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ORIGINAL ARTICLE OPEN ACCESS

Assessing the Quality of Transition Plans in Out-of-Home Care

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Received: 30 May 2025 | **Revised:** 30 March 2026 | **Accepted:** 7 May 2026

Keywords: care leavers | implementation quality | leaving care | out-of-home care | transition plan | transition planning

ABSTRACT

Despite transition planning practices for young people (YP) in out-of-home care (OoHC), many continue to experience inequities after care, suggesting that intended outcomes are not being achieved. In Victoria, Australia, a Care and Transition Plan (transition plan(s)) document is the primary mandated tool to capture YP's transition goals, actions and supports for leaving care. The quality of the transition plans may play a critical role in shaping outcomes, yet little is known about how they are implemented. This study aimed to assess the quality of transition plans for YP across four OoHC providers and the contextual and participatory factors associated with quality. A Transition Plan Quality Assessment Tool was applied to 196 plans. Quantitative analyses explored the demographic factors associated with plan quality. Qualitative content analysis explored how YP's transition planning needs were considered. Most plans were of moderate quality, with significant variation by placement type, age, length of placement, Aboriginal and Torres Strait Islander status, YP's involvement and who authored the plan. Notable gaps were identified in housing, transition-from-care services and cultural considerations. As the first study to examine transition plan quality across placement contexts, the findings underscore the need to redesign transition planning tools and system-wide reform to enhance the quality of transition planning for YP leaving care.

1 | Introduction

This article examines the quality of transition plans, developed for young people (YP) living in statutory out-of-home care (OoHC) to support their transition into independent living. Transition planning is a core practice in Australia and internationally, designed to support YP in OoHC to build their readiness to live independently from the state (Mendes, Martin, et al. 2023; Organisation for Economic Co-operation and Development [OECD] 2022). Despite this, many YP experience inequitable life outcomes when they leave OoHC (Commission for Children and Young People [CCYP] 2020; Muir et al. 2019). This raises questions about the quality of transition planning in practice. Although policy and research define what high-quality planning should involve, no empirical evidence has examined the quality of written transition plans across placement contexts (CCYP 2020; Department of Families, Fairness and Housing [DFFH] 2022; OECD 2022). This study addresses this gap by examining the quality of transition plans in Victoria, Australia. To contextualize this study, the following sections outline the Australian OoHC system, the mandated transition planning practices, evidence on

postcare outcomes and the implementation framework underpinning this research.

1.1 | Australian OoHC Context

As of 30 June 2024, more than 44 800 children and YP were living in OoHC across Australia, of which 20% were in placements in the state of Victoria (Australian Institute of Health and Welfare [AIHW] 2025). Aboriginal and Torres Strait Islander children and YP, the First Peoples of Australia, are overrepresented in OoHC, comprising 43% of the Victorian OoHC population and being more than 10 times more likely to enter care (AIHW 2025; Commonwealth of Australia 2021; Productivity Commission 2024).

In Victoria, most (94%) children and YP reside in home-based care (foster or kinship care), whereas 5% live in residential care (AIHW 2025). Although residential care represents a small proportion of placements overall, it is concentrated among older adolescents, with 57% of those in residential care aged 15–17 years compared with 17% in home-based care (AIHW 2025). This reflects residential care's function as a shorter term placement option for older YP when home-based placements are unavailable or unsuitable because of their complexity of need (OECD 2022; Thoburn 2016). As OoHC is designed as a time-limited intervention, exit from the system is an expected outcome for all YP. Each year, approximately 969 YP aged 15–17 years are 'discharged' from OoHC placements, with Aboriginal and Torres Strait Islander YP representing 24% of this group (AIHW 2025). This age range marks the formal transition planning phase, during which all YP in OoHC are required to participate in *transition planning* to prepare to exit from state guardianship by age 18 (Department of Human Services [DHS] 2012; DFFH 2022).

1.2 | Transition Planning Practices

In Victoria, the formal transition planning process comprises two mandated practices: (1) the development of a *Looking After Children (LAC) 15+ Care and Transition Plan* (plan(s) hereafter) and (2) a referral to the *Better Futures* transition-from-care service (DFFH 2022; DHS 2012). The plan is the primary document used to structure preparation for leaving care around seven LAC domains: health; emotional and behavioural development; education; family and social relationships; identity; social presentation; and self-care skills (DFFH 2022; DHS 2012). It records YP's identified needs, planned actions and the roles of those involved in supporting their transition and is intended to be developed with YP at 15 years and 9 months and reviewed regularly until they leave OoHC. Similar documents exist internationally under terms such as independent living plans or aftercare plans, with a consistent purpose of supporting YP to identify goals and monitor progress until they leave care (Mhongera and Lombard 2018; Raymaekers et al. 2025). The intent of these plans is grounded in theory and research evidence that identify the core practices required to support a successful transition to adulthood (Grage-Moore et al. 2025; van Breda and Reuben 2025).

Although the plans structure transition planning within OoHC, Better Futures provides 'extended' support beyond age 18. The programme is intended to commence at age 16 to build relational continuity while YP are in OoHC and then provides coaching and flexible funding from ages 18–21 after they leave care (DFFH 2022; Mendes 2021). YP may also access *Home Stretch* funding to subsidize transition-related needs, including housing and education costs (DFFH 2022; Mendes et al. 2025). These extended care arrangements are informed by evidence that ongoing relational and financial support beyond age 18 is associated with positive postcare outcomes (Courtney et al. 2019; Mendes 2024; Storø 2018; van Breda et al. 2020). However, although YP in home-based care may remain with their carers after turning 18, YP in residential care must transition to private or public housing (Mendes et al. 2025). Although these practices exist, persistently inequitable life outcomes for YP leaving OoHC indicate that they are not receiving the transition planning as intended.

1.3 | Transition-From-Care Outcomes

Despite mandated transition planning practices, many YP continue to experience adverse outcomes, suggesting that the intended benefits are not consistently realized. Although some YP experience positive outcomes, others face significant challenges influenced by factors such as placement stability, family connections and available support (Asif et al. 2024; Campo and Commerford 2016; Galvin et al. 2022; Jedwab et al. 2019; McMahon et al. 2021; O'Donnell, Hatzikiriakidis, et al. 2020). These challenges contribute to disproportionate difficulties across multiple life domains, including finances, health, justice, education, social well-being and housing (AIHW 2023; Smales et al. 2020; Taylor et al. 2021; Zhao and Waugh 2025).

Transitions from care are particularly challenging for YP with a disability (CCYP 2020; Mendes and Snow 2014), Aboriginal and Torres Strait Islander YP (CCYP 2020; Jau et al. 2022; Mendes et al. 2021; Walsh et al. 2023) and those leaving residential care (Mendes et al. 2025). These groups of YP are more likely to rely on income support, access homelessness services earlier and use them for longer (AIHW 2022, 2023; Chikwava et al. 2022). For YP leaving residential care, poorer outcomes have been linked to earlier exits from care compared to those in home-based placements (Mendes, Martin, et al. 2023), exposure to inconsistent and unsafe environments (Slaatto et al. 2023), being absent or 'missing' from placement (Galvin et al. 2022), crisis-driven practices and high staff turnover (Kor et al. 2021), lack of ongoing support (O'Donnell, MacRae, et al. 2020) and placement instability (Asif et al. 2024; Jedwab et al. 2019).

Low-quality transition planning has been identified as one factor contributing to the adverse postcare outcomes for YP, particularly when plans lack active participation and are poorly developed (CCYP 2020; Martin et al. 2021; Muir et al. 2019; Walsh et al. 2023). Evidence also shows that with adequate support and high-quality transition planning, many YP can experience positive outcomes (Campo and Commerford 2016; Raymaekers et al. 2025). Although outcomes for YP differ significantly by placement context and demographic characteristics, no research

has examined whether the quality of transition plans also varies across these contexts.

1.4 | Quality Transition Planning

Transition planning practices in Victoria are accompanied by DFFH guidelines that outline what constitutes best practice and high-quality planning (DFFH 2022; DHS 2012). Plans should address all LAC domains, respond to individual needs and circumstances, ensure safe and sustainable living arrangements and include referrals to transition-from-care services (DFFH 2022; DHS 2012). However, although housing and transition-from-care services are considered essential to a successful transition from care, they do not have a dedicated domain in the plan.

For Aboriginal and Torres Strait Islander YP, high-quality planning must also uphold rights to cultural identity, kinship and community, which are central to physical, emotional and spiritual well-being and serve as protective factors during transition (Bamblett 2014; Bamblett et al. 2012; Krakouer 2023; Krakouer et al. 2018; Mendes et al. 2021). YP's meaningful involvement in decision-making is central to quality planning, as it builds agency, supports future-oriented goal setting, and ensures plans reflect their health, social, relational, material and developmental needs (Bengtsson et al. 2020; McPherson et al. 2021; Muir et al. 2019; Raymaekers et al. 2025; van Breda and Reuben 2025). Plans should also be reviewed regularly to reflect YP's evolving goals, written in plain English, assign clear roles and responsibilities to the care team, and align with best practice goal-setting principles—ensuring goals are specific, measurable, actionable, realistic and time-limited (DFFH 2022; DHS 2012; Stewart et al. 2024).

Although transition planning is a multifaceted process, the written plan is the primary mandated tool used to formalize YP's goals, actions and supports. Therefore, the quality of the written plan is considered central to implementation. If plans do not reflect best practice standards or the needs and aspirations of YP, the transition planning process may be undermined, which may help explain the inequitable transition outcomes observed for some groups of YP leaving OoHC.

1.5 | Implementation of Transition Planning

Despite well-established factors associated with successful transitions from care (Alderson et al. 2023; Grage-Moore et al. 2025; van Breda and Reuben 2025), there is limited understanding of why transition planning is not achieving intended outcomes. Implementation research shows that poor implementation of evidence-informed practices can prevent them from achieving intended outcomes (Proctor et al. 2011). One key strategy for improving implementation success is understanding whether practices are delivered with high quality and as described in guidelines and the contextual factors that influence delivery (Carroll et al. 2007; Green et al. 2022; Proctor et al. 2011). Quality is theorized as an important indicator of implementation success and refers to the skill or competence with which required components are delivered (Carroll et al. 2007).

This is a knowledge gap as no empirical research examining the quality of transition plans has been undertaken in the Australian context. This represents a critical gap, as assessing plan quality is necessary for determining whether transition planning is being delivered as intended. International evidence offers some insight, with one study from Belgium identifying several factors that support effective implementation of transition plans, including stable relationships between YP and staff, shared decision-making, staff capability and training, and sufficient time for meaningful engagement in the planning process (Raymaekers et al. 2025).

1.6 | This Study

Therefore, this exploratory study aimed to examine the quality of transition planning in Victoria, Australia, and the contextual and participatory factors associated with quality. To address the aim, four research questions were explored:

1. What is the overall quality of transition plans, and how does quality vary by placement type and YP characteristics?
2. Who is involved in the development of transition plans, and how does quality vary by their involvement?
3. How does quality vary across transition planning domains?
4. What are YP's transition needs, and to what extent are they addressed in the transition plans?

To address the research gap, first, we present our methodological approach. Second, our findings are presented in four sections: 'Demographic Characteristics', 'Overall Quality and Variation by Contextual Factors', 'Quality Across Transition Planning Domains' and 'YP's Transition Needs'. Third, we discuss the results' limitations and conclusions.

2 | Methods

2.1 | Study Design and Ethics

This study employed a mixed-methods document analysis of transition plans, integrating quantitative scoring of plan quality with qualitative content analysis of YP's transition needs. This study was approved by the Monash University Human Research Ethics Committee (project ID: 39433).

2.2 | Procedure

Plans for YP of transition planning age (15–17 years) living in kinship care, foster care and residential care were requested from three community service organizations (CSOs) and one Aboriginal Community Controlled Organisation (ACCO). For the three CSOs, written consent was not required, as existing consent procedures already encompassed the use of transition plans for research purposes, and no identifiable data were included. For the ACCO, existing consent procedures did not encompass research; therefore, written consent was obtained from all YP for their transition plans to be included in the study.

All organizations were voluntary partners in an Australian Research Council Linkage Project (LP210300791). As part of this partnership, each organization provided organizational consent for the research team to access de-identified transition plans. None of the researchers were affiliated with or had any existing relationship with any of the organizations during the planning of the study.

Two CSOs provided plans for 100% of YP meeting the study inclusion criteria. One CSO provided plans for 41% of YP, whereas the ACCO provided plans for approximately 8% of YP. For the ACCO, this lower proportion reflected consent procedures, whereby invitations were distributed to all teams to invite YP to participate and provide consent for their plans to be included in the study. A total of 196 de-identified plans were provided electronically to the research team for analysis. Methodological limitations related to sampling and consent processes are reported in Section 5.

2.3 | Measure

Table 1 presents the Transition Plan Quality Assessment Tool (Assessment Tool hereafter), which comprises four domains and 23 items identified as best practice transition planning, including (1) plan clarity (e.g., use of plain English), (2) Aboriginal and Torres Strait Islander YP's specific needs, (3) YP's involvement and (4) YP's transition needs. The development of the Assessment Tool is reported in Supporting Information S1.

TABLE 1 | 23-Item Assessment Tool.

Assessment Tool items	Scoring
Domain 1: Plan clarity	
How the success/outcome of needs will be measured or reviewed is specified	*Not at all* = 1 *Somewhat* = 2 *Mostly* = 3 *Not applicable* = excluded
There are clear timelines around needs	
The plan is reviewed and updated to reflect new needs (if multiple plans)	
There are clear care team roles and responsibilities	
The needs are realistic and actionable	
The needs and actions are written clearly in plain English	
There are discrepancies within the plan	*Yes* = 1 *No* = 3
Domain 2: Aboriginal and Torres Strait Islander young people's needs	
Aboriginal and Torres Strait Islander family or kin have been involved in the planning	*Not at all* = 1 *Somewhat* = 2 *Mostly* = 3 *Not applicable* = excluded
Aboriginal-controlled/led organizations have been involved in the planning	
Positive recognition of Aboriginal and Torres Strait Islander cultures	
There is the opportunity to connect to Aboriginal-led organizations	
There is the opportunity to connect to their Aboriginal and Torres Strait Islander identity	
There is the opportunity to connect to their Aboriginal and Torres Strait Islander family and kin	
Domain 3: Young people's involvement	
The plan builds on the young person's strengths	*Not at all* = 1 *Somewhat* = 2 *Mostly* = 3
The young person has been involved in the development of the plan	
The plan is tailored to the individual needs/aspirations of the young person	
Domain 4: Young people's transition needs	
Postcare-appropriate housing options are being planned for	*Not at all* = 1 *Somewhat* = 2 *Mostly* = 3
Young people have been linked in with transition-from-care services	
The young person is engaged in the development of independent living skills	
The young person is engaged in support that enables engagement with employment and education	
The social and emotional well-being of the young person has been considered	
The young person's connections outside of the care system are being fostered	
The young person is being encouraged to engage with health services	

Note: Each item was framed as 'Is there evidence that [item] ...?'. Scoring reflects the extent to which evidence was present for each item.

Each item was rated according to the extent to which it was addressed within the plan using a 3-point scale (1 = *not at all*, 2 = *somewhat* and 3 = *mostly*). One item ('Is there evidence of discrepancies within the plan?') was rated dichotomously (1 = *yes* and 3 = *no*). If required sections of a plan were left blank (e.g., no goals identified within a LAC section), the item was assigned a score of 1 (*not at all*). Seven items could be marked as *not applicable* where they were only relevant to specific subgroups (e.g., Aboriginal and Torres Strait Islander YP). The Assessment Tool was applied to each plan in Microsoft Excel. Most plans (90%) were rated by the lived-experience researcher (S.M.). Twenty per cent of plans ($n = 40$) were independently corated by two members of the research team to assess reliability, demonstrating 91.4% agreement.

TABLE 2 | Demographic characteristics of young people ($N = 196$).

Demographics	*N* (%)
Gender ($n = 178$)	
Female	95 (53)
Male	83 (47)
Placement type ($n = 190$)	
Residential care	128 (67)
Kinship care	41 (22)
Foster care	17 (9)
Lead tenant	4 (2)
Disability ($n = 196$)	27 (14)
Aboriginal or Torres Strait Islander ($n = 196$)	36 (18)
ACCO	3 (2)
CSO	33 (17)
Case management contracted to CSO ($n = 196$)	135 (69)
Mean age (years) at time of plan (SD) and range	15.89 (0.80) 14–18
Mean years spent in placement (SD) and range	4.92 (3.14) 1–10

Note: n = 6 plans did not report placement type; $n = 18$ did not report YP's gender.

2.4 | Data Analysis

2.4.1 | Scoring of the Assessment Tool

To assess plan quality, scoring was conducted at two levels: (1) for each plan (plan-level) and (2) for each Assessment Tool item across all plans (item-level). For plan-level scoring (Research Question 1), each plan was assigned a raw score and percentage score. The raw score was calculated in Microsoft Excel by summing the scores for all applicable Assessment Tool items within each plan. Items marked as *not applicable* were excluded. The plan-level percentage score was then calculated by dividing the raw score by the maximum possible score and multiplying by 100. The maximum possible score for each plan was calculated by multiplying the number of applicable (i.e., scored) items by 3 (3 = highest possible item score). This percentage was treated as a continuous variable in descriptive and inferential analyses. To explore Research Question 3, item-level percentage scores were calculated using the same scoring approach. For each item, the total score achieved across applicable plans was divided by the maximum possible score and multiplied by 100. These results were reported as percentage scores only.

Quality scores were classified into three quality categories: high quality (≥ 75%), medium quality (50%–74%) and low quality (< 50%). These thresholds were informed by prior fidelity and implementation research, where 75% is commonly used as a benchmark for high-quality implementation (e.g., Schaap et al. 2018). Example excerpts from plans were included to demonstrate differences between quality categories.

2.4.2 | Quantitative Data Analysis

Statistical analyses were conducted using IBM SPSS Statistics Version 28. No plans were excluded based on missing data. Frequencies and descriptive statistics were generated for demographic characteristics reported in the plans (Table 2). One-way analysis of variance (ANOVA) was conducted to examine whether plan-level quality differed across demographic characteristics and by who participated in plan development. The continuous dependent variable was the plan-level quality score. Categorical independent variables included placement type, gender, disability status, Aboriginal and Torres Strait Islander identity, whether the young person participated in developing the plan and the role of the person who completed the plan. For independent variables with more than two levels, post hoc comparisons were conducted to identify specific group differences (Tables 3 and 5).

TABLE 3 | Difference in plan-level quality across placement type.

Placement type	*M* (%)	SD	Post hoc comparison	ANOVA mean difference	SE	*p*
Residential	59.25	6.90	Residential vs. kinship	−10.43	1.552	**< 0.001**
Foster	67.34	14.14	Residential vs. foster	−8.10	2.294	**0.003**
Kinship	69.68	10.87	Kinship vs. foster	2.34	2.55	1.000

Note: M (%) represents the mean plan-level percentage quality score within each placement type. The lead tenant was excluded from placement type analysis because of the small sample size ($n = 2$). *p* values in bold denote statistically significant results.
Abbreviations: SD = standard deviation; SE = standard error.

Linear regression analyses were conducted to examine if age and time in current placement predicted plan-level quality. All relevant underlying statistical assumptions were assessed and met for each separate analysis, and demographic characteristics were controlled for where applicable. A Bonferroni correction was applied where multiple comparisons were tested to reduce Type 1 error. Item-level percentage scores were not included in inferential analyses. These scores were tabulated descriptively to identify patterns of strength and weakness across Assessment Tool items and are presented in Tables 4–6.

2.4.3 | Qualitative Content Analysis

Qualitative content analysis was used to identify and categorize transition needs that were documented in YP's transition plans (Elo and Kyngäs 2008). This method enabled identification and categorization of common needs and exploration of the extent to which those needs were addressed across transition plans. The unit of analysis was segments of text describing an identified need. A combination of inductive and deductive content analysis was used (Elo and Kyngäs 2008; Hsieh and Shannon 2005). Textual data were first inductively coded into descriptive categories by two researchers. Coding was conducted iteratively, with categories refined through discussion and comparison across cases. Fifty per cent of plans

TABLE 4 | Involvement of care team members in plan development ($N = 196$).

Care team members	*N* (%)
Carer	158 (81)
Key residential worker	106 (54)
Kinship carer	34 (17)
Foster carer	15 (8)
Lead tenant	3 (2)
Case manager/key worker	154 (79)
Child protection worker/practitioner	156 (80)
Biological parent	34 (17)
Mother	30 (15)
Father	4 (2)
Education	55 (28)
Disability	27 (14)
Mental health	24 (12)
Therapeutic practitioners	17 (9)
Aboriginal services	15 (8)
Youth justice	15 (8)
Alcohol and other drug services	14 (7)
Behaviour support	13 (7)
Health (e.g., general practitioner, occupational therapist and speech pathologist)	13 (7)
Youth mentor/support worker	7 (4)
Police	6 (3)
Community engagement worker	2 (1)

Note: Care team member categories reflect the fixed response options available in the transition plan template and were constrained by the design of the form. As such, the involvement of extended family, siblings or other significant people is not known.

TABLE 6 | Item-level quality scores for Domain 1.

Assessment Tool items	Item-level score (%)	Categorization
How the success/outcome of needs will be measured or reviewed is specified	37.44	Low
There are clear timelines around needs	44.44	Low
The plan is reviewed and updated to reflect new needs (if multiple plans, $n = 38$)	52.25	Moderate
There are clear care team roles and responsibilities	66.67	Moderate
The needs are realistic and actionable	71.79	Moderate
There are discrepancies within the plan	78.46	High
The needs and actions are written clearly in plain English	95.90	High

Note: Item-level score (%) represents the percentage score for each Assessment Tool item. Items are categorized as low (< 50%), moderate (50%–74%) or high (≥ 75%) quality.

TABLE 5 | Difference in plan-level quality based on the role of the person completing the plan.

Role (*n*)	*M* (%)	SD	Post hoc comparison	MD	SE	*p*
Case manager (125)	63.38	10.28	Case manager vs. residential carer	5.91	2.13	**0.037**
Residential carer (24)	57.47	6.27	Residential carer vs. house supervisor	−0.90	3.14	1.00
House supervisor (15)	58.37	6.95	Case manager vs. house supervisor	5.01	2.61	0.340

Note: N = 166. *M* (%) represents the mean plan-level percentage quality score within each placement type. The lead tenant was excluded from placement type analysis because of the small sample size ($n = 2$). *p* values in bold denote statistically significant results.
Abbreviations: SD = standard deviation; SE = standard error.

were independently double-coded, and discrepancies were resolved through consensus.

The descriptive categories were then deductively grouped into higher level categories aligned with the standardized LAC sections embedded within each transition plan. An additional category of 'housing and transition-from-care services' was created to capture needs not represented within the existing LAC framework. In line with qualitative content analysis, category frequencies were calculated to describe the prevalence of identified needs across plans, and quotes were extracted to illustrate how the needs were documented by practitioners (Elo and Kyngäs 2008).

3 | Results

3.1 | Demographic Characteristics

A total of 196 transition plans across three CSOs ($n = 193$) and one ACCO ($n = 3$) were identified. All had been completed within the last 3 years. YP's demographic characteristics are presented in Table 2.

3.2 | Overall Quality and Variation by Contextual Factors

The average overall quality score of the 196 plans was 62.23% (SD = 9.68). Most plans ($n = 166$, 85%) were of moderate quality, 21 (11%) were of high quality, and nine (5%) were of low quality. Plan quality ranged from 39.58% to 93.75%.

3.2.1 | Placement Type and Length

There was a significant main effect for placement type on the quality of the plans ($F = 17.131$, $p < 0.001$). Residential care plans were of significantly lower quality than foster and kinship care plans (Table 3). There was no significant difference between the two home-based care placement types. Quality was also significantly predicted by time in current placement ($b = -0.320$, $p < 0.001$). The longer the young person was in their placement, the lower the quality of their plan.

3.2.2 | YP's Characteristics

Plan quality was significantly predicted by age ($b = 0.191$, $p = 0.017$). As the age of the young person increased, the quality of the plan also increased. Plan quality was lower for YP who identified as Aboriginal and Torres Strait Islander (59.53%), in comparison to plans for non-Aboriginal YP (63.22%, $F = 4.123$, $p = 0.044$). There were no statistically significant differences in quality based on YP's gender or disability.

3.2.3 | YP's Involvement

YP were reported to be involved in the development of most plans (73%). Quality was higher for plans where YP were involved in the development process ($M = 63.87$, SD = 9.89), in comparison to when they were not involved ($M = 58.21$, SD = 7.70, $F = 11.165$, $p = 0.001$). No statistically significant relationships were identified between YP's demographic characteristics and participation in developing the plan.

3.2.4 | Care Team Involvement

Care team members involved in plan development predominantly consisted of YP's carers, case managers and child protection practitioners (see Table 4). Other common care team members included representatives from education, disability and mental health. Biological parents were included in 17% ($n = 34$) of plans. There was no statistically significant difference in quality based on parental involvement.

Most plans were completed by the YP's case manager. There was a significant main effect for the role of the person who completed the plan on the quality score ($F = 4.40$, $p = 0.005$). Plans completed by case managers were significantly higher quality compared to residential carers (Table 5). For YP in residential care, plans that were completed by community engagement workers (a specialist role responsible for promoting engagement in the community, e.g., education) were higher quality than those completed by both residential carers (mean difference [MD] = 16.49, standard error [SE] = 7.02, $p = 0.020$) and house supervisors (MD = 15.59, SE = 7.16, $p = 0.031$).

3.3 | Quality Across Transition Planning Domains

3.3.1 | Domain 1: Plan Clarity

Table 6 presents the quality assessment items related to how plans were written. Most plans used clear and plain language (95.90%), whereas needs and actions were often realistic and actionable (71.79%). There were minimal discrepancies within plans (78.46%). However, some notable discrepancies included the use of incongruent gender pronouns and not identifying the young person as Aboriginal and Torres Strait Islander or in the disability target group, despite needs in the plan indicating otherwise. For YP with multiple plans, there was moderate evidence that each one was reviewed and updated to reflect new needs (52.25%). Lower quality plans were evidently 'copied-and-pasted' (content repeated word-for-word across plans), whereas higher quality plans provided clear updates and tailored the goals based on the outcomes of the previous plan and the needs of the young person. There was a lack of clear timelines around when actions were intended to be achieved (44.44%). Time frames for lower quality plans were commonly reported as 'ongoing', which was incongruent with needs and actions that were likely time-limited (e.g., 'book appointment with general practitioner [GP]—ongoing'). In contrast, higher quality plans included specific, tailored dates for each action to be completed. Finally, only a small portion of plans across all placement types reported the planned outcome(s) of needs (37.44%).

3.3.2 | Domain 2: Aboriginal and Torres Strait Islander YP's Needs

Plan quality for Aboriginal YP from the ACCO (84.22%) was higher than the other service providers (55.77%, $F = 25.761$,

TABLE 7 | Item-level quality scores for Domain 2.

Assessment Tool items	ACCO plans ($n = 3$)		Non-ACCO plans ($n = 33$)	
	Item-level score (%)	Category	Item-level score (%)	Category
Aboriginal and Torres Strait Islander family or kin have been involved in the planning	33.33	Low	36.36	Low
Aboriginal-controlled/led organizations have been involved in the planning	100	High	38.38	Low
Positive recognition of Aboriginal and Torres Strait Islander cultures	100	High	40.40	Low
There is the opportunity to connect to Aboriginal-led organizations	77.78	Moderate	46.46	Low
There is the opportunity to connect to their Aboriginal and Torres Strait Islander identity	100	High	55.56	Moderate
There is the opportunity to connect to their Aboriginal and Torres Strait Islander family and kin	100	High	66.67	Moderate
Overall quality	84.22	High	55.77	Moderate

Note: Item-level score (%) represents the percentage score for each Assessment Tool item. Items are categorized as low (< 50%), moderate (50%–74%) or high (≥ 75%) quality. ACCO plans refer to plans that were developed by Aboriginal-led organizations. Non-ACCO plans refer to plans that were developed by community service organizations.

$p < 0.001$). Table 7 presents the quality of the specific items for Aboriginal and Torres Strait Islander YP. High-quality plans from the ACCO documented specific needs, such as 'arranging for the young person to be connected to a cultural mentor to build confidence in their cultural identity' or 'carer to attend cultural competence training', with a specific training programme mentioned to ensure culturally appropriate care is provided. Also documented were opportunities for YP to connect with family and kin. In contrast, for the non-ACCO plans, needs were often general, such as 'for the young person to attend cultural events and activities', but were not specific. Cultural considerations were consistently missing for Aboriginal and Torres Strait Islander YP, and there was overall limited evidence that Aboriginal and Torres Strait Islander family or kin had been involved in planning.

3.3.3 | Domain 3: YP's Involvement

Table 8 presents the quality of items related to YP's involvement in plan development. Most commonly, it was reported that the person completing the plan 'had discussions with the young person and ensured that their goals/wishes were reflected in the plan'. Evidence of tailoring the plan to the individual needs/aspirations of the young person was moderate quality (66.32%). Lower quality plans for this criterion included repetitive or generic needs and actions that were not specific nor relevant to the unique needs of the young person, for example, 'maintain good health'. Higher quality plans demonstrated deep knowledge of the young person's current needs, interests and goals. Approximately 50% of plans sought to build on the young person's strengths (48.21%). Overall, plans that scored lower for these criteria had reported that the young person was not involved and had limited evidence that the plan had been tailored to the needs and strengths of the young person. The most reported explanation for YP's non-involvement was: 'young person did not wish to actively engage in transition planning discussions'.

TABLE 8 | Item-level quality scores for Domain 3.

Assessment Tool items	Item-level score (%)	Categorization
The plan builds on the young person's strengths	48.21	Low
The young person has been involved in the development of the plan	60.68	Moderate
The plan is tailored to the individual needs/aspirations of the young person	66.32	Moderate

Note: Item-level score (%) represents the percentage score for each Assessment Tool item. Items are categorized as low (< 50%), moderate (50%–74%) or high (≥ 75%) quality.

3.3.4 | Domain 4: YP's Transition Needs

Table 9 presents the quality of items related to YP's transition needs. As the high-level categories generated from the content analysis align with the Assessment Tool items relating to YP's transition needs, the content and quality analysis results are reported together below. The content analysis highlighted the most frequently coded needs grouped under each category, with the full list of all needs coded across the transition plans provided in Supporting Information S2: Table 1. The quotes included provide examples of how needs were addressed in high- versus low-quality plans, with many transition plans

TABLE 9 | Item-level quality scores for Domain 4.

Assessment items	Item-level score (%)	Categorization
Postcare-appropriate housing options are being planned for	37.26	Low
Young people have been linked in with the transition-from-care services	40.00	Low
The young person is engaged in the development of independent living skills	63.59	Moderate
Support that enables engagement with employment and education	72.65	Moderate
The social and emotional well-being of the young person has been considered	73.16	Moderate
The young person's connections outside of the care system are being fostered	73.20	Moderate
The young person is being encouraged to engage with health services	76.24	High

Note: Item-level score (%) represents the percentage score for each Assessment Tool item. Items are categorized as low (< 50%), moderate (50%–74%) or high (≥ 75%) quality.

using similar or identical language in describing YP's transition needs.

3.3.4.1 | Housing and Transition-From-Care Services. Consideration of housing arrangements was mentioned in only 10% of plans and was of low quality (37.26%). Housing was often discussed within the general context of broader transition-from-care supports, such as 'to be linked in with Better Futures to work towards independent living'. Living arrangements were more often mentioned in plans for YP in home-based care: 'young person will remain residing with her grandparents when she turns 18 so she can continue saving money for independent living'. Only 2 out of 128 residential care plans sufficiently addressed this criterion, reporting 'support young person in settling into Lead Tenant placement'. One housing-specific need was coded across all transition plans: explore housing options ($n = 1$).

Similarly, engagement with transition-from-care services was mentioned in only 14% of plans and was of low quality (40.00%). When this was included in plans, they were quite general, for example, 'young person to start engaging with postcare supports'. More specific and relevant needs regarding engagement with services included 'referral to Better Futures' or 'begin to develop a relationship with Better Futures worker'. Two transition-from-care service needs were coded: link in with postcare supports (i.e., refer to) ($n = 3$) and YP to engage in postcare supports ($n = 4$).

3.3.4.2 | Health. The health domain was completed with high quality (75.87%), with comprehensive evidence that the plans were focused on encouraging YP to engage with relevant health services. The most frequently coded health needs were regular health checks (i.e., dental, optometry and audiology, $n = 60$), dental checks specifically ($n = 51$), GP appointments ($n = 50$), maintain good health ($n = 18$), attend health appointments ($n = 15$), sexual health education/support ($n = 14$), nutrition ($n = 12$) and physical activity/exercise ($n = 11$). Lower quality plans included generic health needs, such as 'maintain optimal health' or 'engage in healthy lifestyle', with minimal actions for how to achieve such broad goals. Higher quality plans specified how YP would be supported to engage with various health services, such as 'young person to book and attend annual GP, dental, optometry and audiology check-up'. For YP with multiple plans, those of higher quality used the outcomes of previous health assessments/check-ups to inform updated health goals.

3.3.4.3 | Emotional and Behavioural Development. Consideration of YP's emotional and behavioural needs in the plans was of moderate quality (73.16%). The most frequently coded needs were mental-health support (i.e., engagement with a psychologist, $n = 53$); developing positive relationships with peers and family members ($n = 28$); general emotional support needs (not specified, $n = 26$); to be safe, stable and nurtured in the placement ($n = 26$); emotion regulation skills ($n = 25$); and behaviour support plans ($n = 21$). Lower quality plans often reported 'ensure emotional and behavioural needs are met' without describing the needs or how they could be met and often did not use strengths-based language to frame emotional and behavioural needs, such as 'think before acting on something'. Higher quality plans used more specific and strength-based language with a focus on how needs may be met, such as 'continue to develop emotion and behavioural regulation skills' and 'provide a safe, stable and predictable living environment with caregivers attuned to meet emotional needs'.

3.3.4.4 | Education, Employment and Training. The extent to which YP were supported to engage with education and employment in the plans was of moderate quality (72.65%). The most frequently coded need was to attend and engage in school ($n = 181$). Employment needs were less common and included support to find and apply for work ($n = 32$), build employment readiness (i.e., job skills, resume and work experience [$n = 27$]), and explore career pathways and interests ($n = 24$). Plans rated lower in quality often framed education needs in a paternalistic tone, such as 'young person to focus on education and not engage in inappropriate behaviours with other students'. In contrast, higher quality plans focused on specific and strength-based ways to support engagement with education and employment.

3.3.4.5 | Family and Social Relationships. Consideration of YP's family and social connection needs across the plans was of moderate quality (73.20%). The most frequently coded need was to establish and/or maintain family contact ($n = 117$), followed by establish and/or maintain appropriate social relationships ($n = 52$); develop and/or strengthen positive connections with biological family members ($n = 50$); identify and/or engage in social and community activities ($n = 24$); and positive adult role models ($n = 10$). Those that were lower quality were broad and did not specify the nature of relationships, for example,

'develop positive relationships'. Higher quality plans included specific and tailored goals related to developing, maintaining or enhancing both family and social relationships, for example: 'to support young person and her mother to work towards her visiting mother's home and spending time with her in the community'.

3.3.4.6 | Social Presentation and Self-Care Skills. The extent to which YP were being supported to develop their independent living skills was of moderate quality (63.59%). Lower quality plans for this item provided the generic need to 'develop independent living skills' or 'build life skills', without further elaboration or actions. Higher quality plans were specific and considered how to support the young person to engage in relevant life skills, such as 'young person to learn how to cook easy and healthy meals'. Independent living skills were consistently identified across both the social presentation and self-care skills domains. The most frequently coded needs included identify and/or engage in social and community activities ($n = 49$); develop social and/or interpersonal skills ($n = 30$); develop and/or maintain healthy and positive relationships ($n = 28$); improve personal hygiene ($n = 22$); foster self-confidence, self-esteem and sense of self ($n = 16$); and develop independent living skills ($n = 16$). Common self-care skills included independent living skills ($n = 76$) and personal hygiene ($n = 60$).

3.3.4.7 | Identity. The identity domain focused on supporting YP's understanding of and connection to their culture(s), family history and own self-identity. The most frequently coded identity needs were to build and maintain cultural connections ($n = 34$), develop a life story book ($n = 31$), foster a sense of self and/or identity ($n = 27$), explore and engage in hobbies or interests ($n = 25$), and obtain identity documents ($n = 18$). Specific items for YP who identified as Aboriginal and Torres Strait Islander were of low quality across the plans from the CSOs, whereas plans completed by the ACCO were of higher quality.

4 | Discussion

This study aimed to examine the quality of transition plans developed for YP preparing to transition from OoHC. The findings of the research questions are discussed below.

4.1 | Variability in Plan Clarity

Although strength-based practice is a core principle across the OoHC sector (Caiels et al. 2021; Finan et al. 2018), its application in transition planning documentation was inconsistent. Plans frequently emphasized YP's risks or challenges rather than their strengths, aspirations or capabilities. How YP are described in written records is important, as language that prioritizes problems can influence YP's sense of self, shape future expectations and limit how capable they perceive themselves to be in navigating adulthood (McDowall 2022; Purtell and Hawkes 2023; Schofield et al. 2017). This may reflect broader workforce and system influences, including practitioner training, LAC requirements, and compliance or risk-management pressures that shape implicit biases (Bessant and Broadley 2016; Lee et al. 2015; Mirick 2013; Venables et al. 2023).

The use of SMART goal principles was limited (Stewart et al. 2024), with many plans lacking specificity, measurable outcomes and time frames to guide action. In the absence of clear deadlines, plans offer limited mechanisms for accountability, which may contribute to delayed or rushed planning and inadequate preparation for YP leaving care (McDowall 2022; O'Donnell, MacRae, et al. 2020; Smales et al. 2020). A key barrier may relate to the design of the planning template, as both paper-based and digital formats were in use. Although the digital version included dedicated fields for recording outcomes and monitoring progress, the paper-based format lacked equivalent prompts, which may have constrained the consistent application of SMART goal principles (Damschroder et al. 2022; Stewart et al. 2024). Introducing consistent, structured prompts for measurable goals and time frames may enhance the utility of transition plans by supporting accountability, coordinated practice and clearer pathways for YP during transition (Stewart et al. 2024).

Another contributing factor may be that the plan is not consistently perceived as appropriate or acceptable by staff or YP. Low perceived acceptability (i.e., satisfaction) and appropriateness (i.e., meeting the needs of YP) can reduce engagement and compromise the quality of implementation (Evans et al. 2016; Fehlberg et al. 2024; Lewis et al. 2016; Palinkas et al. 2017; Rafeld et al. 2020). To inform strategies for improving quality, further research is needed to examine how perceived appropriateness and acceptability of plans influence implementation.

4.2 | Quality by Placement Type

Plans for YP in residential care were of lower quality than home-based care, and plans completed by residential carers were significantly lower than those completed by case managers. These findings raise concerns about equity, given YP in residential care experience a higher rate of adverse outcomes (Chikwava et al. 2022; Mendes et al. 2025; Slaatto et al. 2023). These differences likely reflect a combination of relational and structural factors characteristic of residential care settings. Compared with home-based care, YP in residential care are less likely to have access to a consistent, trusted adult, which is central to active participation in planning and decision-making (CCYP 2021; Kor et al. 2021; Mendes, Bollinger, and Flynn 2023; Purtell et al. 2022; Slaatto et al. 2023; ten Brummelaar et al. 2017). These relational challenges may be compounded by differences in training, role expectations and support structures across the workforce. Case managers, for example, may receive more specialized training or have dedicated time to complete the plans as intended (James et al. 2017; Mendes and Purtell 2020). Moreover, high levels of placement and workforce instability—including turnover and casual staff—in residential care may also disrupt continuity, limiting opportunities for iterative goal setting and follow-through (Kor et al. 2021; Leloux-Opmeer et al. 2016; Mendes, Bollinger, and Flynn 2023). This highlights the need to better support residential carers to deliver higher quality plans and prioritize stability and relationship building within residential care. This may include scaling therapeutic residential care

principles, such as lower staff-to-young person ratios, evidence-informed practice, clinical roles, and staff support and supervision structures that decrease instability and increase quality (Daly et al. 2018; Kor et al. 2021).

Longer placement duration was associated with lower transition plan quality, which contrasts with prior evidence suggesting that placement stability supports more consistent and person-centred practice (Asif et al. 2024; Jedwab et al. 2019). One explanation is that YP in stable placements accumulate multiple plan iterations over time, as they must be revised regularly (DHS 2012), which may encourage the retention of earlier content without meaningful revision or renewed engagement with the young person. As a result, plans may become generic or outdated, highlighting the need for further research to examine how placement duration and review processes influence plan quality. This reinforces the need for further qualitative research to understand perceptions of the plan's suitability and feasibility in practice.

4.3 | YP's Involvement

YP's active participation in developing their plan was associated with higher quality, indicating that engagement supports more meaningful and relevant planning. Including YP in the planning process fosters ownership and commitment, resulting in personalized, aspiration-aligned goals and stronger motivation to achieve positive postcare outcomes (Bengtsson et al. 2020; CCYP 2020; Häggman-Laitila et al. 2018; Purtell et al. 2022). Beyond being a practice ideal, participation is a legal and ethical requirement, with legislation affirming YP's rights to be involved in decisions that affect their lives, including the creation and management of their records (Evans et al. 2024; Victorian Government 2005, 2006). Despite this, many YP experience limited agency within the child protection system, not only in transition planning but also across their broader interactions with OoHC, where opportunities to influence significant life decisions are often minimal (Delgado et al. 2023; McPherson et al. 2021; ten Brummelaar et al. 2017). Further qualitative research, particularly with YP themselves, is needed to better understand the barriers and facilitators to meaningful participation in transition planning.

4.4 | YP's Age

Plan quality improved with increasing age, which may reflect greater practitioner engagement as YP's capacity to advocate for themselves develops over time (Križ and Roundtree-Swain 2017; Kwon and Yang 2020; ten Brummelaar et al. 2017). Nonetheless, younger people who may have less capacity to advocate for their needs should not receive lower quality transition planning. Practitioners' perceptions of YP's developmental capacity may further shape opportunities for participation, with younger YP more likely to be excluded from decision-making (Toros 2021), potentially limiting the time available to identify goals, explore options and build the skills required for a successful transition (CCYP 2020; Mendes, Martin, et al. 2023). This highlights the need for practitioner training and capability building to better support and engage YP in the transition planning process.

The relationship with age and quality may also indicate increased practitioner responsiveness as YP approach their 18th birthday, raising questions about the consistency and timing of planning efforts. Rather than operating as a gradual, developmentally informed process, transition planning may be deprioritized in earlier stages because of competing demands (Muir et al. 2019). Further research is needed to examine how these factors interact to influence the timing, quality and effectiveness of transition planning.

4.5 | Aboriginal and Torres Strait Islander YP

Plans completed by the ACCO were rated higher quality (84%) than those completed by non-ACCO providers (54%), particularly on the Aboriginal and Torres Strait Islander criteria. However, only 3 of the 36 transition plans for Aboriginal and Torres Strait Islander YP were available for the study from the ACCO, limiting understanding of transition planning within ACCOs. Nonetheless, existing evidence highlights the importance of ACCO involvement in enabling culturally safe and effective planning for Aboriginal and Torres Strait Islander YP (Walsh et al. 2023).

Across all plans, documentation of family and kin involvement was minimal, raising questions about whether this reflects limited practice or inadequate record-keeping. This finding is concerning given the likelihood of Aboriginal and Torres Strait Islander YP's cultural identity being compromised when placed in OoHC, particularly with non-Aboriginal service providers (Krakouer 2023; Krakouer et al. 2018). Many Aboriginal and Torres Strait Islander YP are supported by non-Aboriginal staff, who may lack the cultural knowledge, confidence or resources required to meaningfully incorporate these elements into transition planning (Krakouer 2023; Krakouer et al. 2018). Additionally, the current plan template is a mainstream tool used broadly and may not be appropriate to meet the specific cultural needs of Aboriginal and Torres Strait Islander YP (Baidawi et al. 2017; Bamblett et al. 2012). This reflects the ongoing legacy of colonization that continues to shape child protection systems and highlights the need to embed practices that centre culture, family, kin and community.

4.6 | YP's Transition Needs

The findings indicate that YP transitioning from OoHC have high levels of need in areas such as mental health, education, family relationships, social connections and independent living skills. However, these needs were inconsistently considered across the plans. Although these areas are critical to successful transitions from care and often remain unmet postcare (Smales et al. 2020), many plans contained generic or duplicated content, suggesting that transition planning is often deprioritized in the face of competing demands (Jabbour et al. 2018). In crisis-driven environments, such as OoHC, staff are frequently required to respond to urgent issues like placement instability and safety concerns (Collings et al. 2022; Galvin et al. 2022; Green et al. 2022), which may limit attention to longer term planning. As a result, transition planning risks becoming a 'tick-a-box' task (Evans et al. 2024) rather than a meaningful, individualized process.

Importantly, these findings reflect what was documented in the plans and may not fully capture what was delivered in practice. Many transition planning requirements sit outside the direct remit of OoHC and rely on coordination with health, education and housing systems. Consequently, the gaps in documentation may reflect broader interagency and systemic challenges rather than lack of intent or effort by OoHC practitioners alone (Damschroder et al. 2022). Consistent with wider child welfare evidence, effective transitions depend on collaboration and shared accountability across service systems (Baidawi and Ball 2023; Courtney et al. 2019; Palinkas et al. 2014). Strengthening service integration and shared responsibility is therefore critical to ensuring that transition planning translates into timely and meaningful support for YP.

Moreover, despite the well-established importance of stable housing for care leavers and transition-from-care services (CCYP 2020; DFFH 2022; O'Donnell, Hatzikiriakidis, et al. 2020; O'Donnell, MacRae, et al. 2020; Taylor et al. 2021), these areas were frequently absent from the plans—particularly for YP in residential care. Housing was documented more often for YP in home-based care, raising equity concerns given the heightened risk of housing instability and homelessness among those leaving residential care (Chikwava et al. 2022). One contributing factor may be the design of the transition planning template, which was designed in 2012 and has not been updated to reflect subsequent policy and programme developments, including the introduction of Better Futures and Home Stretch (DHS 2012; Mendes et al. 2025). Given evidence that the design of tools can shape how they are used in practice (Damschroder et al. 2022; Weeks 2021), limitations in the current template may constrain the consistent consideration of housing and transition supports in planning. These findings underscore the need to review and update the template to better support comprehensive and equitable transition planning across OoHC and partner services.

Plans that included transition-from-care service needs and goals frequently lacked specificity, including referral timelines, responsible parties and follow-up mechanisms. This is inconsistent with guidelines and research recommending that referrals commence from age 15 years and 9 months to allow for relationship building and coordinated support before statutory involvement ends at 18 (DFFH 2022; Häggman-Laitila et al. 2018; Prendergast et al. 2024; Storø 2018).

These omissions may reflect broader system constraints and complexities of coordination across sectors, rather than individual practice alone. One key constraint is that transition-from-care services and the housing market are outside the direct control of OoHC practitioners. As a result, care team members may document actions without the authority or resources to ensure follow-through, which may influence what and how needs are recorded (Wollter 2024). This aligns with broader implementation challenges in human services, where workforce capacity, fragmented cross-sector coordination and limited fit-for-purpose tools constrain enactment of intended practice (Fischer et al. 2016; Galvin et al. 2022; Green et al. 2022). Strengthening shared accountability and clarifying cross-system roles are therefore critical as YP approach care-leaving age and responsibility shifts beyond OoHC.

5 | Limitations

Although this study offers valuable insights in relation to transition planning quality for YP across OoHC, several limitations must be acknowledged. First, the sample was drawn from four organizations within one state in Australia. Practices, policies and resourcing vary across jurisdictions within Australia and internationally, limiting the generalizability of our findings. Additionally, the sample may not fully represent variation across all placement types, service regions or practitioner roles. Although plans for all YP currently in care were requested from each organization, plans from one CSO and the ACCO were under-represented because of consent processes and recruitment challenges. Plans were not screened for quality prior to submission to the research team, and the wide variation in plan quality suggests that they were not selectively provided. Therefore, future studies should examine transition planning practices in other contexts to explore variation and commonalities.

The analysis relied solely on written documentation, which may not reflect the full scope of planning practices. The absence of information in the plan does not necessarily indicate that conversations or supports did not occur but may reflect limitations in documentation practices. We were also constrained by the data available within the transition plans themselves. For instance, cultural and linguistic diversity is not recorded in plans, meaning that quality for these cohorts could not be assessed. Additionally, although the study examined associations between total quality scores and contextual factors (e.g., placement type), it did not analyse item-level variation. As a result, potential differences in how specific quality items are addressed across contexts remain unexamined.

This study represents an initial component of a broader research programme on the implementation of transition planning in OoHC in Victoria. Focusing on the written transition plan as the primary document used to guide and record planning activity provides a clear and objective assessment of the quality of this mandated practice. This document-level analysis establishes an essential foundation for understanding how transition planning is enacted. Complementary qualitative research will be conducted to examine the systemic, organizational, interpersonal and practice-level factors that influence plan quality.

Furthermore, all items in the tool were weighted equally, as aligned with the exploratory nature of this study. Introducing differential weights would require value judgements that cannot currently be justified by the evidence base. Nonetheless, future research could address these limitations by incorporating multiple data sources to more broadly assess transition planning quality, examining documentation practices and developing evidence-informed weighting criteria.

Although interrater consistency was supported through piloting and team discussion, scoring relied on subjective interpretation, which may have introduced bias. Although the tool incorporated broad indicators (such as whether YP were involved in planning), it may assume a one-size-fits-all approach. Although the tool includes Aboriginal-specific items, most items were based on policy documents and templates

grounded in dominant Western knowledge systems. Despite Aboriginal researchers contributing to the refinement of all items, the tool largely reflects mainstream frameworks and may not fully capture culturally grounded practices or diverse definitions of quality. Future research should examine how quality assessment frameworks can be tailored or adapted to reflect the varied needs, cultural contexts and experiences of diverse YP.

The small sample size of Aboriginal and Torres Strait Islander YP plans developed by the ACCO limits the ability to provide a representative picture of practice within ACCO settings. Although ACCO-developed plans were higher quality, particularly on culturally relevant indicators, the small sample precludes firm conclusions. This was due to current low numbers of YP in the age cohort for which transition plans are required (e.g., 15–18 years of age) and variability in policies regarding consent to use data for research across services. Selection bias may have also been likely, as only the plans from YP who provided consent were shared with the research team. Future research should prioritize culturally appropriate methodologies that are acceptable to ACCOs and grounded in Aboriginal and Torres Strait Islander knowledge and practice wisdom. This is critical for improving understanding of the appropriateness, acceptability, and implementation of current planning tools and practices within ACCO contexts and for Aboriginal and Torres Strait Islander YP more broadly. Further, this study did not examine how Cultural Support Plans or the Aboriginal Child Placement Principle (ACPP) (mandated elements of Victorian policy) shapes transition planning (Baidawi et al. 2017). Future research should explore how these instruments influence the planning process and how they can be more effectively integrated to support culturally safe and responsive transition planning.

Finally, the study did not examine the broader policy, funding and practice frameworks within which transition plans are developed and implemented. These system-level factors likely influence both the content and quality of plans. Future research should explore how these contextual factors shape planning processes and outcomes to inform more effective system-level reform.

6 | Conclusions and Recommendations

This is the first study to examine the quality of transition plans for YP leaving OoHC across residential and home-based care. Findings highlight significant variability by placement type, demographic characteristics and YP's participation, with key health and social care needs often inconsistently addressed. The design of the template likely influenced overall quality. Further research is needed to understand the contextual factors underpinning plan quality, including practitioners' and YP's perceptions of the acceptability and appropriateness of transition planning in addressing leaving care needs. As the transition plan is just one tool within a broader planning process, improving outcomes will also require attention to the wider policies, practices, relationships and support that underpin effective transitions from care. Key recommendations for policy, practice and future research to enhance the quality of transition planning and improve outcomes for YP as they prepare for adulthood include the following:

1. Refine and standardize transition planning tools: A system-wide revision of transition planning tools is recommended to ensure alignment with YP's contemporary needs and workforce requirements. Core domains such as housing, transition-from-care services (i.e., Better Futures) and independent living skills should be embedded, and demographic fields should be expanded to reflect gender, cultural and linguistic diversity. This review should also assess other tools currently in use to determine their relative advantages and inform the development of a fit-for-purpose, standardized policy tool.
2. Enhance practitioner capacity: A system-wide mandate for practitioner training is recommended to ensure transition plans are developed as intended (i.e., SMART goals and strength-based language). A review of existing training should also be undertaken to identify gaps and inform the development of training content.
3. Embed quality assurance mechanisms: To improve consistency and accountability, a system-wide policy directive is recommended to implement quality monitoring, not just compliance. Embedding standardized review processes for transition planning may help identify gaps, highlight good practice, and inform continuous improvement in both policy and frontline delivery.
4. Greater consideration of cultural support needs for Aboriginal and Torres Strait Islander YP: Recommendations include prioritizing the role of culture in implementing transition planning for Aboriginal and Torres Strait Islander YP, comprehensive cultural competency training for OoHC staff, building and supporting the Aboriginal and Torres Strait Islander workforce, transition planning practices that better support cultural connection (e.g., strengthening relations with family and kin), and greater engagement with ACCOs in developing plans to improve their quality and cultural safety. This work should build on, rather than duplicate, existing cultural support planning processes by focusing on how transition planning can uphold and continue cultural connection as YP leave care.
5. Explore facilitators and barriers to high-quality transition planning across placement settings: Further investigation is needed to understand the contextual factors influencing plan quality. This should include exploration of factors such as the strength of relationships between YP and staff, care team coordination, funding, housing availability and age-based transition-from-care policies. Engaging YP, carers, CSOs, ACCOs and child protection staff will be critical to ensure planning practices are fit for purpose.
6. Examine the use and perception of transition plans in practice: Research should explore whether gaps in plan quality reflect a lack of planning or poor documentation of practice. Qualitative research should be conducted with YP, carers, family members and practitioners to understand how transition plans are used across service contexts. These insights may identify where reforms are most needed and ensure planning processes reflect on-the-ground realities.
7. Evaluate outcomes of high-quality transition planning: Future research should explore the relationship between

plan quality and postcare outcomes to build a stronger evidence base for which aspects of transition planning are most impactful.

Acknowledgements

We thank our project partners at the Department of Families, Fairness and Housing who reviewed the manuscript and teams across Anglicare Victoria, Baptcare, MacKillop Family Services and VACCA who retrieved, de-identified and shared the transition plans. Open access publishing facilitated by Monash University, as part of the Wiley - Monash University agreement via the Council of Australasian University Librarians

Funding

This study was supported by the Australian Research Council (LP210300791).

Ethics Statement

This study was approved by the Monash University Human Research Ethics Committee (MUHREC) (project ID: 39433).

Consent

Written consent was not required for three of four of the participating organizations, as existing consent procedures already encompassed the use of transition plans for research purposes and no identifiable data were included. Existing consent procedures did not encompass research for one organization; therefore, written consent was obtained from all young people for their transition plans to be included in the study.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data generated and/or analysed during this study are not publicly available because of their sensitive nature and the lack of participant consent for sharing raw data.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Supporting Information S1:** Assessment Tool Development Process. **Supporting Information S2:** Content Analysis.