FY21

Annual Report

High & Complex Needs

Me mahi tahi tātou

Contents

Introduction

Guiding/Governing Force

The Vision of the 'Intersectoral Strategy for Children & Young People with High and Complex Needs' is: *Improved outcomes for children and young people with high and complex needs, through effective intersectoral service collaboration.*

The Strategy:

- Focuses on addressing unmet needs, with these needs dictating the type and mix of services provided.
- Seeks to support and strengthen whānau (including kin and non-kin caregivers) capacity to nurture and care for children and young people with high and complex needs.
- Will promote and encourage intersectoral partnerships nationally and locally to enable increased responsiveness of local services so the needs of children and young people can be met locally.

The Strategy is cross-government and utilises resources from the Ministry of Health, the Ministry of Education, and Oranga Tamariki — Ministry for Children.

Our Role

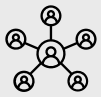
The Strategy defines the role of the High and Complex Needs (HCN) Unit is to:

- Support the development of interagency working and relationships at all levels.
- Provide day-to-day management of the funding allocated to the Strategy.
- Allocate funding for individualised packages of care through regional panels with final oversight from the HCN Manager.
- Allocate funding for some collaboration initiatives at the local level.
- Collect and manage information and knowledge.
- Provide regular reports to Ministers, the partner agencies, and key stakeholders.

Our Contribution to New Zealand

By working collaboratively with multiple government and non-government agencies, private providers, and whānau (including kin and non-kin caregivers) we create interagency plans that work towards finding solutions and support for children and young people who have high and complex needs that are not being met by mainstream services. We strive to meet these needs by setting achievable goals across eight domains that contribute to overall wellbeing:

Tuakiri ahurea
Cultural Identity



Oranga mātauranga
Education/ Vocational

Oranga hinengaro
Emotional Wellbeing

Hononga ā-whānau
Family Relationships

Whakawhanaketanga pūkenga ora
Life Skills Development

Tūāhuatanga noho
Living Arrangements

Hononga ā-hoa, ā-pāpori
Peer and Social Relationships

Oranga tinana
Personal Health

Intensive services are coordinated around children and young people and their whānau in a way that is intended to bring hope, stability, new skills, and a positive future. Close collaboration is at the heart of what the HCN Unit does. HCN & the three Ministries work closely together to close service gaps, providing focus on the needs and outcomes for children and young people with high and complex needs.

As the unmet needs are specific to the individual, so are the goals. Some examples of which are:

- Educational/Vocational Domain: _____ will maintain good attendance at school.
- Cultural Domain: _____ will be connected to their Hapū/Iwi Whakapapa.
- Family Relationships Domain: _____ will independently contact Dad at least once a week.

Often these unmet needs prevent children and young people from exhibiting factors that would indicate good adult life outcomes such as school involvement, self-control, family relations & social strengths and talents.

Beyond the plans, the HCN Unit provides an avenue for three Ministries supporting the same children and young people to synergise their approach, share information and make better decisions. HCN Specialists are in regions all across New Zealand and each one heads an Interagency Management Group where members of the three Ministries engage with one another to find solutions for children and young people.

Client Story – E

When the referral was made to HCN E was a 10-year-old boy, struggling at both home and school. He had been diagnosed with PTSD. He was living with his grandparents after a history of neglect, transience, and experience of domestic violence, related to his parents' drug and alcohol use. He was emotionally volatile and there were often fights with his siblings, particularly his brother. His behaviour would worsen after contact with his birth parents, particularly with his mother. E was slowly transitioning into his neighbourhood school, but had issues with anxiety and hypervigilance, and would either refuse to enter the classroom, or would enter but quickly disrupt the class and be asked to leave.

The team worked together to notice when things were going well, which included helping out (e.g., in the garden at home), spending time with his father (who was in a new relationship) and having short and easy schoolwork tasks to do, so he could experience success. When E asked to go and live with his father, his grandparents allowed this on a trial basis and the HCN team provided support to his new family and to his new school. E flourished at his new school – it was a fresh start and there was a group of others in the class who were at his level academically (which was below expected level for his age). His teacher naturally did things that helped him such as putting a whole week's timetable on the board and reminding the class if there was something unusual, or a change in routine, coming up, so he knew what to expect. He responded well to being given responsibility for certain tasks in the school and was quietly supported to shine in areas of strength e.g., being part of the school's technology challenge team, or attending an art session for talented children. If the teacher needed to give advice about how to play nicely and manage conflict, she did this with the whole class, so E never felt singled out. Having a teacher aide in the classroom enabled E's teacher to devote more time to supporting E individually or in small group learning situations, and to be able to notice and celebrate even the tiniest evidence of progress with him.

After a year, E was able to transition to Year 7 in a secondary school environment without issue, and the new school was surprised that he was being supported by HCN, as he was indistinguishable from all the other children who were starting with him. E has a secure group of friends who he spends time with both at school and after school, has established a positive relationship with his new teacher, engages in the classroom programme without disrupting anyone, and has been able to come off the anxiety medication he had been prescribed previously. He has positive and supportive relationships with his father, his father's partner and her two children, and his relationships with his siblings has improved when he stays with them with at his grandparents' place in the weekends. He also manages contact with his mother better and there were no emotional upsets afterwards. From the anxious, hypervigilant child at the start of the HCN plan, he is now a happy, relaxed member of his family and community.

From the Chair

As Chair of the HCN Governance Board, it is great to have such a supportive and strong service delivery team, led by Nicole Lambe, and dedicated board members working together.

The impacts of COVID-19 over the last year have been particularly challenging. Staying safe during the pandemic has at times limited the ability of those involved in the HCN process, to meet face-to-face and engage collaboratively, be that the child or young person, whānau, HCN Specialists or members of interagency teams. This is a difficult obstacle to overcome when communication and interaction are so intrinsic to the HCN process.

Despite the challenges, all involved have adapted well and the number of children and young people engaged in HCN has grown. Additionally, we have seen comparatively strong levels of goal achievement across the eight HCN domains that contribute to wellbeing – HCN's primary indicator of outcomes.

After two years of full budget utilisation the limiting factor to increasing service is the number of frontline staff available and the resources they can allocate. The HCN Unit aims to fill the gaps in existing services provided by Health, Oranga Tamariki and Education and to continue to grow case numbers to meet the demand. Over the past 12 months, the HCN Governance Board and Manager have been investigating ways to employ more staff to meet demand from existing funding. Optimising the utilisation of existing funds will remain an important agenda item at each HCN Governance Board meeting going forward.

The other major area needing the Board's attention is the predominance of Education as a referrer and increased funding of education focused interventions. Education was one of the two required agencies involved for referrals in 86% of new plans this year. Comparatively Health & Oranga Tamariki were involved in 53% & 46% respectively. In the past ten years we have seen education related costs have replaced care related costs as the larger expense for plan costs. For six years in a row now the highest single component of plan costs for HCN is the funding of Teacher Aide (TA) hours. The HCN Governance Board is seeking information and clarification as to why so many TA hours are needed and supplied for individualised plans.

The HCN Governance Board has been looking at ways to increase support for females with high and complex needs. This year the percentage of new HCN plans that were for female children and young people increased by 48% from 2020 yet this cohort still accounts for only 23% of the total. The HCN Governance Board will look to continue to improve the gender balance for those receiving HCN.

The percentage of Māori tamariki and rangatahi has remained steady at around the 44-49% mark over the last 10 years. While there is little disparity between the average monthly service provision costs of plans ended who identify as Māori & NZ European over the past five years, this year those who identify as NZ European have received approximately 13% more. While we should expect minor fluctuations year on year, we must ensure this event does not transform into a trend as we look to the future. The

HCN Governance Board will ensure HCN staff are fully aware of a broader range of interventions available for Māori. This may require a greater emphasis on professional guidance and development of support plans for Māori. There is potential for improvement within the Cultural Identity Domain, which records the lowest goal attainment scaling of all the eight wellbeing domains.

The HCN Annual Outcomes Report has detailed analysis of a wide range of critical areas of service delivery. The Unit will continue to use this analysis to identify areas of service delivery to improve. In summary, the HCN Governance Board is committed to continuing to improve HCN and to enhance the service for Māori, strengthen its commitment to the Treaty of Waitangi and increase the number of females experiencing the benefits of the HCN service.

David Pluck

HCN Board Chair and Ministry of Education Representative

The Board

David Pluck

HCN Board Chair and Ministry of Education Representative

David has been the Board Chair for over four years, and prior to that a Board member for three years. David is a registered psychologist and national manager of Te Kahu Tōī - Ministry of Education Intensive Wraparound Service. During his career, David has been committed to improving the outcomes for all students, particularly outcomes for Māori students to assist the Government to meet our obligation under the Treaty of Waitangi.

Sharon Thom

General Manager Specialist Services, Oranga Tamariki

Sharon is a registered social worker and an experienced senior manager who has worked for Oranga Tamariki for 38 years. Her current role covers a team focussed on the needs of children with health and disability challenges and as such is leading out the project that is managing the change due to the repeal of S141/2 for disabled children who require out of home placements. She also manages Clinical Services teams that are made up of Psychologists, Therapists, Specialist Child Witness Interviewers and is working on the future scope of these teams nationally.

Denise Tapper

Manager Clinical Services, Care Services, Oranga Tamariki

Denise has worked for Oranga Tamariki for 11 years and provides clinical support to residential and high needs services. Denise has worked with children, youth and their families across mental health, education and disability services over her 25 years as a clinical psychologist. She also worked as a neuropsychology assessor with children who sustained traumatic brain injuries.

Stephen Enright

Manager Rights and Protection, Mental Health and Addictions, Ministry of Health

Stephen has been a board member since 2019. Stephen has a bachelor's degree in Biological Science with 11 years as manager of the Rights and Protection team and 21 years in Ministry of Health, mental health teams watching out for the rights of tangata whai ora obliged to accept treatment in hospital and the community. Stephen has previously worked in occupational regulation at the Ministry.

Dr Amanda Smith

Chief Advisor, Disability Directorate, Ministry of Health

Amanda Smith is a registered social worker who has been working the health and disability field for the last 26 years. Her current role as Chief Advisor, provides a range of policy, operational and clinical advice in the area of disability. She has oversight of the High and Complex Framework that provides support for individuals under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.

Foreword

While the aggregation of data and collation of information are well-established methods of understanding trends in human behaviour, there is always a risk that they diminish the narrative of the those behind the trends.

For over 15 years now HCN has provided support directly for a substantial cohort of children and young people. We must acknowledge that each is unique, with highly specific needs and histories.

The scale of those supporting these children and young people is immense. It approximately consists of:

- A multiagency Board consisting of 5 Senior Representatives from Health, Education & Oranga Tamariki – Ministry for Children.
- 20 HCN Unit Team Members, including 15 HCN Specialists.
- 17 Interagency Management Groups across New Zealand with over 75 members & countless more members of Interagency Teams.
- A wide array of private providers.
- The whānau, friends and communities of the children and young people.

We must also acknowledge the magnitude of effort this group exerts towards a shared goal of bettering the lives of others.

That said we have a role to learn from our past and prepare for our future. This report seeks to utilise data to highlight the HCN Unit's performance in FY21 as well as FY20 for comparison.

It also takes a wider breadth, looking as far back as ten years ago at times. In doing so the report strives to provide further context to the performance of the HCN Unit today and how it has grown and changed since its inception. A core principle that guides HCN is that it exists to fill service gaps that are not being met by mainstream services. As these gaps fill, appear and morph over time so will HCN's provision of services. In this sense the HCN Unit needs to be, by its nature, adaptable.

Views of whānau from successful HCN Plan

"It (The HCN Process) helped me feel supported as a parent knowing that I was not alone and that professionals were there to offer advice and possible solutions with issues that _____ was facing."

Overview

FY21 Highlights

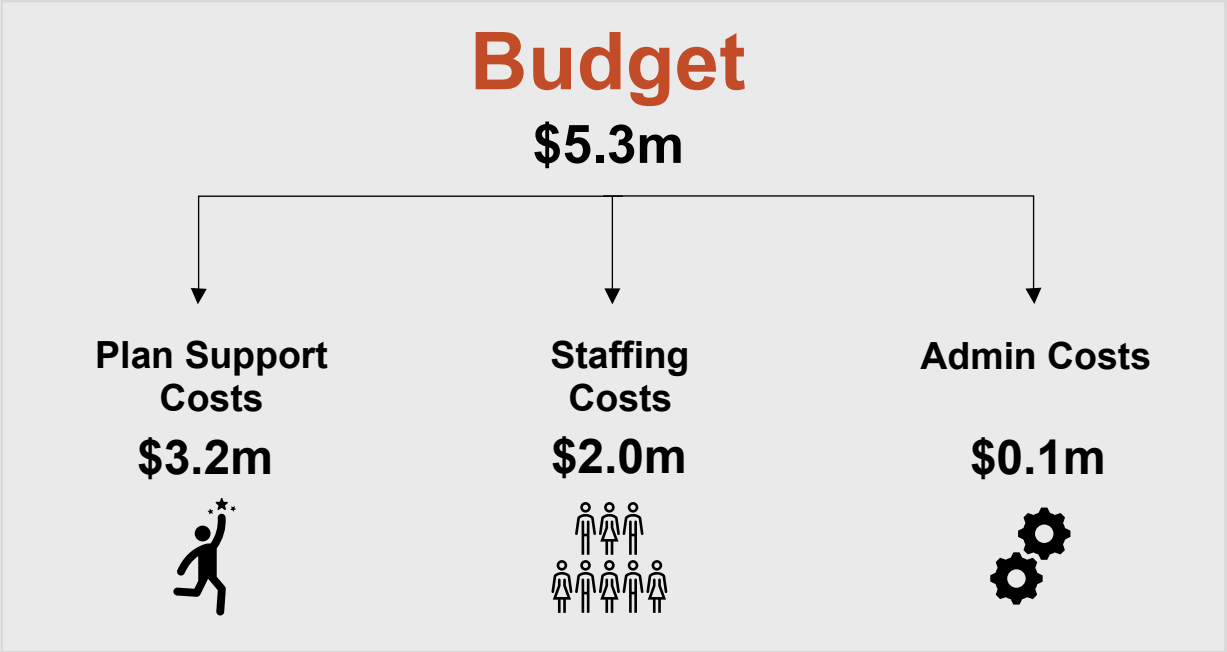
Plans Active (At any point in FY)	Plans Started	Goal Achievement (For Plans Ended)
229 ↑ *(FY20)* 224	90 ↓ *(FY20)* 108	60% ↑ *(FY20)* 58%

Key Improvements to HCN Unit

- Commencement of a project to help develop the cultural competency of the Unit, including a recently held workshop focusing on:
  - Unpacking culture, what it means to kaimahi, the strength/mana connections can bring, the impact of lost connections and the risks of disconnection.
  - Increasing knowledge of Hapū/Iwi in the regions.
  - Goal writing and interventions specific to the Cultural Identity Domain.
- Establishment of Kaimahi Māori Rōpū: A group for Māori staff members to meet, develop a support network and to champion culturally appropriate practice relating to Māori tamariki, rangatahi and whānau.
- Participation in professional development courses, for example a recent PD led by Sir Mason Durie was attended by multiple HCN Specialists.
- Development of monthly reporting processes to better manage the Unit's capability, financial capacity & outcomes.
- Review and streamlining of administration processes.
- Hosted development courses in regions to increase capability to meet the specific needs (e.g., those associated with FASD) of children and young people within the region by various HCN Specialists.
- Commencement of project to review and update the HCN external website.

FY21 Financial Story

The HCN Unit's Budget for FY21 was $5.35 million of which $5.37 million (100.3% utilisation) was spent.



Service Provision – Plan Support Costs (Top 10 by %)

	FY21	FY20	Change (%)	F17 – 21 AVG
Teacher aide	32.0%	32.6%	*-1.9%*	31.1%
Mentor/Coach	18.3%	12.5%	*46.8%*	14.7%
Teacher costs	11.4%	10.8%	*5.4%*	13.0%
Individual therapy	8.3%	8.2%	*1.5%*	6.7%
Other Therapist/Specialist	5.9%	4.9%	*22.2%*	3.9%
Occupational Therapy/Physio	5.6%	4.8%	*15.8%*	2.9%
Other interventions	3.0%	0.6%	*436.8%*	2.4%
Family training, support & therapy	4.4%	4.4%	*1.4%*	5.0%
Team training & support	1.9%	1.4%	*77%*	1.5%
Other education costs	1.8%	4.6%	*-62%*	3.1%

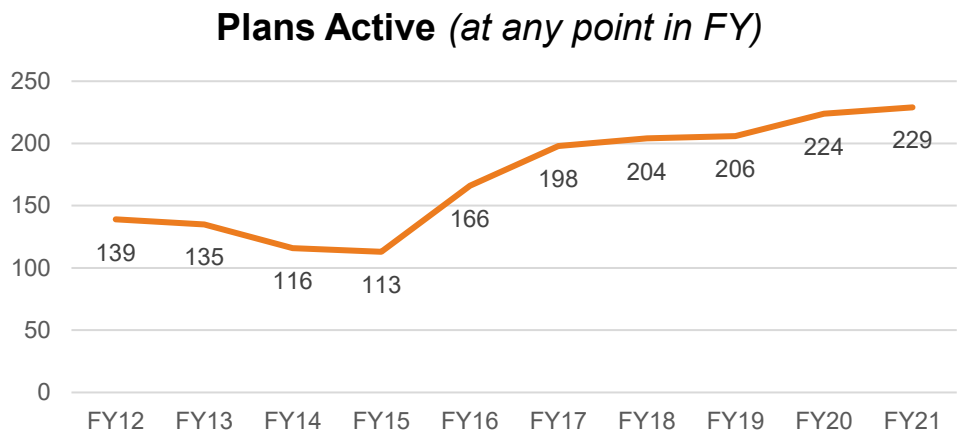
The HCN Cohort Size & Scope

Service Delivery

	FY21	FY20	Change (%)	F17 – 21 AVG
Plans Active *(at any point during FY)*	229	224	*2%*	212
Active Days	54,923	50,140	*10%*	49,021
Plans Started	90	108	*-17%*	90
Plans Ended	95	85	*12%*	87
AVG Monthly Service Provision Costs (excludes staff/admin) – Plans Ended	$1,855	$1,662	*12%*	$1,996

While the number of Plans Started has decreased from FY20, there has been a higher throughput of plans in FY21 whilst achieving GAS scores & AVG Service Provision Costs consistent with years prior.

The HCN Unit's throughput can be measured by both Plans Active (*at any point during FY)* & Active Days – the number of days every HCN Plan was collectively active throughout the FY. In this regard, the HCN Unit has certainly outperformed itself, not just from FY20, but from the past ten FYs.

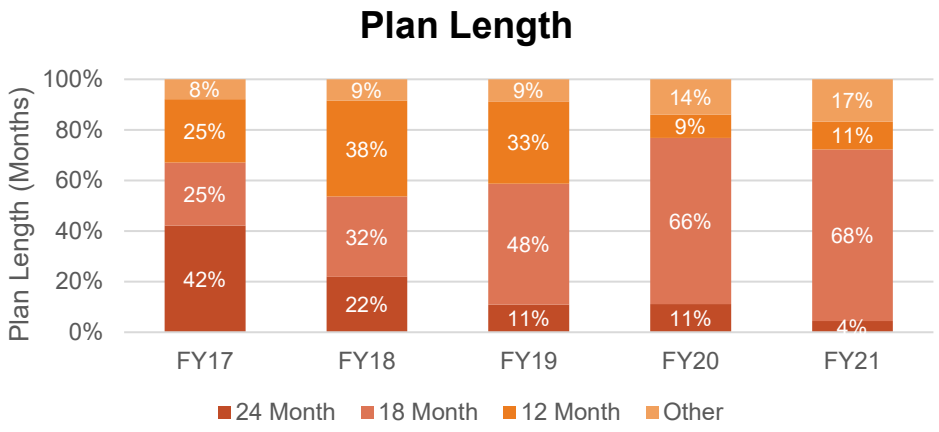


It should be noted that a key limiting factor in Service Delivery is budgetary restraints. Regardless of capability and demand, the HCN Unit must not exceed its financial capacity. The HCN Unit again utilised its full budget as it did in FY20. This indicates that Service Delivery was maximized given the HCN Unit's current resources & processes.

Duration

	FY21	FY20	Change (%)	F17 – 21 AVG
% 24 Month – Plans Started	4%	11%	*-60%*	17%
% 18 Month – Plans Started	68%	66%	*3%*	49%
% 12 Month – Plans Started	11%	9%	*20%*	22%
***% Other* Month** – Plans Started	17%	14%	*20%*	11%
Average Plan Length – Plans Started	16.9	17.7	*-5%*	17.2

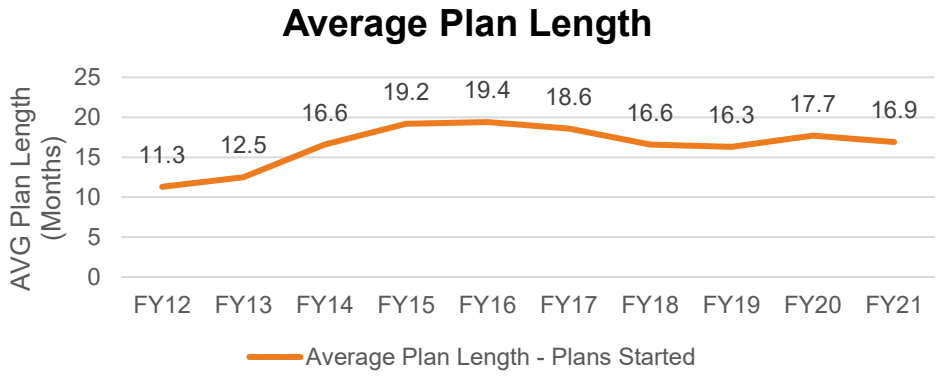
This FY we have seen a continuation in the uptake of 18-Month Plans with 24-Month Plans decreasing to a proportionate 5-year minimum.



While the number of Plans Started has been trending upwards since FY12 it has not increased at the rate throughput has.

	F17 – 21 AVG	F12 – 16 AVG	Change (%)
Plans Started	90	70	*29%*
Plans Active *(at any point during FY)*	212	134	*58%*

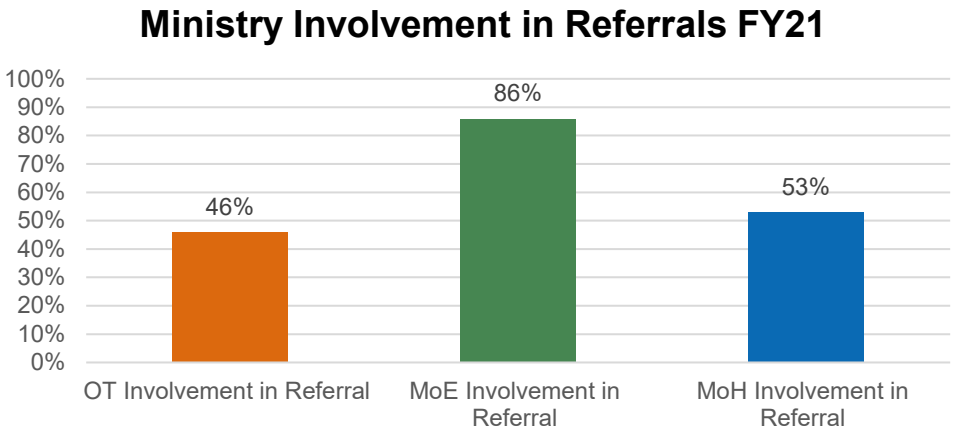
This discontinuity can be attributed to the elongation of Average Plan Length over this time as 18- & 24-Month plans were introduced in FY14.



Referring Agencies

	FY21	FY20	Change (%)
% OT Involvement in Referral – Plans Started	46%	60%	-24%
% MoE Involvement in Referral – Plans Started	86%	86%	-1%
% MoH Involvement in Referral – Plans Started	53%	41%	31%

In FY21 MoE was again the predominant referrer of plans. To meet HCN criteria a plan must have two agencies collaborating on the referral. If accepted, a plan will have, at least, the involvement of these two agencies and it is not uncommon for all three agencies to be involved.



Views of whānau from successful HCN Plan

"HCN has helped us see _____ mature and develop. We have seen a huge shift in how she has come along. It has increased our knowledge of her and how to interact with her. She shares her thoughts and talks with us now; she comes for a cuddle. We are very proud of the person she has become. It has brought the family together more."

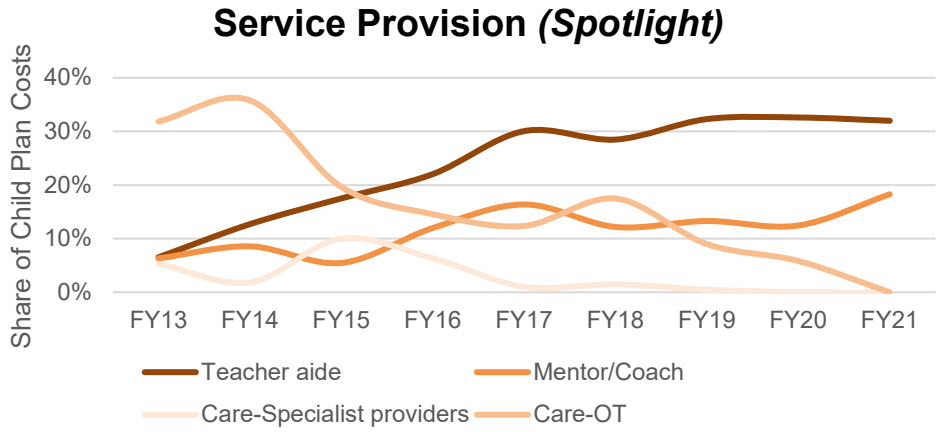
Service Provision – Plan Support Costs

	FY21	FY20	Change (%)	F17 – 21 AVG
Teacher aide	**32.0%**	32.6%	*-1.9%*	31.1%
Mentor/Coach	**18.3%**	12.5%	*46.8%*	14.7%
Teacher costs	**11.4%**	10.8%	*5.4%*	13.0%
Individual therapy	**8.3%**	8.2%	*1.5%*	6.7%
Other Therapist/Specialist	**5.9%**	4.9%	*22.2%*	3.9%
Occupational Therapy/Physio	**5.6%**	4.8%	*15.8%*	2.9%
Other interventions	**3.0%**	0.6%	*436.8%*	2.4%
Family training, support & therapy	**4.4%**	4.4%	*1.4%*	3.5%
Team training & support	**1.9%**	1.1%	*77.2%*	1.5%
Other education costs	**1.8%**	4.6%	*-62.1%*	3.1%
Assessment and programme	**1.7%**	0.5%	*205.4%*	0.8%
Recreation	**1.5%**	1.8%	*-18.1%*	0.9%
Respite-Specialist providers	**1.1%**	2.2%	*-50.0%*	1.7%
After school programme	**0.9%**	0.1%	*512.9%*	0.5%
Other living	**1.0%**	3.7%	*-73.2%*	1.4%
Other team costs	**0.1%**	0.1%	*64.5%*	0.2%
Counselling	**0.4%**	0.1%	*163.8%*	0.3%
Other health costs	**0.3%**	0.2%	*95.2%*	1.0%
Clinical Advisor	**0.2%**	0.0%	*1073.9%*	0.1%
Other culture	**0.1%**	0.2%	*-7.3%*	0.1%
BSW	**0.1%**	0.8%	*-86.2%*	0.9%
Care-OT	**0.0%**	0.0%	*-100.0%*	0.6%
Care-Specialist providers	**0.0%**	5.8%	*-100.0%*	8.8%
Cultural advisor	**0.0%**	0.0%	-	0.0%
Family Visits	**0.0%**	0.0%	-	0.0%
Respite-OT	**0.0%**	0.0%	-	0.0%

In general, the HCN Unit's Provision of Services has stayed consistent from FY20 to FY21. The predominant service provided was Teacher Aide. This has been the case the last six FYs. Before this it was Care – OT & Care – Specialist Providers. Overall, the largest cost the HCN Unit incurs is staffing.

Notable variances from FY20 to FY21 include a 39.5% increase in the Mentor/Coach cost share, no Care – Specialist Providers costs, and Other living & Other education cost share significantly reducing

Beyond FY17 there are four trends in the HCN Unit's provision of services that offer significant insight into the Unit. Those being the rise in the share of Teacher Aide & Mentor/Coach costs & the fall in the share of Care-Specialist providers & Care OT costs.



With reference to these trends:

"It needs to be stressed that all interventions directly funded under the strategy are in addition to what is provided by families, communities and local agencies. They are not a replacement for existing services." – Intersectoral Strategy for Children & Young People with High & Complex Needs

As the machinery of the three Ministries adapts to the need over time, so will service gaps high and complex needs children and young people are facing. The HCN Unit's provision of services today reflects the need HCN Specialists and their IMGs identify in their respective regions.

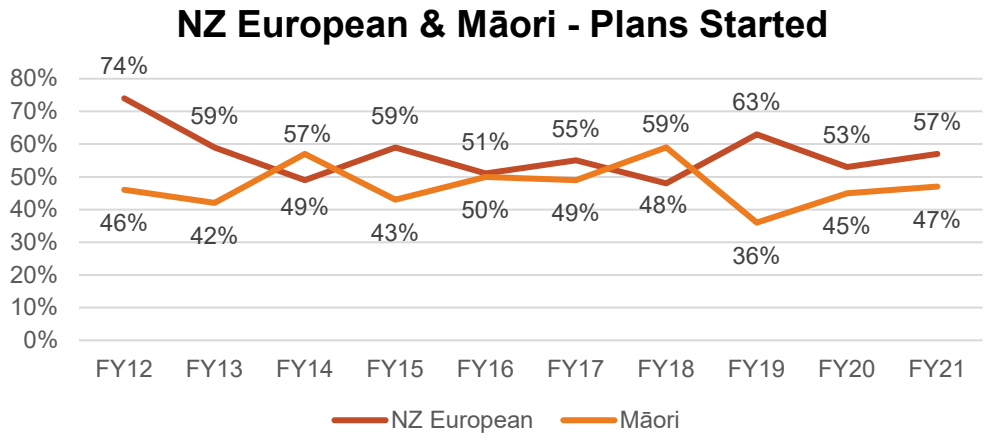
The HCN Cohort Demographic

Ethnicity

	FY21	FY20	Change (%)	FY17 – 21 AVG
% Identify as NZ European – Plans Started	57%	53%	*6%*	55%
% Identify as Māori – Plans Started	47%	45%	*4%*	47%
% Identify as Pasifika – Plans Started	6%	7%	*-25%*	6%
% Identify as Other Ethnicity – Plans Started	8%	12%	*-36%*	9%

Note: Many HCN children and young people identify as belonging to multiple ethnicities. To acknowledge this the following analysis focuses on the percentage of the cohort that identify as a certain ethnicity and therefore the percentages in the above columns will not add to 100%.

Over the past three FYs there has been an increase in the percentage of HCN Plans where the child or young person identifies as Māori. Beyond this period, the percentage of new plans that identified as NZ European & Māori in FY21 has remained fairly consistent.



For Plans Ended in FY21, children and young people that identified as Māori received on average less funding for Service Provision *(excludes staff/admin)* per plan than NZ European.

	FY21	FY20	Change (%)	F17 – 21 AVG
Māori Average Monthly Service Provision Costs – Plans Ended	$1,693	$1,720	*-2%*	$1,892
NZ European Average Monthly Service Provision Costs – Plans Ended	$1,915	$1,382	*39%*	$1,942

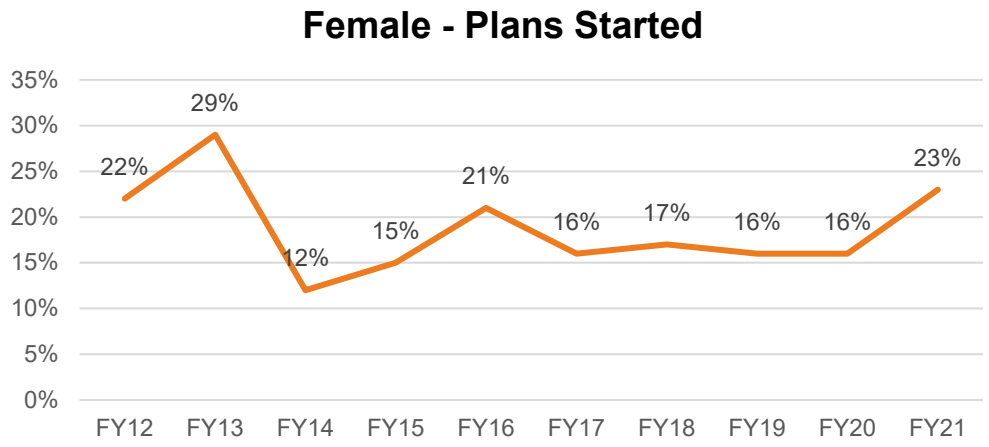
Note: While this analysis factors in the discrepancy in average plan length between the NZ European & Māori cohort it does not factor in discrepancies in Diagnostics – HCN's indicator of complexity.

Gender

	FY21	FY20	Change (%)	F17 – 21 AVG
% Male – Plans Started	76%	84%	*-10%*	81%
% Female – Plans Started	23%	16%	*48%*	18%
% Gender Diverse – Plans Started	1%	0%	–	1%

Historically the predominate gender in the HCN cohort has always been Male. Extensive analysis of this trend was completed in 2019 by Sioban Doran-Read in 'Understanding Differences in Male and Female Referrals to the High and Complex Needs Unit'.

One of the key recommendations implemented from this report was to encourage IMGs to give extra consideration to referrals for female children and young people. The reason for this is because females tend to present with less externalizing behaviours at a young age. This appears to have encouraged uptake as for plans started in FY21, 23% identified as Female - the highest proportion of plans started of this gender since FY13.



For Plans Ended in FY21, Females have received on average more funding for Service Provision *(excludes staff/admin costs)* per plan than males.

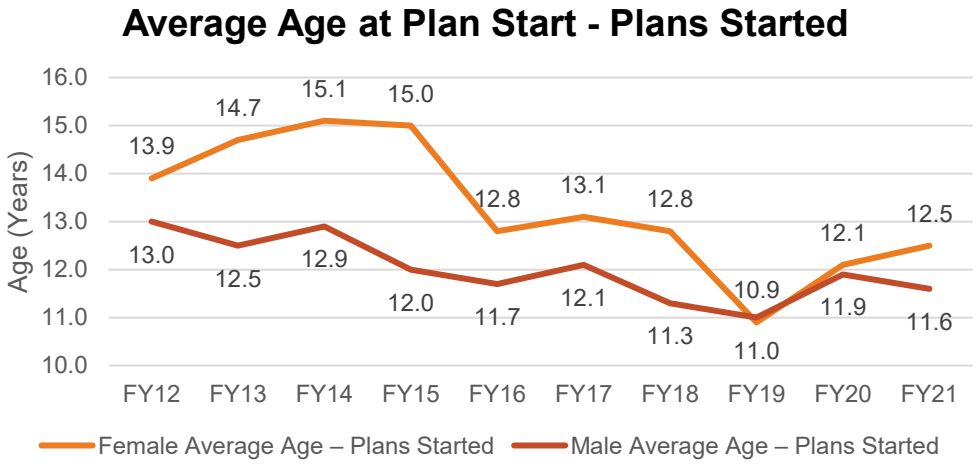
	FY21	FY20	Change (%)	F17 – 21 AVG
Male Average Monthly Service Provision Costs – Plans Ended	$1,842	$1,589	16%	$1,897
Female Average Monthly Service Provision Costs – Plans Ended	$1,955	$1,960	0%	$2,504

Note: While this analysis factors in the discrepancy in average plan length between the male/female cohort it does not factor in discrepancies in Diagnostics – HCN's indicator of complexity.

Age

	FY21	FY20	Change (%)	F17 – 21 AVG
% Age 0 to 9 – Plans Started	30%	26%	*16%*	32%
% Age 10 to 14 – Plans Started	60%	58%	*3%*	54%
% Age 15 to 19 – Plans Started	10%	16%	*-36%*	14%
Male Average Age – Plans Started	11.6	11.9	*-2%*	11.6
Female Average Age – Plans Started	12.5	12.1	*4%*	12.2

Fluctuations in the Average Age of Plans Started have been small. In FY21 both the average for males & females has remained consistent with the average of the past five years.



Views of whānau from successful HCN Plan

"It (The HCN Process) kept _____ in school."

Indicators of Complexity – Diagnostics

Overall

	FY21	FY20	Change (%)	F17 – 21 AVG
AVG Adverse Life Experiences Present – Plans Started	8.4	10.0	*-17%*	N/A
AVG Presenting Problem Behaviours Present – Plans Started	8.8	9.0	*-1%*	N/A
AVG High Level Diagnoses Present – Plans Started	3.2	2.8	*12%*	N/A

Note: There are many factors that could influence these diagnostics (e.g., average age, gender, awareness of diagnostics presence & data collection to name a few). The data presented is collected by HCN Specialists during the Referral process.

At a high level there are two key trends that indicate change in the HCN Cohort from FY20 to FY21. The decrease in AVG Adverse Life Experiences per Plan Started and the increase in AVG Diagnoses per Plan Started.

There are tables highlighting the highest frequency diagnostics for the HCN Cohort at the end of this document. Underpinning the increase in AVG High Level Diagnoses per Plan Started is an increase in % of the HCN Cohort in FY21 with Neurodevelopmental Disorders such as Autistic Spectrum Disorder (incl. Asperger Syndrome), Intellectual Disability, Global Developmental Delay and Communication Disorders as well as an increase in Eating Disorders such as Anorexia Nervosa & Binge-Eating Disorder.

Client Story – H

H was 16 when she commenced her HCN plan. She comes from a loving family in Tauranga, but she had experienced several challenges in her life after primary school. At primary H excelled at her schoolwork, but this changed when her older brother had a series of Mental health issues. These affected the whole family, and as H was going through puberty, this caused her to have increased anxiety meaning she was unable to attend school. Life skills that H had acquired through her childhood were lost and she was a shadow of her former self.

The family struggled for 3 years, during which time H's mental health deteriorated; H's psychologist suggested HCN.

HCN did not spend a large budget on H, but the process allowed H to open up to her family about what she needed them to do to support her. Interventions included therapy for her family to understand H's unique set of needs, plus school supports, speech language therapy and occupational therapy to help H overcome her anxiety and return to education. By working collaboratively, the HCN team were able to achieve outcomes for H and her family that excelled everyone's expectations.

H recently enrolled at the local polytechnic and has develop a 10-year plan for her future, which includes attending Waikato University and gaining qualifications to enable her to help others. H is planning her pathway to independent living and enjoying life to the full.

The HCN Cohort Outcomes

How we measure progress – Goal Attainment Scaling

The key component of the HCN Unit's ability to report on outcomes is the use of the Goal Attainment Scaling (GAS) to measure individual child and young person progress on their identified goals. The HCN Unit has also developed Domain Descriptors for each of the eight domains. These provide a high-level goal that all individual goals work towards.

Individual goals are determined under each domain to understand whether a multidisciplinary approach to plan development, goal setting, and implementation and measurement, makes a quantifiable difference. The HCN Unit uses GAS, a multidisciplinary measure, to determine a child or young person's performance.

GAS enables individualised goals to be set under each domain on a five-point scale and evaluates effectiveness by measuring the extent to which individualised goals are achieved in a specific timeframe. As shown in the below table, the goal attainment scale is characterised by five levels of achievement. The expected outcome is the middle or 'zero' score and is determined first (that is, it is determined at the plan development stage) and then two better and two worse outcomes are documented at a six-month review and at the final review.

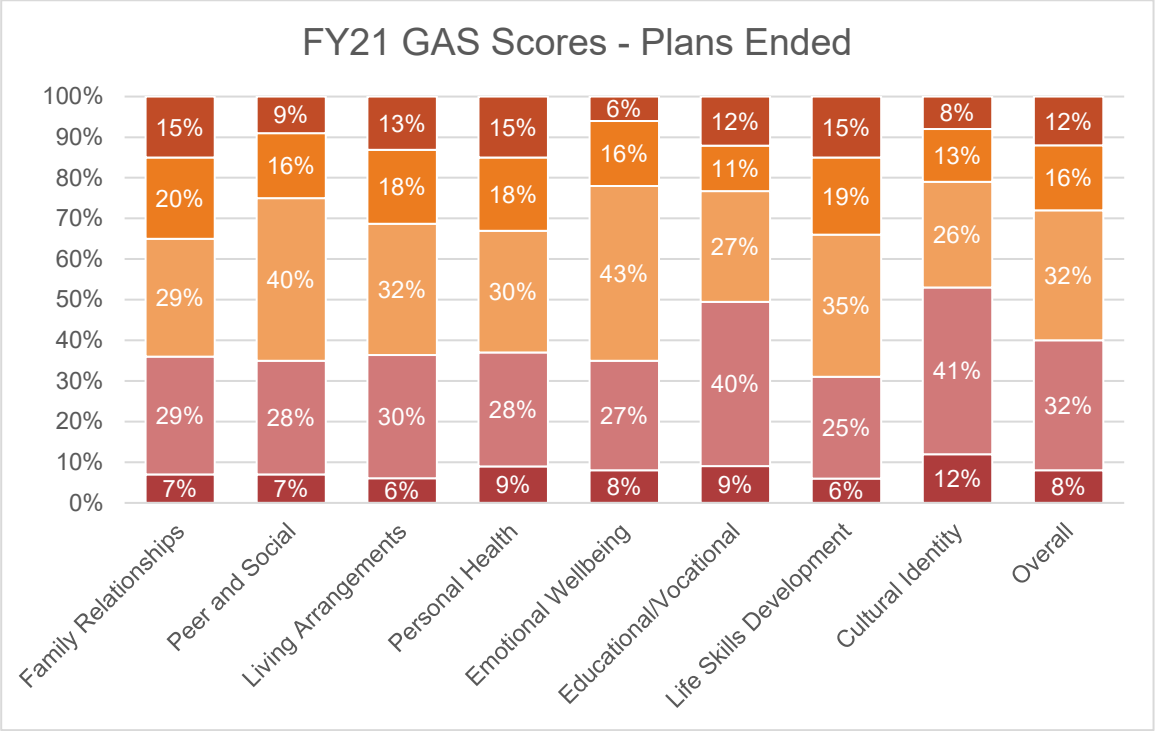
Value	Indicator
2	Much more than expected outcome
1	More than expected outcome
0	Domain goal / expected outcome
-1	Less than expected outcome
-2	Much less than expected outcome

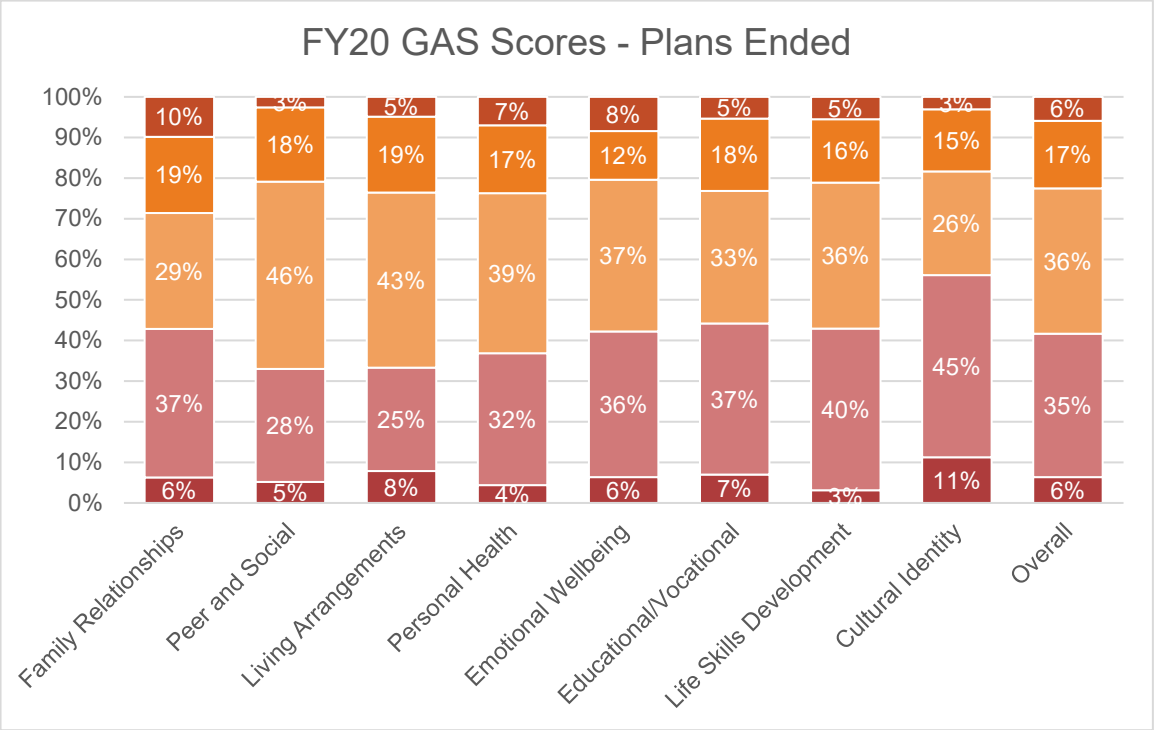
Note: Beyond the Domains, there are two further factors explored – Gender & Ethnicity. Male/Female & Māori/NZ European are the only levels of detail displayed. This is because they form the overwhelming majority in both factors and beyond them samples sizes are small and may be misleading.

All Domains

In FY21, plans ended with higher GAS Scores than in FY20 across most Domains. Goals within the Cultural Identity & Educational/Vocational Domains achieved the poorest scores while goals within the Life Skills Development Domain excelled.

Both years experienced the impact COVID-19 but plans ended in FY20 ($1,662/month) received less Average Monthly Service Provision Costs than in FY21 ($1,855/month) due to this disruption.





Family Relationships Domain – Hononga ā-whānau

Domain Descriptor

HCN children and young people have enduring relationships with members of their family/whānau group and/or safe adults who care for and protect them.

Overall

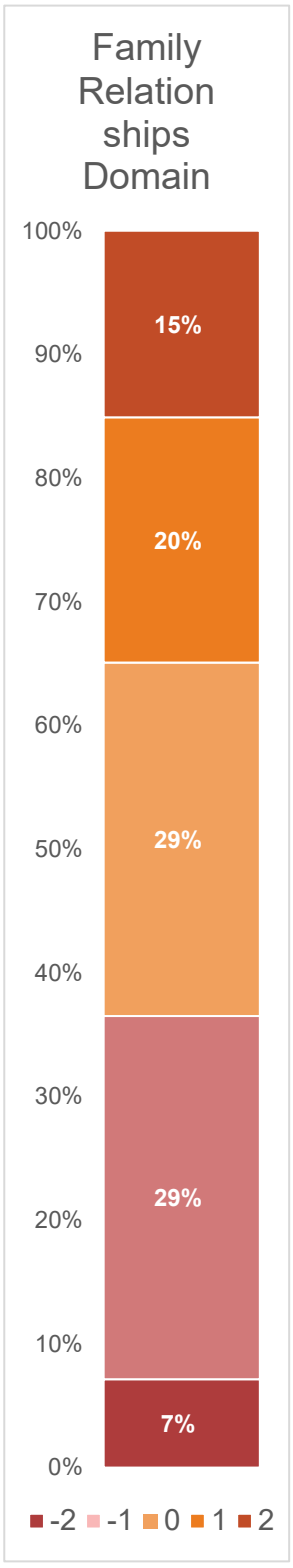
Goals attempted in the Family Relationships Domain were achieved at a rate of **63%** for plans ended in FY21, 55% of which achieved results greater than expected.

Examples of goals achieved include:

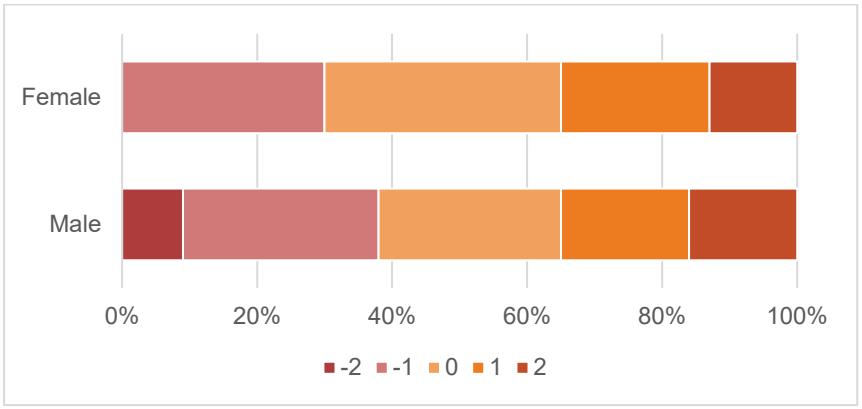
– _____ will talk confidently to his mum about what is going on for him.

– _____ will send letters to her family.

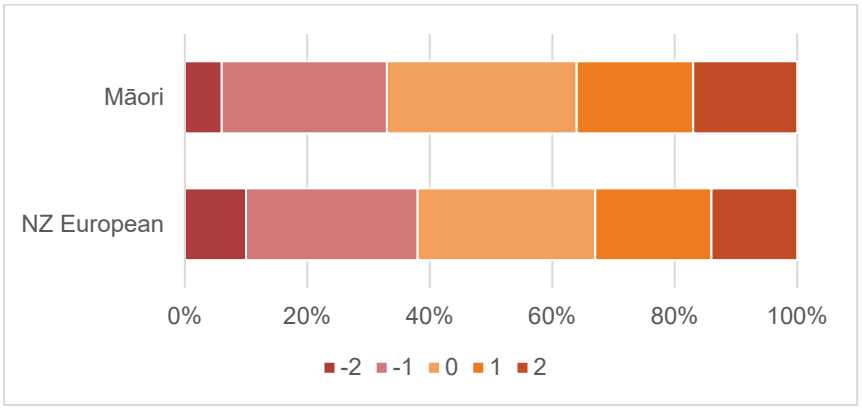
– _____ will prepare for contact with his biological family.



Gender



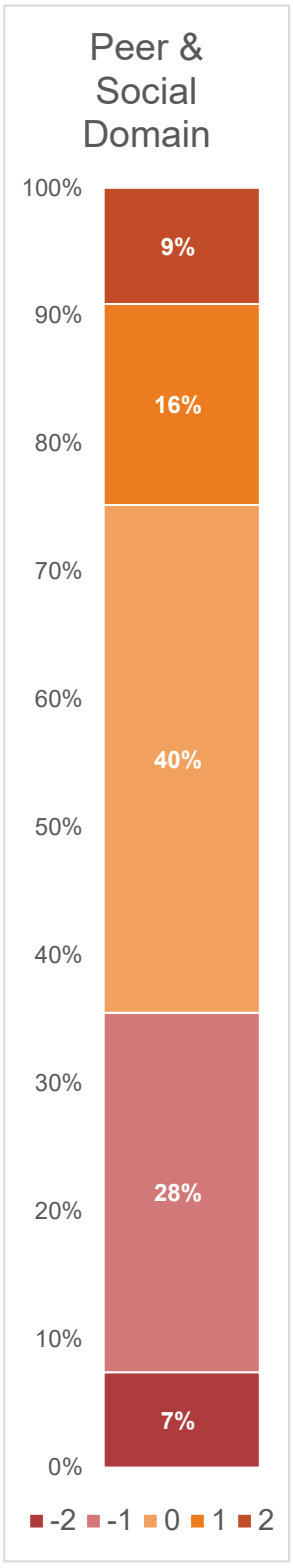
Ethnicity



Peer and Social Domain – Hononga ā-hoa, ā-pāpori

Domain Descriptor

HCN children and young people have enjoy a wide range of positive relationships with friends, peer, and interest groups within their wider community.



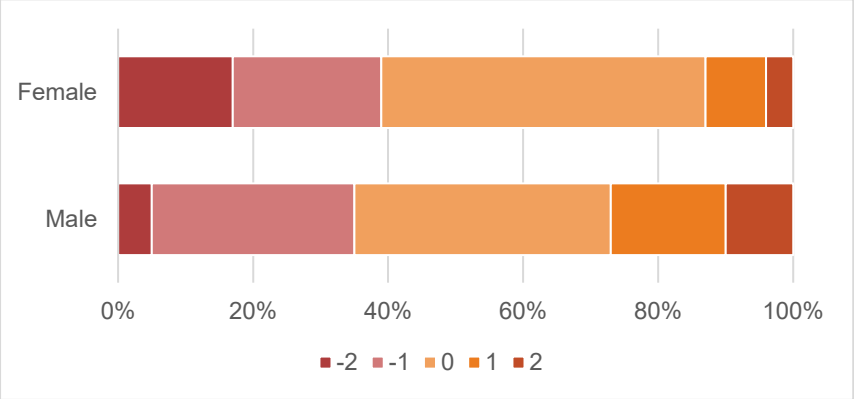
Overall

Goals attempted in the Peer and Social Domain were achieved at a rate of **64%** for plans ended in FY21, 38% of which achieved results greater than expected.

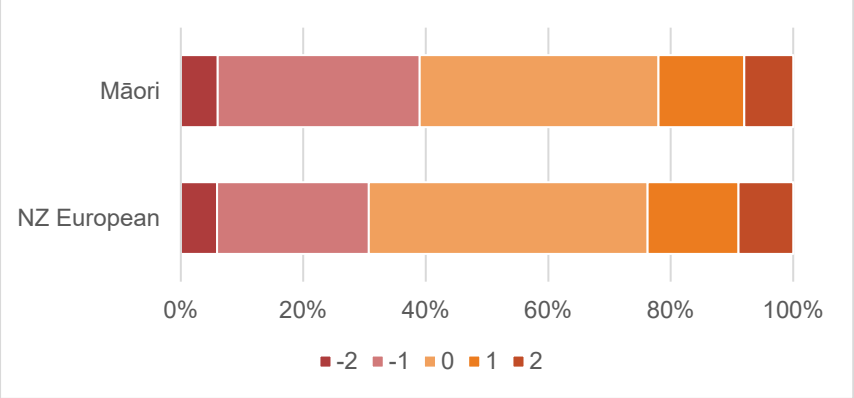
Examples of goals achieved include:

- _____ will tolerate others being near him.
- _____ will use good friendship skills, at school and at community activities.
- _____ will spend as much time on physical/social activities in his leisure time as on a computer or tablet.

Gender



Ethnicity



Living Arrangements Domain – Tūāhuatanga noho

Domain Descriptor

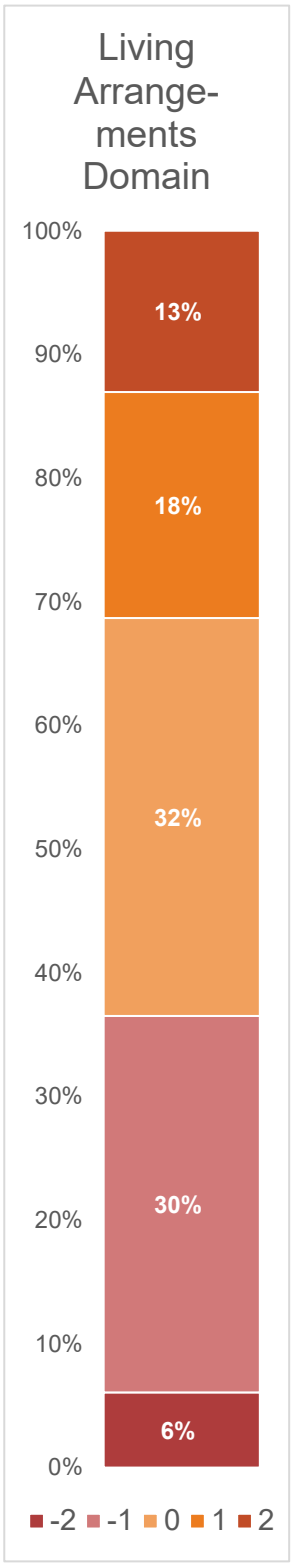
HCN children and young people have live in a stable, safe and healthy environment where their wellbeing needs are met.

Overall

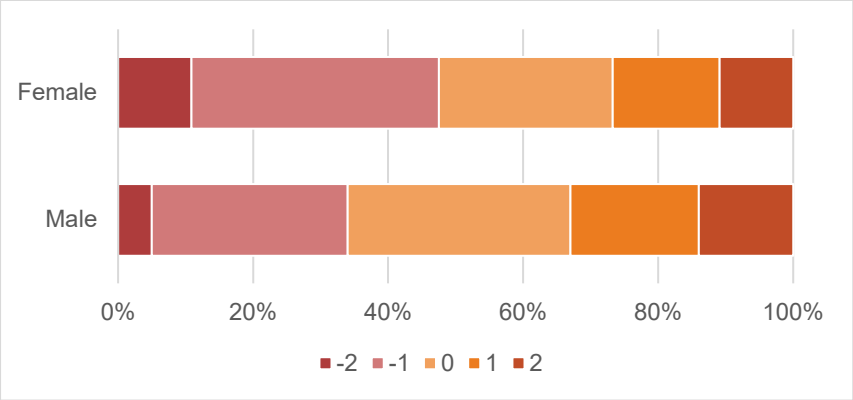
Goals attempted in the Living Arrangements Domain were achieved at a rate of **64%** for plans ended in FY21, 49% of which achieved results greater than expected.

Examples of goals achieved include:

- _____ will let family know when she is leaving the house.
- _____ will follow the rules of the people he is living with.
- _____ will respond positively to adult requests.



Gender



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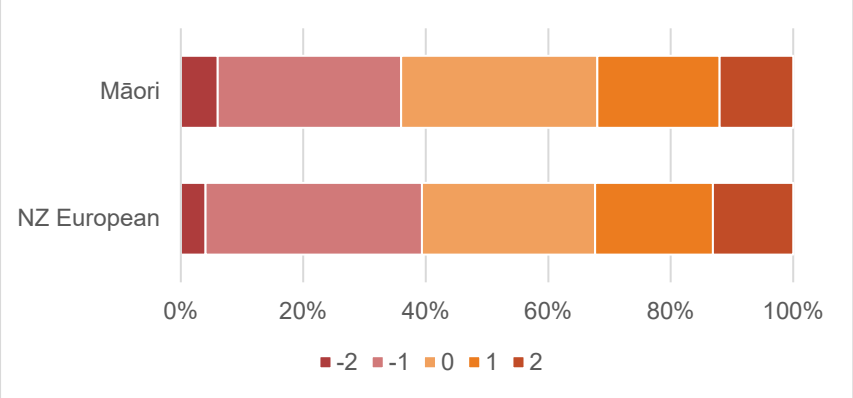


Personal Health Domain – Oranga tinana

Domain Descriptor

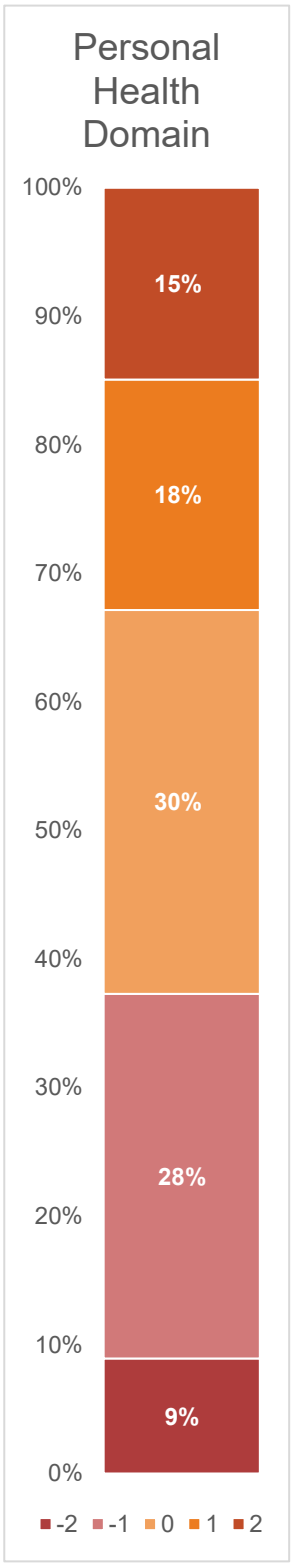
HCN children and young people have have stable or improved physical health.

Overall

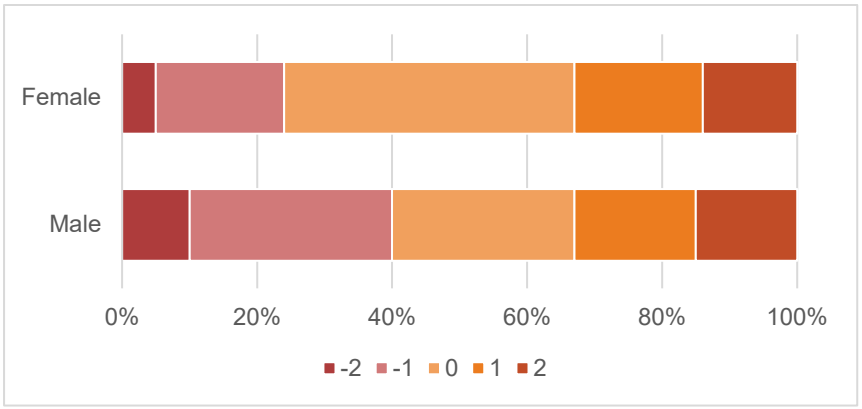
Goals attempted in the Personal Health Domain were achieved at a rate of **63%** for plans ended in FY21, 52% of which achieved results greater than expected.

Examples of goals achieved include:

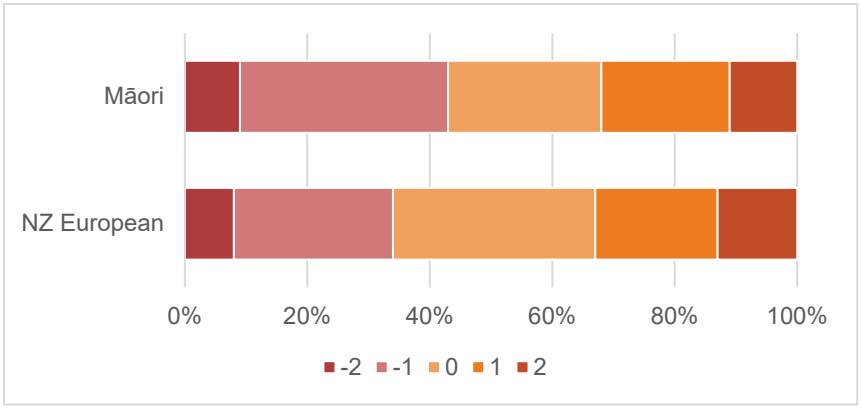
- _____ will practice good hygiene.
- _____ will act responsibly for her own healthcare.
- _____ will do 30 minutes of physical activity 3 times a week.



Gender



Ethnicity



Emotional Wellbeing Domain – Oranga hinengaro

Domain Descriptor

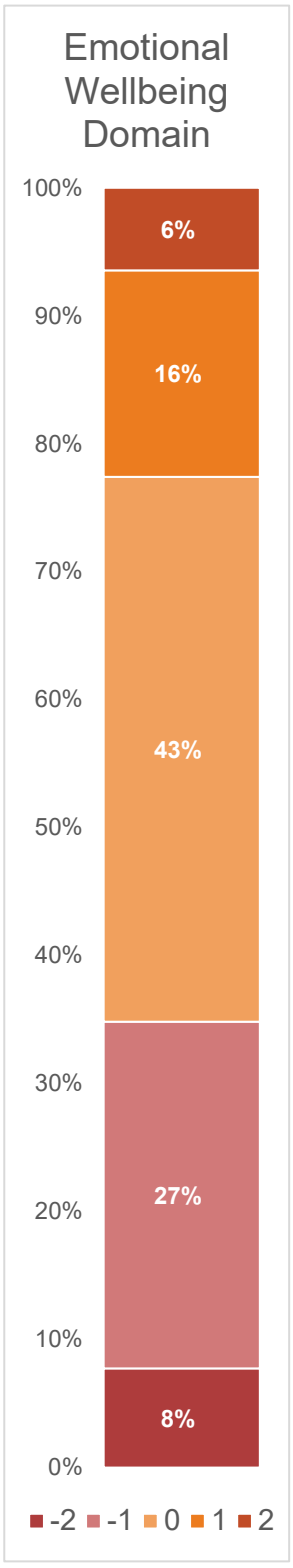
HCN children and young people have have stable or improved emotional/mental wellbeing.

Overall

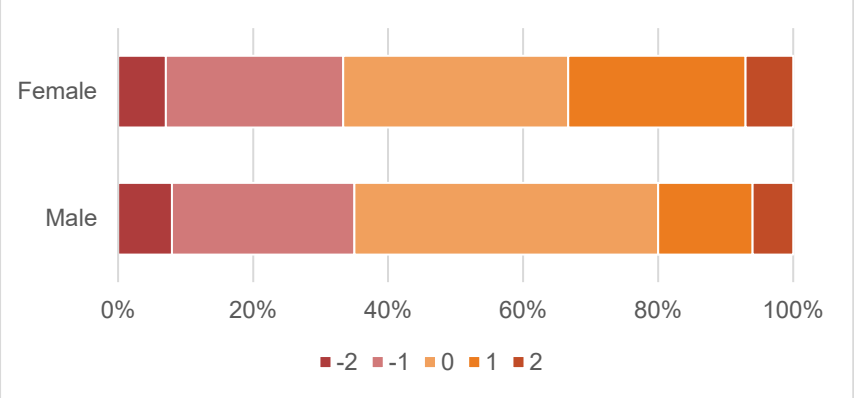
Goals attempted in the Emotional Wellbeing Domain were achieved at a rate of **65%** for plans ended in FY21, 35% of which achieved results greater than expected.

Examples of goals achieved include:

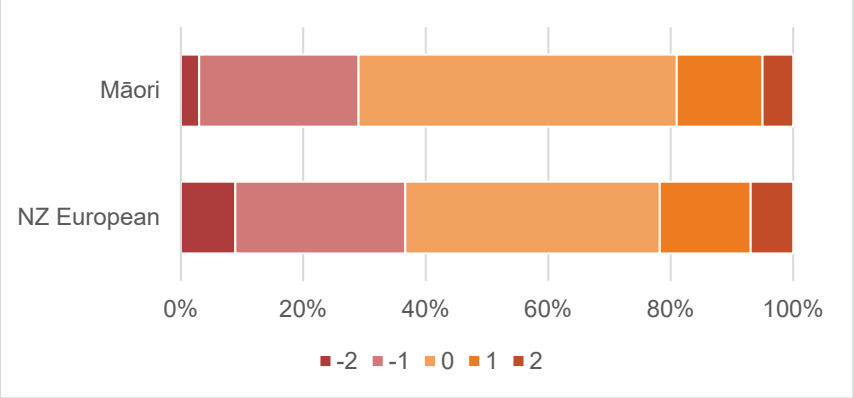
- _____ will identify the emotions and feelings he has.
- _____ will use positive self-talk when talking about himself.
- _____ will use safe ways to calm herself when she is angry and upset.



Gender



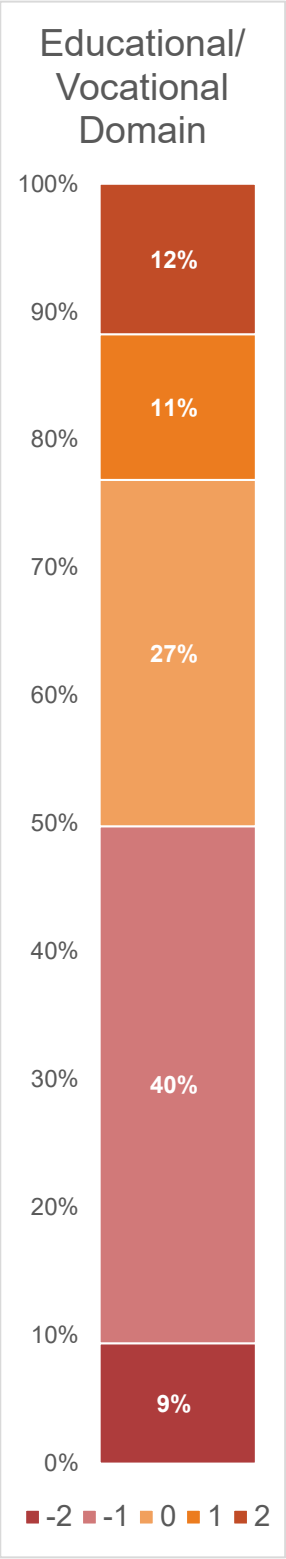
Ethnicity



Educational/Vocational Domain – Oranga mātauranga

Domain Descriptor

HCN children and young people have have access to, and participate in education/vocational training, as well as having strong pathways out of school.



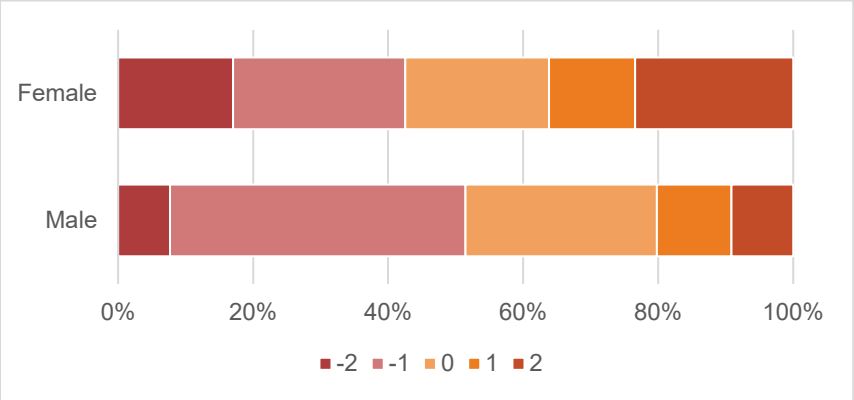
Overall

Goals attempted in the Educational/Vocational Domain were achieved at a rate of **51%** for plans ended in FY21, 46% of which achieved results greater than expected.

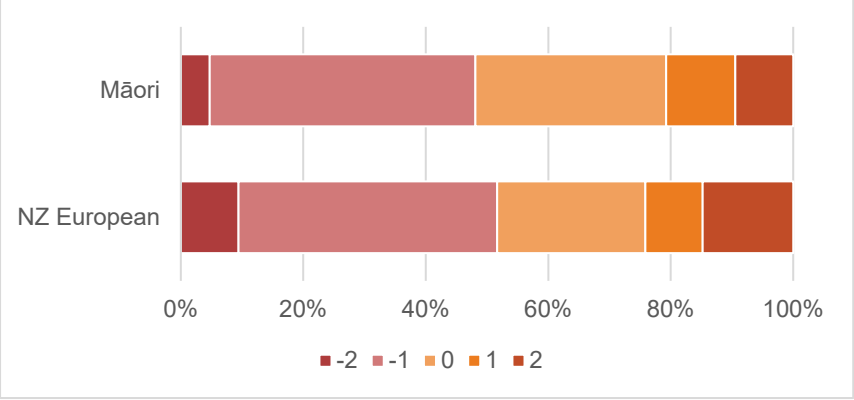
Examples of goals achieved include:

- _____ will be able to confidently use a range of mathematics strategies to solve problems.
- _____ will participate in all areas of the curriculum.
- _____ will have good attendance at school.

Gender



Ethnicity



Life Skills Development Domain – Whakawhanaketanga pūkenga ora

Domain Descriptor

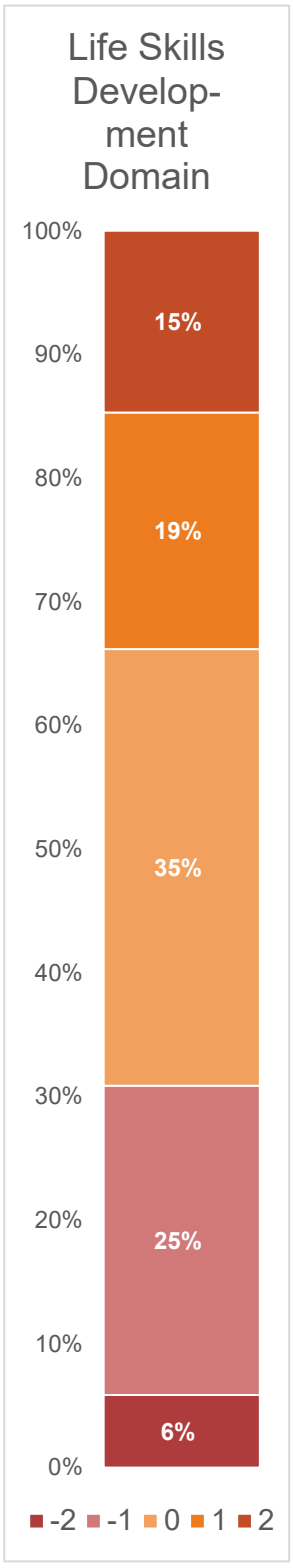
HCN children and young people have are able to exercise developmentally appropriate autonomy and learn skills to live as independently as possible.

Overall

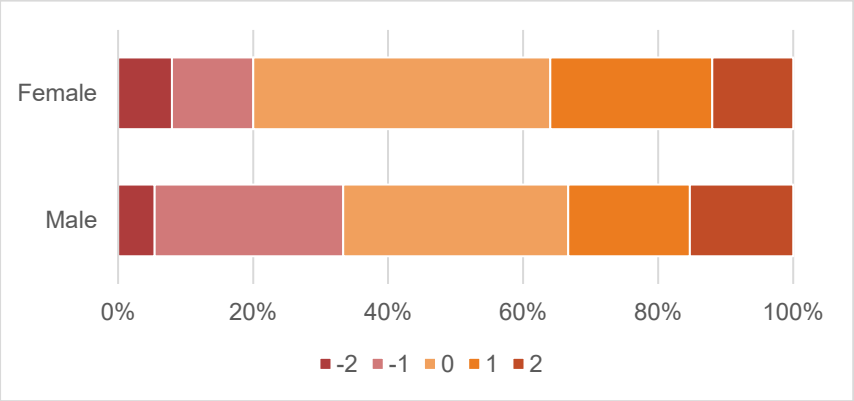
Goals attempted in the Life Skills Development Domain were achieved at a rate of **69%** for plans ended in FY21, 49% of which achieved results greater than expected.

Examples of goals achieved include:

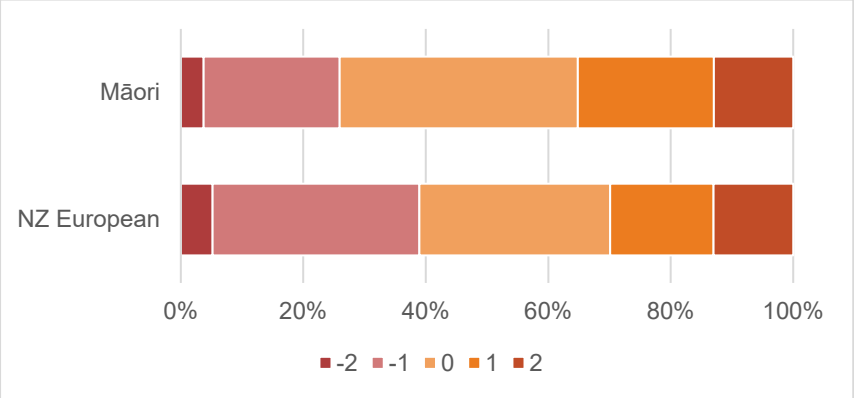
- _____ will follow a visual chart of small steps to keep his room tidy.
- _____ will be able to catch the bus by himself.
- _____ will regularly save his money.



Gender



Ethnicity



Cultural Identity Domain – Tuakiri ahurea

Domain Descriptor

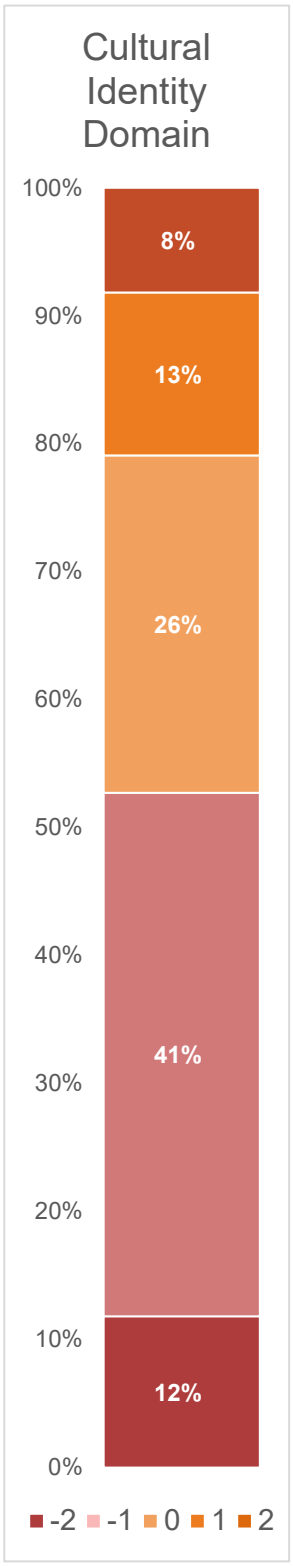
HCN children and young people have have a sense of belonging by being positively connected to a culture, heritage, and/or spirituality.

Overall

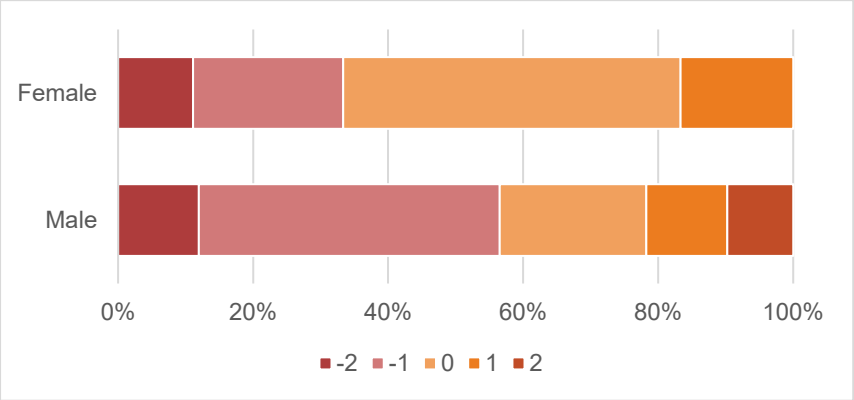
Goals attempted in the Cultural Identity Domain were achieved at a rate of **47%** for plans ended in FY21, 44% of which achieved results greater than expected.

Examples of goals achieved include:

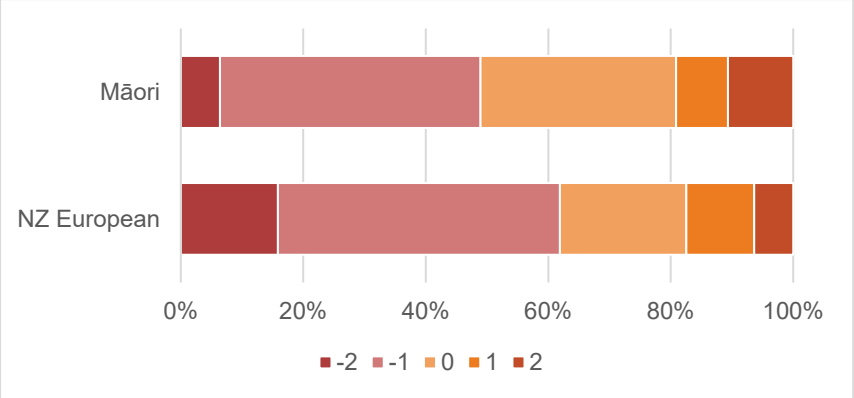
- _____ will participate in an activity once a week that connects him to others and his local community.
- _____ will participate in at least two activities that strengthen her connection to Māori heritage each week.
- _____ will research his Whakapapa and be able to share this with other people.



Gender



Ethnicity



Indicators of Complexity – Diagnostics Tables

Diagnoses High Level – Plans Started

Note: The bold rows are higher-level diagnoses describing whether a category is present. The indented rows are the lower-level diagnoses. One would usually expect the lower-level diagnoses to sum to, at least, the total of the higher-level diagnosis. In many instances this is not the case. Not presented here is lower-level diagnoses 'Other' or 'Others'. The diagnoses data set does not allow for the categorisation of these lower-level diagnoses into higher-level diagnoses.

	FY21	FY20	F17 – 21 AVG
% Neurodevelopmental Disorder(s) Present	**78%**	69%	N/A
% Attention Deficit Hyperactivity Disorder (ADHD)	56%	51%	54%
% Autistic Spectrum Disorder (incl. Asperger Syndrome)	33%	20%	23%
% Intellectual Disability	28%	21%	22%
% Communication Disorders	17%	7%	N/A
% Global Developmental Delay	16%	10%	N/A
% Specific Learning Disorder	11%	8%	N/A
% Disruptive, Impulse-Control, and Conduct Disorder(s) Present	**46%**	43%	N/A
% Oppositional Defiant Disorder	37%	35%	33%
% Conduct Disorder	11%	11%	13%
% Intermittent Explosive Disorder	5%	4%	N/A
% Anxiety Disorder(s) Present	**43%**	32%	37%
% Separation Anxiety Disorders	17%	10%	N/A
% Selective Mutism	4%	1%	N/A
% Social Anxiety Disorder (Social Phobia)	10%	6%	N/A
% Panic Disorder	2%	3%	N/A
% Generalized Anxiety Disorder	22%	11%	N/A
% Trauma and Stressor-Related Disorder(s) Present	**37%**	51%	46%
% Reactive Attachment Disorder	14%	23%	32%
% Posttraumatic Stress Disorder	20%	27%	N/A
% Adjustment Disorder	5%	3%	N/A

% Acute Stress Disorder	1%	4%	N/A
% Sleep-Wake Disorder(s) Present	**22%**	13%	N/A
% Insomnia Disorder	5%	5%	N/A
% Elimination Disorder(s) Present	**19%**	9%	N/A
% Enuresis	10%	5%	N/A
% Encopresis	12%	6%	N/A
% Foetal Alcohol Spectrum Disorder (FASD)	**16%**	12%	11%
% Eating Disorder(s) Present	**15%**	6%	6%
% Anorexia Nervosa	1%	0%	N/A
% Binge-Eating Disorder	4%	1%	N/A
% Sensory Disability(s) Present	**11%**	13%	N/A
% Vision	4%	10%	N/A
% Hearing impaired	6%	5%	N/A
% Depressive Disorder(s) Present	**11%**	6%	11%
% Disruptive Mood Dysregulation Disorder	2%	2%	N/A
% Major Depressive Disorder	4%	3%	N/A
% Persistent Depressive Disorder (Dysthymia)	0%	1%	N/A
% Physical Disability Present	**7%**	7%	7%
% Obsessive Compulsive Disorder(s) Present	**4%**	4%	N/A
% Obsessive Compulsive Disorder	0%	3%	N/A
% Neurocognitive Disorder(s) Present	**4%**	6%	N/A
% Traumatic Brain Injuries (TBI)	1%	3%	N/A
% Substance-Related and Addictive Disorder(s) Present	**2%**	6%	N/A
% Substance-Related Disorders (Alcohol, Drugs of Abuse)	2%	5%	3%
% Non-Substance-Related Disorders (Gambling)	0%	2%	N/A
% Bipolar and Related Disorder(s) Present	**1%**	3%	N/A
% Bipolar I Disorders	1%	3%	N/A
% Psychotic Disorder(s) Present	**1%**	4%	N/A
% Dissociative Disorder(s) Present	**1%**	2%	N/A
% Brain Injury	**0%**	0%	2%

Adverse Life Experiences – Plans Started

	FY21	FY20	F17 – 21 AVG
% Stand-down /suspension/exclusion from education	69%	72%	N/A
% Parental separation	69%	74%	74%
% Family violence	60%	75%	69%
% Multiple school placements/enrolments	56%	64%	57%
% Parental alcohol or other drug abuse	54%	63%	61%
% Substantiated reports of abuse*	54%	75%	67%
% Parental/caregiver mental illness	53%	60%	58%
% Multiple caregiving situations	53%	68%	60%
% Poor attachment	52%	65%	66%
% Parental benefit dependence	44%	35%	N/A
% Known exposure to alcohol or drugs prenatally	41%	52%	45%
% Parental offending	37%	38%	42%
% Family/whanau placements	33%	41%	N/A
% Family transience	28%	39%	33%
% Non kin caregivers	26%	36%	N/A
% Parent in prison	22%	25%	N/A
% Exclusion/stand-down from early childhood facilities	20%	17%	13%
% Premature birth/low birth weight	12%	10%	12%
% Exposure to Gang culture during formative years	10%	16%	18%
% Significant accident or injury	7%	17%	16%
% Non-enrolment in early childhood facilities	6%	20%	21%

** Substantiated reports of abuse subcategories – Plans Started*

% Neglect	42%	52%	N/A
% Emotional	36%	58%	N/A
% Physical	31%	43%	N/A
% Sexual	9%	15%	N/A

Presenting Problem Behaviours – Plans Started

	FY21	FY20	F17 – 21 AVG
% Social difficulties with peers	94%	94%	94%
% Physical aggression (people, animals, property, arson)	91%	92%	N/A
% Verbal aggression	85%	87%	90%
% Excessive fear, anxiety (separation, phobia, panic attacks, obsessions, compulsions)	69%	60%	N/A
% Deficits in adaptive functions (activities of daily life)	60%	49%	N/A
% Hyper or hypo reactivity to sensory input	58%	53%	N/A
% Mood (lability, elevated, depressed)	58%	55%	32%
% Deficits in intellectual functions (reasoning, planning, problem-solving)	57%	64%	N/A
% Absconding	52%	53%	58%
% Non-suicidal self-harm	44%	31%	38%
% Inappropriate sexualised behaviours	37%	39%	40%
% Restrictive food intake	30%	21%	N/A
% Theft	25%	30%	32%
% Truancy from education	25%	33%	N/A
% Abnormal motor behaviour (restrictive, repetitive, disorganised)	23%	27%	N/A
% Delusions (fixed/false beliefs)	19%	22%	N/A
% Property damage	11%	19%	N/A
% Use of alcohol or other drugs of abuse	10%	19%	14%
% Suicide attempts	10%	17%	N/A
% Hallucinations (false perceptions)	7%	11%	N/A
% Sexually abusive to others	7%	9%	11%
% Non-attendance at school	6%	9%	N/A
% Cruelty to animals	2%	2%	11%
% Fire-lighting	1%	1%	7%

High & Complex Needs

Me mahi tahi tātou