $\alpha = 0.914$). Content validity was supported by aligning scale items with transition planning components outlined in government guidelines and through consultation with the author (SM), who has a lived experience of care and professional experience in residential transition planning.

Second, staff were asked, "thinking about the young people aged 15 years and older you are currently working with, how many have started transition planning?" Response options were "None," "Some," "Most," "All," and "Don't know/Not applicable." This item assessed whether transition planning had commenced for young people, reflecting plan initiation as foundational to subsequent transition planning activities. To quantify the extent to which transition planning components were implemented in practice, numerical values were assigned to Likert-scale responses: "Don't know/Not applicable" = 0, "Never" = 1, "Sometimes" = 2, "Mostly" = 3, and "Always" = 4. For each transition planning component, a weighted adherence score was calculated based on valid responses only, meaning "Don't know/Not applicable" and missing data were excluded. For each item, the number of respondents that selected each scale category was multiplied by its corresponding value and the products were summed. This total was then divided by the maximum possible score for that item (i.e., the number of valid respondents multiplied by the highest response value [4]) to produce a standardised adherence score ranging from 0 to 1. Scores were then multiplied by 100 to generate a percentage adherence score, where higher percentages indicate greater adherence to the implementation of that transition planning component.

Transition Plan Quality Assessment Tool

To address Aims 2 and 3, transition plans were obtained for all young people in MacKillop's residential care at the time of data collection and assessed using the Transition Plan Quality Assessment Tool (TPQAT). A total of 95 de-identified transition plans were received for 61 young people. Plans were developed between 2022 and 2024. Most young people had one plan (68.4%, $n = 65$), while 13.7% ($n = 13$) had two plans, 8.4% ($n = 8$) had three, and smaller proportions had four (6.3%, $n = 6$) or five (3.2%, $n = 3$). Participant characteristics are reported in Supplementary File 2, Table S2.

The TPQAT was developed as a pragmatic indicator of transition plan quality, informed by lived experience expertise and policy and practice guidance, rather than a psychometrically driven scale development process (Akiba et al., 2022). The development process and scoring approach are described in Supplementary File 3. The TPQAT comprised 24 items that are grouped under four areas: (1) goal setting principles (7 items); (2) youth-centred planning principles (3 items); (3) needs across key life domains (8 items); and (4) needs specific to Aboriginal and/or Torres Strait Islander young people (6 items). Items were rated based on how each criterion was addressed in the plans on a 3-point Likert scale where, 1 = "Not at all", 2 = "Somewhat", and 3 = "Mostly". One item—"Is there evidence of discrepancies within the plan?"—was rated as a binary response, where 1 = "Yes" and 3 = "No". This aligns with the common approach of exploring quality through observation or Likert-type scales (Duppong Hurley et al., 2017).

Six items were assessed based on specific sections of the plan (e.g., evidence that young people were receiving support to engage in education or employment), while the rest required consideration of the entire plan. Specific items had the option of "Not applicable" if the criterion was relevant for certain subgroups (e.g., Aboriginal and Torres Strait Islander needs).

Author SM applied the TPQAT to each transition plan and entered item scores into Microsoft Excel. Plans were coded independently and analysed at the plan level, with separate scores assigned to each plan, including when young people had multiple plans during the study period. Plan sequence was retained to examine whether quality differed across successive planning cycles. While SM scored all plans in the present study, 10% of plans were co-rated in a parallel study examining quality across out-of-home placement types, demonstrating high inter-rater reliability (91.4% agreement; Wainwright et al., under review).

To assess plan quality, a raw score and percentage score were calculated for each plan within Microsoft Excel. Total raw 'quality' scores were calculated by summing item scores across the 24-TPQAT criteria, with items marked not applicable (N/A) excluded from the calculation. Only items with a valid response were included in the total score for each plan. Percentage scores were then calculated by dividing the total raw score by the maximum possible score for the applicable items and multiplying by 100. The same scoring approach was applied to each TPQAT criterion to examine variation in quality across plan areas, with criterion-level percentage scores summarised in a Table 4. Illustrative excerpts from transition plans were extracted to provide examples of lower- and higher-quality plans.

MacKillop Administrative Data

To address Aims 1 and 3, administrative data routinely collected by MacKillop was requested. These data were used to corroborate staff-reported transition planning activity, specifically the proportion of young people with a transition plan in place, and to examine variation across demographic groups. De-identified data for all young people aged 15 and over at the time of data collection ($n=77$) was transferred to HW in a password-secured Microsoft Excel spreadsheet. On average, young people had lived in the residential home for 6 months, had spent 5.7 years in out-of-home care, and had experienced more than 10 placements. Participant characteristics are reported in Supplementary File 2, Table S3.

The administrative dataset is collected bi-annually (April and October) and completed by Case Managers or Therapeutic Practitioners, with one entry per young person. It captures staff-reported information on key demographics (e.g., gender), placement history (e.g., length of time in care), and whether a transition plan has been completed, is in progress, or has not commenced.

Data Analyses

All statistical analyses were conducted using IBM SPSS Statistics (Version 30). Summary statistics were calculated for all variables. Continuous variables were assessed for normality using the Shapiro–Wilk test, with statistical significance set at $p<0.05$. Normally distributed variables were summarised using means (*M*) and standard deviations (*SD*), while non-normally distributed variables were summarised using medians and interquartile ranges (*IQR*). Categorical variables were summarised using frequencies and proportions.

Group differences for categorical variables were examined using chi-square tests, and where significant associations were identified, adjusted residuals were examined to clarify the nature of the differences. Group differences for continuous variables were examined using parametric or non-parametric tests, as appropriate. Independent samples *t*-tests (two-level variables) and one-way analyses of variance (ANOVA; three or more levels) were used for normally distributed variables, with Bonferroni-adjusted post-hoc tests applied where ANOVA results were significant. Mann–Whitney *U* tests (two-level variables) and Kruskal–Wallis tests (three or more levels) were used for non-normally distributed variables, with post-hoc pairwise comparisons conducted following significant Kruskal–Wallis tests. Associations between two non-normally distributed continuous variables were examined using Spearman's rank correlation coefficients.

Given the presence of small and uneven subgroup sizes within the transition plan dataset, rank-based non-parametric tests (Mann–Whitney *U* and Kruskal–Wallis) were prioritised for subgroup analyses, and Fisher's exact tests were used for categorical comparisons where expected cell counts were below five. Categories with very small cell sizes ($n\leq2$) were excluded from inferential testing. All tests used a two-tailed α of 0.05.

No transition plans were excluded due to missing data. Where information was absent from plans, this was coded as "no evidence of" the relevant criterion. For staff adherence analyses, scores were calculated using available responses only, and item-level non-completion was not imputed.

Results

Adherence Across Demographic Groups

Across the 18 transition planning components, mean staff adherence was 71.9% ($SD=11.85$, $SE=1.31$). Component-level adherence ranged from 50.9% to 83.9%. The most frequently delivered components were developing a transition plan, ensuring Aboriginal and/or Torres Strait Islander young people had a Cultural Support Plan, and regularly reviewing and updating the plan. The least frequently delivered were young people's participation in care team meetings, supporting connections with family and community, and engagement with education or vocational pathways (Table 2). The full distribution of staff responses is reported in Supplementary File 4, Table S1.

Mean adherence scores were lower among staff working in the home with young people ($n=60$; $M=70.8\%$, $SD=13.07$) than those working outside the home ($n=22$; $M=74.4\%$, $SD=7.26$). Adherence was similar across metropolitan ($n=66$; $M=72.1\%$, $SD=12.63$) and regional or rural teams ($n=16$; $M=70.9\%$, $SD=8.15$). Lower adherence was reported by staff in Australia ($n=57$; $M=70.5\%$, $SD=10.96$) than those born outside Australia ($n=25$; $M=74.9\%$, $SD=13.40$). Mean adherence was slightly higher among staff with a lived experience of care ($n=6$; $M=73.3\%$, $SD=20.01$) compared with those without ($n=77$; $M=71.7\%$, $SD=11.56$). Aboriginal staff reported higher adherence ($n=5$; $M=76.4\%$, $SD=16.81$) than non-Aboriginal staff ($n=75$; $M=70.9\%$, $SD=10.94$).

No statistically significant associations were observed between adherence scores and staff demographic characteristics, including years of experience, role type, geographic location, Australian-born status, lived experience of care, or Aboriginal status. Due to small cell sizes, respondents who selected "prefer not to say" for lived experience of care

Table 2 Frequency That Transition Planning Components Were Delivered in Practice

Transition planning components	Adherence score (valid *n*)[A]
Young people have a transition plan	83.9 (79)
Aboriginal and/or Torres Strait Islander young people have a Cultural Support Plan	82.8 (77)
Transition plan is reviewed and updated regularly	80.9 (80)
Young people are referred to Better Futures	79.5 (77)
Staff consult with Disability Services about how the specific needs of a young people with a disability will be addressed	78.5 (78)
Transition planning is tailored to the unique needs of young people	78.0 (82)
Staff discuss how the young person would like to maintain contact in the first 3 months after leaving care	77.8 (79)
Young people develop core independent living skills such as budgeting, cooking, personal hygiene and cleaning, driver's license	73.8 (81)
Aboriginal and/or Torres Strait Islander young people have connections to culture, family, Country, and community	73.7 (79)
Planning starts at 15 years	70.3 (80)
Young people have connections with required specialist support services	70.3 (80)
Young people are connected with Better Futures worker early	67.9 (77)
Young people have a My Journey to Independent Living Plan[B]	67.3 (68)
Young people are active participants in planning and preparing for their future	67.1 (82)
Young people receive and store personal documents	67.0 (81)
Young people engage with education or vocational pathways	61.9 (82)
Young people have positive ongoing connections with family and community	61.4 (81)
Young people actively participate in care team meetings	50.9 (82)

This table reports the overall adherence score per transition planning component and is ordered from highest adherence to lowest adherence. [A]The score was calculated using the valid responses per item. [B]This is a MacKillop specific transition from care plan, that staff are required to complete in addition to the government mandated transition plan

($n=2$) and Aboriginal identity ($n=4$) were excluded from inferential analyses.

To explore whether adherence to specific transition planning components varied by staff demographics, associations between adherence scores and demographic variables were analysed. Adherence was largely consistent across staff, with one exception. Responses for "regularly reviewing and updating care and transition plans" differed significantly by years of experience working in out-of-home care ($H(3)=8.88$, $p=0.031$), and years working within MacKillop ($H(3)=8.00$, $p=0.046$). Mean rank patterns indicate a non-linear association, with more experienced staff more frequently reporting that plans were reviewed and updated "always" or "sometimes."

Several significant component-level differences were observed for workplace location and country of birth (Table 3). Workplace location was associated with young people's participation in care team meetings, $\chi^2(3)=8.96$, $p=0.030$ and referral to Better Futures, $\chi^2(3)=14.08$, $p=0.003$. Staff in the home were more likely to report young people "never" or "sometimes" participating in care team meetings, while those outside the home were more likely to report participation "sometimes". Staff in the home were more likely to report "mostly" or "always" referring young people to Better Futures, while staff working outside the home more often reported "always".

Country of birth was associated with young people's participation in care team meetings ($\chi^2(3)=8.13$, $p=0.043$), development of a My Journey to Independence plan ($\chi^2(3)=11.21$, $p=0.011$), and supporting Aboriginal and/or Torres Strait Islander young people to maintain cultural connections ($\chi^2(3)=11.12$, $p=0.011$). Staff born outside Australia more likely to report young people "always" participating in care team meetings and less likely to report "sometimes" compared to those born in Australia.

Staff born outside Australia were more likely to report young people "always" having a My Journey to Independence Plan and Aboriginal and/or Torres Strait Islander young people maintaining cultural connections. No other statistically significant associations were observed. Adjusted residuals for all significant comparisons are presented in Table 3.

Staff were asked to estimate how many young people they were currently working with had commenced transition planning. Most reported that "some" young people had started (52.3%, $n=46$), followed by "most" (19.3%, $n=17$), "none" (15.9%, $n=14$), and "all" (12.5%, $n=11$). A significant association was identified between transition plan commencement and workplace location, $\chi^2(3)=14.90$, $p=0.002$. Staff working in the home most frequently reported "some" (59.4%, $n=38$) or "none" (20.3%, $n=13$) of the young people had commenced transition planning, whereas staff working outside the home more often reported "most" (37.5%, $n=9$) or "some" (33.8%, $n=8$) had. Adjusted residuals indicated that staff working outside the home were significantly more likely to report that all (+2.2) or most (+2.6) young people had commenced transition planning.

Administrative data indicated that 45.5% of all young people 15 and above ($n=35$) had a transition plan in progress, 33.8% ($n=26$) had a completed plan and 20.8% ($n=16$) had no plan. A Kruskal–Wallis test identified a significant difference in the length of current placement across transition plan status ($H(2)=7.60$, $p=0.022$). Post-hoc comparisons with Bonferroni correction indicated that young people

Table 3 Transition Planning Components Associated with Staff Demographics

Transition planning component	Variable	Group	Response category	Interpretation	Adjusted residual	*p*-value
Young people are referred to Better Futures	Workplace location	Inside home	Sometimes	More likely	+2.3	<0.05
			Always	Less likely	−3.5	<0.001
		Outside home	Sometimes	Less likely	−2.3	<0.05
			Always	More likely	+3.5	<0.001
Young people actively participate in care team meetings	Workplace location	Inside home	Never	More likely	+2.1	<0.05
			Sometimes	Less likely	−2.7	<0.01
		Outside home	Never	Less likely	−2.1	<0.05
			Sometimes	More likely	+2.7	<0.01
	Born in Australia	Yes	Sometimes	More likely	+2.5	<0.05
			Always	Less likely	−2.0	<0.05
		No	Sometimes	Less likely	−2.5	<0.05
			Always	More likely	2.0	<0.05
Young people have a My Journey to Independent Living Plan	Born in Australia	Yes	Always	Less likely	−3.3	<0.001
		No	Always	More likely	3.3	<0.001
Aboriginal and/or Torres Strait Islander young people have connection to culture	Born in Australia	Yes	Sometimes	More likely	+2.2	<0.05
			Always	Less likely	−3.0	<0.01
		No	Sometimes	Less likely	−2.2	<0.05
			Always	More likely	+3.0	<0.01

The *p*-value column for adjusted residuals refers to *z*-scores; values above ± 1.96, ± 2.58, and ± 3.29 indicate significance at $p<0.05$, $p<0.01$, and $p<0.001$, respectively. The interpretation and adjusted residuals columns indicate whether a demographic group is significantly more or less likely than expected to select a response category. Response category refers to the survey scale items. Positive residuals reflect over-representation (more likely than expected), while negative residuals reflect under-representation (less likely than expected)

with a completed plan had significantly longer placements than those with no plan ($p=0.020$). No significant differences were observed between the "no plan" and "in progress" groups ($p=0.469$) or between the "in progress" and "completed" groups ($p=0.277$).

Transition Plan Quality and Contextual Factors

The median quality score for transition plans was 58.33%, with scores ranging from 45.83% to 81.25%. Most scores fell within a narrower range from the 25th percentile (54.9%) to the 75th percentile (62.8%). Median scores, percentiles and *p*-value for all variables are reported in Supplementary File 4, Table S2.

Plan quality was significantly higher when authored by metropolitan-based staff compared with those from regional or rural teams ($U=721.50$, $Z=-2.75$, $p=0.006$). Differences were also observed by Aboriginal and/or Torres Strait Islander status ($H(2)=14.99$, $p<0.001$). Median quality scores were highest for non-Aboriginal young people (60.4%) and lowest for those whose cultural identity was not reported (49.3%). Post-hoc comparisons showed a significant difference between the "not reported" and non-Aboriginal groups ($p<0.001$, adjusted $p=0.002$). Although initial differences were observed between the "not reported" and Aboriginal groups ($p=0.041$, adjusted $p=0.122$), and between Aboriginal and non-Aboriginal groups ($p=0.033$, adjusted $p=0.099$), these were not statistically significant after the Bonferroni correction.

Quality Across Demographic Contexts

Table 4 presents the quality scores for each TPQAT criterion across four areas: goal-setting principles, youth-centred planning, needs across life domains, and the specific needs of Aboriginal and Torres Strait Islander young people. The highest and lowest scoring criteria within each area are reported below.

Goal Setting Principles

Most plans were written in clear, plain English, avoiding acronyms and professional jargon. While the majority were free from discrepancies, nearly 30% contained inconsistencies such as conflicting demographic details or incongruent gender pronouns. Among young people with multiple plans, there was limited evidence that plans were reviewed and updated to reflect evolving needs. Lower quality plans were often replicated with little or no modification, whereas higher quality plans documented reflections on progress and adjustments to goals based on previous outcomes or emerging needs. Documentation of how goals would be measured or reviewed was limited, reducing the ability to assess progress over time.

Table 4 Quality Score by TPQAT Criteria

Areas and criteria	Quality score
Area 1–Goal setting principles	
How the success/outcome of needs will be measured or reviewed is specified	35.8%
The plan is reviewed and updated to reflect new needs (if multiple plans)	43.1%
There are clear timelines around needs	43.9%
There are clear care team roles and responsibilities	67.7%
The needs are realistic and actionable	68.4%
There are no discrepancies within the plan	71.9%
The needs and actions are written clearly in plain English	98.3%
Area 2–Youth-centred planning principles	
The plan builds on the young person's strengths	41.8%
The young person has been involved in the development of the plan	53.0%
The plan is tailored to the individual needs/aspirations of the young person	62.5%
Area 3–Needs across life domains	
The young person has been linked in with post-care support services	34.0%
Post-care appropriate housing options are being planned for	35.5%
Young people with a disability are engaged in disability supports and services ($n=11$, 11.6%)	55.6%
The young person is engaged in the development of independent living skills	60.0%
The young person is engaged in support that enables engagement with employment and/or education	69.4%
The social and emotional wellbeing of the young person has been considered	70.2%
The young person's connections outside of the care system are being fostered	70.2%
The young person is being encouraged to engage with health services	77.5%
Area 4–Aboriginal and Torres Strait Islander young people specific needs ($n=18$, 18.9%)	
Aboriginal and/or Torres Strait Islander family or Kin have been involved in the planning	33.3%
Aboriginal controlled/led organisations have been involved in the planning	38.1%
There is positive recognition of Aboriginal and/or Torres Strait Islander cultures	38.1%
There is the opportunity to connect to Aboriginal led organisations	50.8%
There is the opportunity to connect to their Aboriginal and/or Torres Strait Islander identity	58.7%
There is the opportunity to connect to their Aboriginal and/or Torres Strait Islander family and/or kin	65.1%

Results are reported in order of the lowest to highest quality criteria per quality area

Youth-Centred Planning Principles

Just over half of the plans provided evidence that young people were involved in developing the plan, and a higher proportion showed that plans were tailored to individual needs and aspirations. Higher-quality plans reflected a nuanced understanding of young people's needs and included specific actions, for example "*young person to be linked in with Kids First Sexual Abuse Counselling Prevention Program to support her mental health and to begin processing her trauma and sexual assault.*" In contrast, lower quality plans were often generic or duplicated across multiple young people within the same team. These included vague goals such as "*engage in education"* or goals that were repeated verbatim across multiple plans, including "*young person to be supported to manage relationships with co-residents*." Fewer plans (41.75%) demonstrated a strength-based approach. Many instead included directive language that emphasised compliance rather than empowerment, for example, "*young person to remain in school and not leave unless given permission.*"

Needs Across Life Domains

Although the health criterion had the highest overall quality score, health needs were often described in general or repetitive terms. Lower-quality plans frequently included identical, vague statements across multiple young people, such as *"Annual health appointments including dental, audiology, dental, optometry*" and "*young person to have annual GP check-ups and as required*." These plans often lacked detail on how needs would be addressed or when. In contrast, higher-quality plans included more specific actions and clear timeframes, for example "*young person to complete X-ray on hand injury*."

Consideration of connections outside the care system and social and emotional wellbeing was the second-highest scoring criterion. Lower-quality plans often used vague language replicated across multiple plans, for example, "*young person to be supported to maintain appropriate social relationships*." Higher-quality plans included more specific and tailored actions, such as "*case manager and Child Protection to arrange contact with young person's mother, carers to support young person to engage with his mother and facilitate the* [family] *contact*."

Housing and Post-Care Supports

Consideration of post-care support and post-care housing was largely absent from the plans, making these the lowest scoring criteria. Housing arrangements and post-care services were consistently missing or addressed only in vague terms, for example: "*Refer to lead tenant.*" In some cases, housing or post-care services were only listed as care team members rather than incorporated into goals or actions.

Aboriginal and Torres Strait Islander Young People

Among Aboriginal and Torres Strait Islander young people, connection to family and/or kin was the highest scoring criterion, followed by connection to identity. In contrast, the lowest scoring criteria were family or kin involvement in developing the plan and positive recognition of Aboriginal and Torres Strait Islander culture. Where cultural needs were incorporated, they were often broad and lacked specificity, for example "*young person to feel connected to his Aboriginal culture*," "*young person to be supported to connect with Aboriginal services and programs.*"

Discussion

This is the first study to examine adherence to, and the quality of, transition planning. Findings show that while some components were delivered more frequently and with higher quality than others, substantial opportunities remain to strengthen the consistency of transition planning. This discussion integrates adherence, quality, and contextual factors across core transition planning practices.

Transition Planning Commences Early and is Routinely Updated

Staff self-reports and administrative data indicate that transition planning is generally initiated for most young people at age 15, suggesting that policy mandates support uptake of this core component (Damschroder et al., 2022). However, a meaningful proportion of young people still do not commence planning early, indicating implementation challenges in some contexts. As no significant differences were identified across staff demographic characteristics, these challenges are more likely driven by young people's circumstances and organisational or systemic factors.

Although most staff reported that transition plans were regularly reviewed and updated, the quality assessment showed that fewer than half the plans documented updates reflecting emerging needs. Moreover, plan quality was highest for young people with two plans and declined as the number of plans increased. Quality was also slightly higher at ages 15, when planning is mandated to commence, and 17, immediately prior to leaving care, than at age 16. Together, these patterns suggest that planning may be concentrated around mandated milestones rather than functioning as a continuous process that builds upon prior plans.

The findings highlight a gap between reported adherence and documented practice, which may reflect low appropriateness of the transition plan rather than the absence of planning activity. Feasibility factors affecting staff members' ability to commence planning early and update plans routinely may also contribute. For example, in residential care, placement instability, safety concerns, and workforce turnover can displace structured planning processes and reduce their priority in practice (Galvin et al., 2022; Green et al., 2022; Mendes et al., 2021; Muir et al., 2019). Strengthening the transition plan design and addressing contextual factors shaping early and sustained planning may improve outcomes for young people (CCYP, 2020).

Youth-Centred Planning and Goal-Setting Principles

Adherence to youth-centred planning and goal-setting principles varied, with discrepancies across datasets. Staff reported that transition planning was tailored to most young people, but other core elements, including young people's participation in planning and care teams, were implemented less consistently. Quality assessment showed substantially less evidence of tailoring than reported in the staff survey and only just over half of plans documented young people's involvement, compared with almost three quarters of staff reporting participation in practice. While many plans were individualised, strengths-based goal setting, clear timelines, and mechanisms to track progress were implemented with lower quality. Plans also frequently contained inaccuracies, such as incorrect pronouns or duplicated actions across young people, and most lacked strengths-based framing despite sector-wide commitments to this approach (Toros et al., 2021).

These gaps likely reflect both individual and system-level influences. Staff beliefs and biases shape how young people are engaged and represented in planning (Bührmann et al., 2022; Miller et al., 2013; Slaatto et al., 2023; Wong & Vinsky, 2021), while limitations in planning tools may constrain adherence and quality (Damschroder et al., 2022). For example, most plans retrieved were completed using a writable PDF template ($n=89$), which lacked prompts for outcomes and progress tracking. A digital version embedded in the client management system ($n=6$) included these fields but was longer and used by only one team. Although plan quality did not differ by format, uneven uptake highlights an opportunity to better align plan design with practitioner needs.

Moreover, the finding that plans were of higher quality when young people participated in their development or received a copy underscores the importance of collaboration in transition planning. Strengths-based documentation may therefore function not only as a marker of quality but also as a tool for shared understanding. This extends evidence that sustained involvement promotes agency and more meaningful transitions from care (Moore et al., 2018; Palmer et al., 2022). Young people's participation is shaped

by the quality of relationships with carers and staff (Riise & Paulsen, 2025), while limited involvement can contribute to disengagement (Atkinson & Hyde, 2019; Cameron-Mathiassen et al., 2022; Häggman Laitila et al., 2018). The language used in plans also matters, as problem-focused documentation can undermine identity and reduce engagement when plans are shared with young people (Muir et al., 2019; Purtell & Hawkes, 2023). Further research should examine conditions that enable youth-centred planning and goal setting in practice.

Young People's Needs

Transition plans addressed a broad range of needs, including health, education, relationships, identity, independent living skills, and access to support services, aligning with established transition planning priorities (Grage-Moore et al., 2025; Taylor et al., 2024; O'Donnell et al., 2020b). However, adherence and quality varied across these areas, with consistent discrepancies between staff-reported practice and what was documented in plans. With the exception of family and community connection, staff generally reported addressing needs more frequently than was reflected in documentation.

Health needs were documented in most plans, likely reflecting mandated processes such as routine health assessments (DFFH, 2021). However, goals were often generic or duplicated, suggesting limited tailoring to individual circumstances. In contrast, staff reported high engagement with specialist and disability-related services, indicating that health support may occur more often in practice than is captured in documentation.

A similar pattern was evident for social and emotional wellbeing and independent living skills. While these needs were frequently reported as being addressed in practice, they were documented less consistently or with lower quality in plans. This may partly reflect the design of the planning template, which lacks dedicated sections for independent living skills or structured prompts to track progress (Damschroder et al., 2022). This represents an important gap, as both social connection and life skills are central to post-care outcomes (Garcia-Alba et al., 2022; Nathans & Chaffers, 2022; O'Donnell et al., 2020a; Stubbs et al., 2023).

For Aboriginal young people, cultural identity and connection to family and Country were generally reflected in plans, but culturally specific actions were documented less consistently. Although Cultural Support Plans were usually reported to be in place, limited integration between planning documents may lead to fragmented or incomplete transition planning (Baidawi et al., 2017). Given the protective role of cultural connection in promoting wellbeing and resilience (Hunter et al., 2021; Krakouer et al., 2018, 2023), barriers to effective planning for Aboriginal and/or Torres Strait Islander young people require close attention. With only 4.9% of staff identifying as Aboriginal, strengthening cultural capability among non-Aboriginal staff and partnerships with Aboriginal-led services and kinship networks may be important (Krakouer et al., 2018; Walsh et al., 2023).

Housing planning and post-care support were implemented less consistently. Although staff reported frequent referrals to Better Futures and early engagement with young people from age 16, transition plans often lacked clear housing pathways and post-care arrangements. This is concerning given the strong links between early post-care support, housing stability, and improved outcomes (CCYP, 2020; Storø, 2018; Taylor et al., 2024). Alongside broader system constraints such as limited housing availability and program capacity, differences in how transition planning responsibilities are distributed across teams may also contribute (Damschroder et al., 2022; Mendes et al., 2023; Wainwright et al., 2025). Discrepancies between reported practice and plan documentation may therefore reflect variation in staff roles and responsibilities, as not all staff are directly involved in referral and coordination processes, and these functions differ across teams and contexts (Wainwright et al., 2025). Although staff could select "don't know/not applicable," the exploratory design and limited guidance on role delineation meant that adherence data were analysed by work setting (in the home vs. outside the home) rather than by specific roles. Further research is needed to clarify role expectations and identify the distinct barriers and enablers to transition planning across organisational contexts. Given that residential care leavers are more likely to exit care earlier and face heightened risks of homelessness (Chikwava et al., 2022), stronger attention to these areas within transition planning is essential.

Support for education and employment was documented in most plans but delivered less consistently in practice. Barriers such as placement instability, limited access to trauma-informed education settings, premature exits from care (Tootell & Harvey, 2025), and competing demands such as securing housing (Bucchio et al., 2021) likely constrain delivery. Given the importance of education and employment for long-term outcomes, targeted strategies are needed to strengthen adherence and quality in this area (CCYP, 2023; Goyette et al., 2021; Mendes et al., 2023).

Across the study, the persistent gap between staff-reported adherence and documented quality suggests that transition plans may not fully capture transition planning practice or young people's needs. This divergence likely reflects both differences in how information is reported across data sources and limitations in the transition planning template. Developed in 2012, the template lacks dedicated sections for housing, cultural identity, independent

living skills, and post-care supports, as well as structured prompts for monitoring progress. These limitations restrict how practice can be documented and highlight the need to clarify which data sources should serve as the primary reference point for monitoring implementation.

Contextual Factors

Variation in transition planning adherence and quality was associated with several contextual and demographic factors, highlighting the importance of workforce capability, role clarity, structural conditions, and a shared understanding of transition planning. Placement stability was associated with plan completion, with longer placements linked to a higher likelihood of having a completed plan. This aligns with evidence that stable placements support stronger relationships, a deeper understanding of young people's needs, and more effective planning (Asif et al., 2024; Cameron-Mathiassen et al., 2022; Grage-Moore et al., 2025).

Transition plan quality varied by the cultural identity of young people, with the highest scores observed among non-Aboriginal young people and the lowest among those whose cultural identity was not recorded. This raises concerns about the inclusiveness of planning processes, as identifying cultural identity is essential for providing appropriate and culturally responsive support (Baidawi et al., 2017). This may be partially driven by staff members' discomfort or uncertainty about asking young people about their identity, as well as young people's right not to disclose (Baidawi et al., 2017).

Although differences in transition plan quality by disability status were not statistically significant, higher scores were observed for plans relating to young people without a diagnosed disability compared with those with a disability. However, discrepancies were evident in how disability was recorded across data sources. Administrative data indicated that approximately 49% of young people had a diagnosed disability, whereas only 11% of transition plans identified young people as belonging to a "disability services target group." This under-reporting may reflect limitations in plan documentation, including the use of outdated terminology.

Staff experience levels, work setting, and country of birth were associated with adherence to transition planning. More experienced staff reported reviewing plans more regularly, suggesting that practice familiarity supports more consistent delivery. Given evidence that residential care staff often have limited access to training, support, and practice guidance (CCYP, 2020; Galvin et al., 2022; Fischer et al., 2016), less experienced staff may have fewer opportunities to develop transition planning competencies.

Staff working outside the home reported higher adherence than those based in residential settings. This may reflect differences in access to information, decision-making authority, and opportunities for interprofessional coordination (James et al., 2017). Alternatively, residential staff's close daily contact with young people may provide greater visibility of gaps in implementation that office-based colleagues may not observe (Cameron-Mathiassen et al., 2022; Moore et al., 2018).

Geographic location showed that, although not statistically significant, plan quality was higher in metropolitan teams than in regional or rural teams. This aligns with known challenges in service access, workforce retention, and funding equity that affect planning capacity (Akin et al., 2016; Chapman et al., 2025; Mendes et al., 2021). Differences were also observed by country of birth, with staff born outside Australia more likely to report the occurrence of three transition planning components in practice. These patterns may reflect differences in cultural values that shape practice perspectives and highlight the importance of fostering a shared understanding of transition planning to reduce variation in delivery. A shared conceptual understanding is a recognised enabler of implementation fidelity (Damschroder et al., 2022), while unclear or inconsistent conceptualisations can hinder implementation in child welfare settings (Kor et al., 2021; Weeks, 2021). Promoting clarity around the purpose and scope of transition planning through role-specific guidance and training may therefore strengthen delivery across diverse workforce groups (Weeks, 2021).

Together, these findings demonstrate that transition planning is shaped by workforce, organisational, and system-level conditions as well as individual practice (Nilsen & Bernhardsson, 2019). Addressing variability in adherence and quality will require strategies that strengthen workforce capability and promote equitable practice across settings (Galvin et al., 2021; Gopalan et al., 2019; Kor et al., 2021; Shklarski, 2020; Weeks, 2021; Winters et al., 2020). Further research is needed to determine whether beliefs about transition planning shape delivery or emerge through experience in specific roles or organisational contexts. Drawing on the study findings, Table 5 presents targeted practice, system, and research recommendations to improve the implementation of transition planning in residential care.

Limitations

Several limitations should be considered when interpreting these findings. Analyses of demographic influences were constrained by the availability and consistency of recorded data. Cultural and linguistic diversity was not captured across all data sources, and disability status was recorded inconsistently. This limited the examination of

Table 5 Recommendations

Priority areas for improvement	Recommendations
Operationalise core components of transition planning	• Define a clear set of core transition planning components, with role-specific guidance to support consistent interpretation and application across settings
Examine determinants of adherence and quality	• Investigate barriers and enablers to transition planning fidelity across contexts (e.g. regionality) through research with young people, staff, and child protection practitioners • Examine how transition plans are used in practice to distinguish implementation gaps from documentation limitations
Redesign transition planning documents	• Redesign transition plan templates to include structured prompts for goal setting, review timelines, progress tracking, and outcome measurement • Update plan content to reflect post-care supports, housing pathways, diverse identities, and system contexts (e.g. National Disability Insurance Scheme) • Integrate transition plans with complementary tools (e.g. Cultural Support Plans) and automate referrals to key supports (e.g. Better Futures) within case management systems to promote equitable access
Strengthen youth-centred planning	• Embed participatory, youth-centred approaches across planning tools, training, and practice guidance • Support strengths-based, inclusive language and co-developed plans that reflect young people aspirations, identities, and developmental needs • Promote relationship-based practice through coaching, reflective supervision, and accessible planning processes • Prioritise policies and practices that promote placement stability to support effective transition planning
Enhance culturally responsive planning	• Incorporate structured guidance to support culturally safe planning for Aboriginal and Torres Strait Islander young people • Build workforce cultural competence through targeted training, supervision, and practice tools • Partner with Aboriginal Community Controlled Organisations, family, and kin, and align planning processes with self-determination principles and accountability for cultural rights and wellbeing
Implementation strategies	• Implement ongoing capability-building strategies to support best-practice goal setting, youth-centred planning, and accurate documentation of identity • Refine adherence and quality measures to achieve psychometric validation and integrate fidelity monitoring into routine practice to support feedback and continuous improvement

equity-related differences and may have underrepresented some groups in plan-level analyses.

Moreover, analyses were conducted at the transition plan level rather than the individual young person level. As a result, demographic characteristics for young people with multiple plans were represented more than once in descriptive summaries, which may overrepresent some characteristics. This approach was necessary to examine variation in plan quality across successive planning cycles and aligns with the study's focus on implementation quality rather than individual outcomes.

The staff survey achieved a relatively low response rate (approximately 13%), which may limit generalisability. However, this estimate was based on overall residential care staffing figures that include roles not directly involved in transition planning. To mitigate this limitation, three data sources were used. Administrative data and transition plan documents were obtained for the full population of young people in residential care at the time of data collection, and similar patterns across sources provided triangulated insight into transition planning practice.

The staff survey and transition plan analyses were also subject to methodological constraints. The survey was informed by dominant policy frameworks that may not fully reflect community-led or culturally grounded transition planning practices. Moreover, adherence was measured through staff self-report, which is vulnerable to recall, interpretation, and social desirability biases (Sedgwick, 2015; Wang & Cheng, 2020). Demographic representation was uneven across groups, limiting statistical power for subgroup analyses, particularly for Aboriginal and Torres Strait Islander staff, staff with lived experience of care, Aboriginal and Torres Strait Islander young people, and those receiving disability services. Several multi-category variables also contained sparse subgroups, meaning some meaningful differences may not have been detected.

The adherence measure captured reported frequency of delivery rather than directly observed practice and excluded some activities, such as housing-related planning, which were captured only through free-text responses due to their perceived limited controllability by staff. Administrative data were drawn from an organisational dataset designed for service delivery monitoring rather than implementation measurement, which may introduce reporting bias (Sedgwick, 2015; Wang & Cheng, 2020). Finally, although the TPQAT was grounded in policy and practice guidance, it has not undergone psychometric validation and may reflect Western, policy-driven assumptions.

Conclusion

This study provides the first multi-source examination of how transition planning is implemented in residential care, revealing gaps between policy intent and routine practice. Across administrative data, staff survey responses, and transition plan quality assessments, some components were delivered routinely while others showed variable adherence and quality. These inconsistencies help explain why transition planning does not consistently translate into improved outcomes for young people. Differences across demographic and contextual factors further indicate that implementation is shaped by individual, organisational, and system-level conditions. Future research should extend this work by examining additional implementation outcomes and identifying the multilevel determinants that support more consistent, equitable, and youth-centred transition planning.

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Author Contributions H.W. led the study design, recruited participants, developed the transition plan quality assessment tool, collected data, conducted all data analyses, wrote the manuscript, and prepared all tables. S.M. contributed to the development of the quality assessment tool, applied the tool to all transition plans, and reviewed the manuscript. N.H. supported participant recruitment, administrative data retrieval, and transition plan data retrieval, and reviewed the manuscript. H.S. oversaw the study design and reviewed multiple versions of the manuscript. H.M. oversaw the study design, contributed to, and reviewed multiple versions of the manuscript. All authors critically reviewed the final manuscript.

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Declarations

Conflict of Interest Nick Halfpenny is employed by the funding organisation and contributed to enabling the research and critically reviewing the manuscript. The funder had no role in the study design, data collection, analysis, or interpretation of findings. All other authors have no competing interests to declare that are relevant to the content of this article.

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