FY22

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 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 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** Educational/ Vocational	**Oranga hinengaro** Emotional Wellbeing	**Hononga ā-whānau** Family Relationships
			
Whakawhanaketanga pūkenga ora Life Skills Development	**Tūāhuatanga noho** Living Arrangements	**Hononga āhoā, 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 whenua.
- Family Relationships Domain: _____ will be a good role model to their younger brother.

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.

The Board

David Pluck

HCN Board Chair and Ministry of Education Representative

David has been the Board Chair for over five 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 39 years. Her current role covers a team focused 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 12 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 12 years as manager of the Rights and Protection team and 22 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, Operational Design and Delivery, Whaikaha

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.

Overview

FY22 Highlights

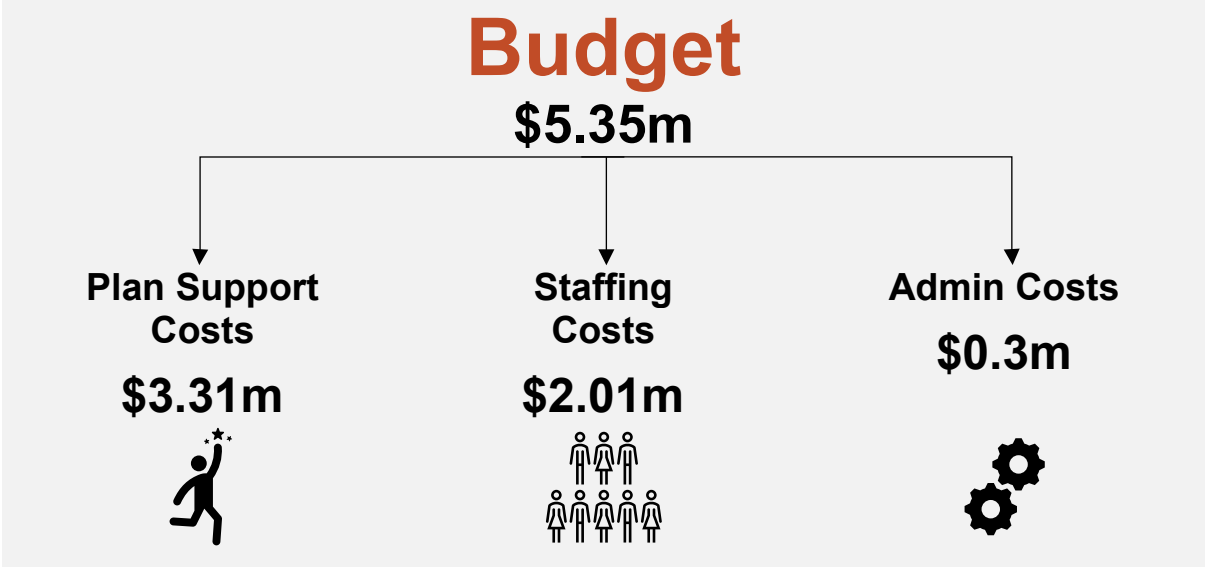
Plans Active
(At any point in FY)
233 ↑ *(FY21) 229*

Plans Started
94 ↑ *(FY21) 90*

Goal Achievement
(For Plans Ended)
63% ↑ *(FY21) 60%*

FY22 Financial Story

The HCN Unit's Budget for FY22 was $5.35 million.



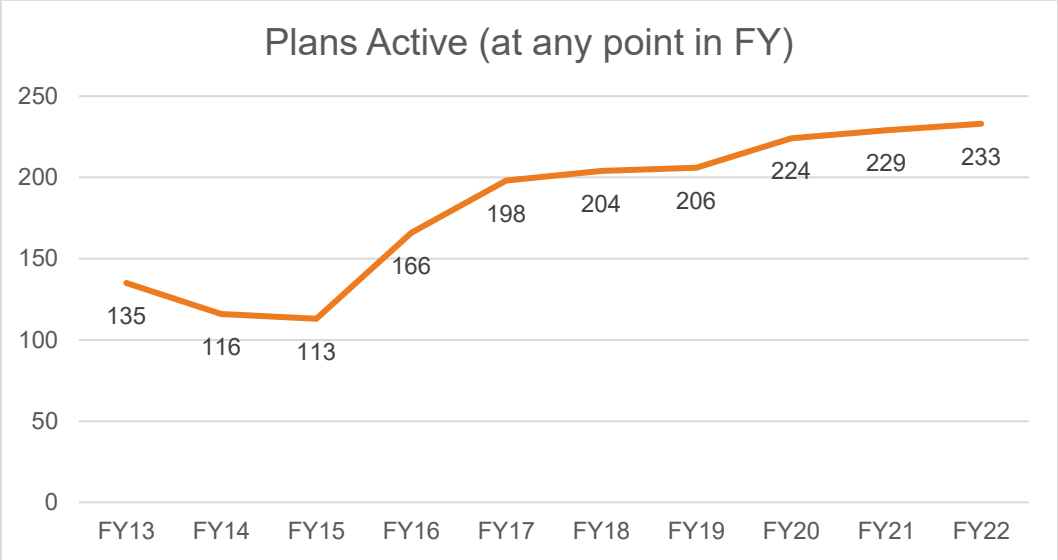
Service Provision – Plan Support Costs (Top 10 by %)

	FY22	Change	FY21	FY18-22 AVG
Teacher aide	29.73%	▼	32.00%	31.65%
Mentor/Coach	20.80%	▲	18.30%	15.72%
Teacher costs	14.43%	▲	11.40%	12.24%
Other Therapist/Specialist	10.34%	▲	5.90%	6.26%
Occupational Therapy/Physio	6.70%	▲	5.60%	4.57%
Other interventions	4.94%	▲	3.34%	3.32%
Individual therapy	2.83%	▼	8.37%	6.56%
Other team costs	2.11%	▲	0.61%	0.74%
Other education costs	1.59%	▼	1.80%	2.60%
Family therapy	1.36%	▼	2.14%	1.51%

The HCN Cohort Size & Scope

Service Delivery

	FY22	FY21	Change	F18 – 22 AVG
Plans Active *(at any point during FY)*	233	229	*2%*	224
Plans Started	94	90	*4%*	90
Plans Ended	98	95	*3%*	94
AVG Monthly Service Provision Costs (excludes staff/admin) – Plans Ended	$1,936	$2,635	*-27%*	$1,745

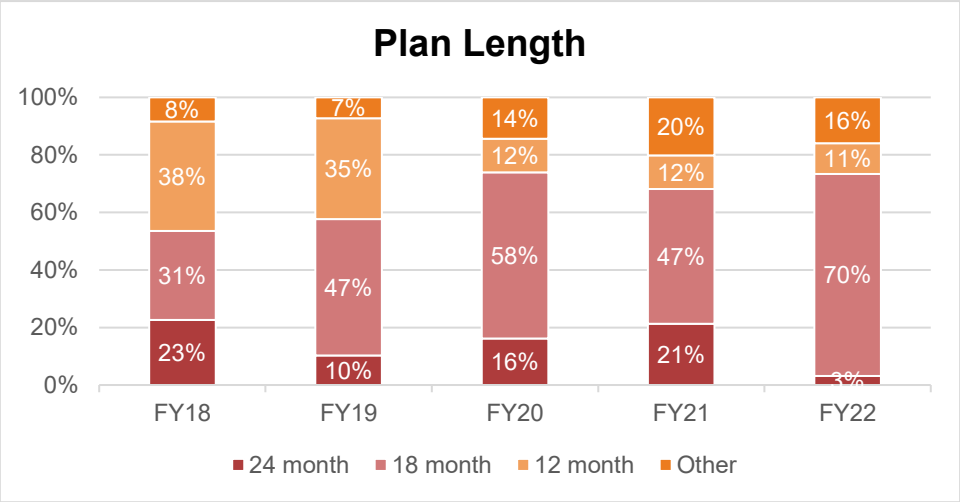


It should be noted that a key limiting factor in Service Delivery is budgetary restraints. Regardless of capability and demand, the HCN Unit must not exceed its financial capacity. The HCN Unit again utilised its full budget as it did in FY21. This indicates that Service Delivery was maximized given the HCN Unit's current resources & processes.

Duration

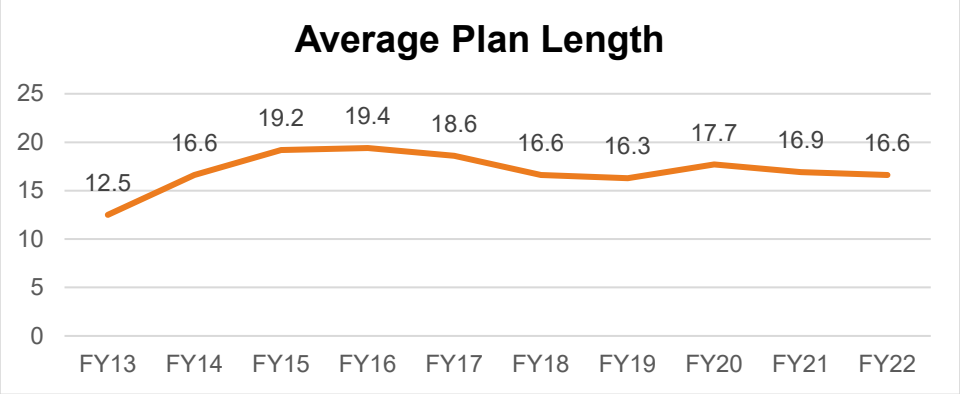
	FY22	FY21	Change	F18 – 22 AVG
% 24 Month – Plans Started	3%	11%	▼	15%
% 18 Month – Plans Started	70%	66%	▲	51%
% 12 Month – Plans Started	11%	9%	▼	21%
***% Other* Month** – Plans Started	16%	14%	▼	13%
Average Plan Length – Plans Started	16.6	16.9	▼	17

This FY we have seen a continuation in the uptake of 18-Month Plans.



While the number of Plans Started has been trending upwards since FY13 it has not increased at the rate throughput has.

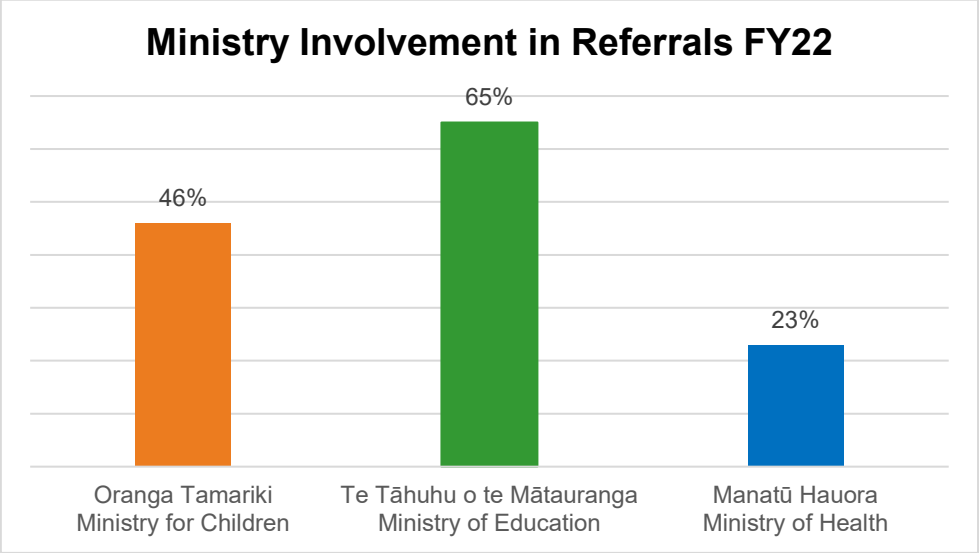
This discontinuity can be attributed to the elongation of Average Plan Length over this time as 18- & 24-Month plans FY14.



Referring Agencies

Involvement in Referral for Plans Started FY22	FY22	FY21	Change
% Oranga Tamariki – Ministry for Children	46%	46%	▲
% Te Tāhuhu o te Mātauranga – Ministry of Education	65%	86%	▼
% Manatū Hauora – Ministry of Health	23%	53%	▼

In FY22 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.



Service Provision – Plan Support Costs

Service Provision	FY22	Change	FY21	FY18-21 AVG
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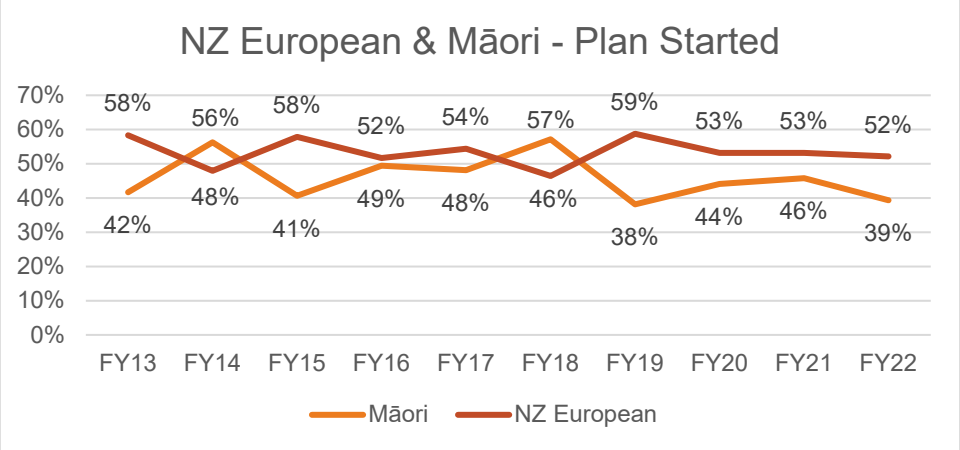
Other team costs	2.11%	▲	0.61%	0.74%
Other education costs	1.59%	▼	1.80%	2.60%
Family therapy	1.36%	▼	2.14%	1.51%
Team training and support	1.23%	▼	1.90%	1.34%
Assessment and programme development	1.06%	▼	1.53%	0.90%
Family training and support	0.70%	▼	2.16%	1.77%
Other culture	0.68%	▲	0.17%	0.25%
After school programme	0.49%	▼	0.87%	0.40%
Recreation	0.48%	▼	1.49%	0.90%
Other living	0.40%	▼	0.88%	1.16%
Counselling	0.38%	▲	0.29%	0.27%
Respite-OT	0.30%	▼	0.00%	0.07%
Other health costs	0.17%	▼	0.23%	0.15%

The HCN Cohort Demographic

Ethnicity

	FY22	Change	FY21	FY18 – 22 AVG
% Identify as NZ European – Plans Started	52%	▼	53%	48%
% Identify as Māori – Plans Started	39%	▼	46%	40%
% Identify as Pasifika – Plans Started	7%	▲	5%	7%
% Identify as Other Ethnicity – Plans Started	17%	▲	10%	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%.



For Plans Ended in FY22, children and young people that identified as Māori received on average less funding for Service Provision *(excludes staff/admin)* per plan than NZ European.

	FY22	Change	FY21	F18 – 22 AVG
Māori Average Monthly Service Provision Costs – Plans Ended	$1,575	▼	$1,683	$1,693
NZ European Average Monthly Service Provision Costs – Plans Ended	$2,011	▲	$1,890	$1,800

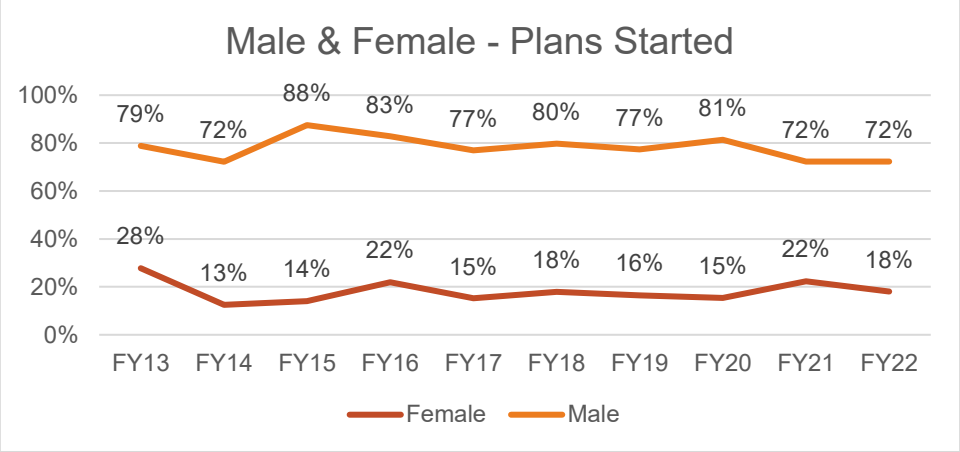
Note: While this analysis factors in the discrepancy in average plan length between the NZ European & Māori cohort it does not factor in discrepancies in Diagnostics – HCN's indicator of complexity.

Gender

	FY22	Change	FY21	F18 – 22 AVG
% Male – Plans Started	80%	▲	72%	79%
% Female – Plans Started	18%	▼	22%	18%
% Gender Diverse – Plans Started	2%	▼	5%	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'.

In FY21, one of the key recommendations implemented from the Annual 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.



For Plans Ended in FY22, Males have received on average more funding for Service Provision *(excludes staff/admin costs)* per plan than females.

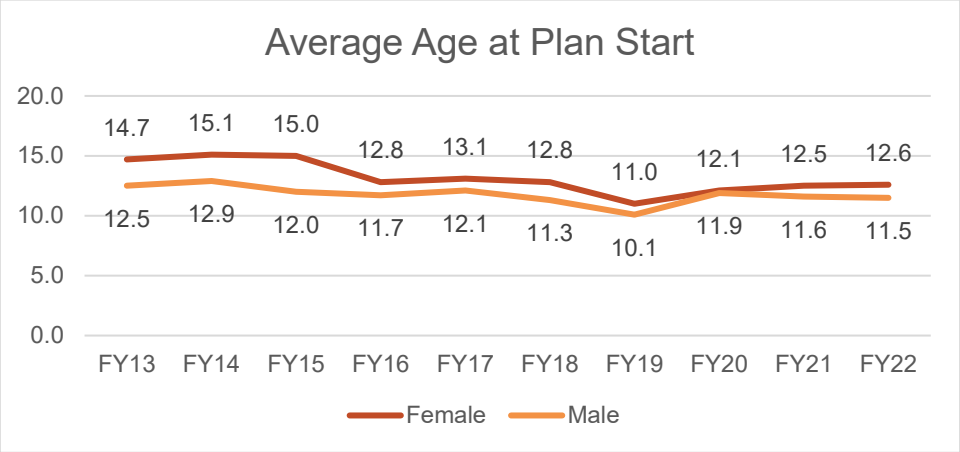
	FY22	Change	FY21	F18 – 22 AVG
Male Average Monthly Service Provision Costs – Plans Ended	$1,814	▼	16%	$1,656
Female Average Monthly Service Provision Costs – Plans Ended	$1,796	▲	0%	$2,069

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

	FY22	Change	FY21	F18 – 22 AVG
% Age 0 to 9 – Plans Started	23%	▼	29%	31%
% Age 10 to 14 – Plans Started	65%	▲	62%	56%
% Age 15 to 19 – Plans Started	12%	▲	10%	13%
Male Average Age – Plans Started	12.6	▲	12.1	11.9
Female Average Age – Plans Started	11.5	▲	11.1	11.0

Fluctuations in the Average Age of Plans Started have been small. In FY22 both the average for males & females has remained consistent with the average of the past five years.



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.
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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.

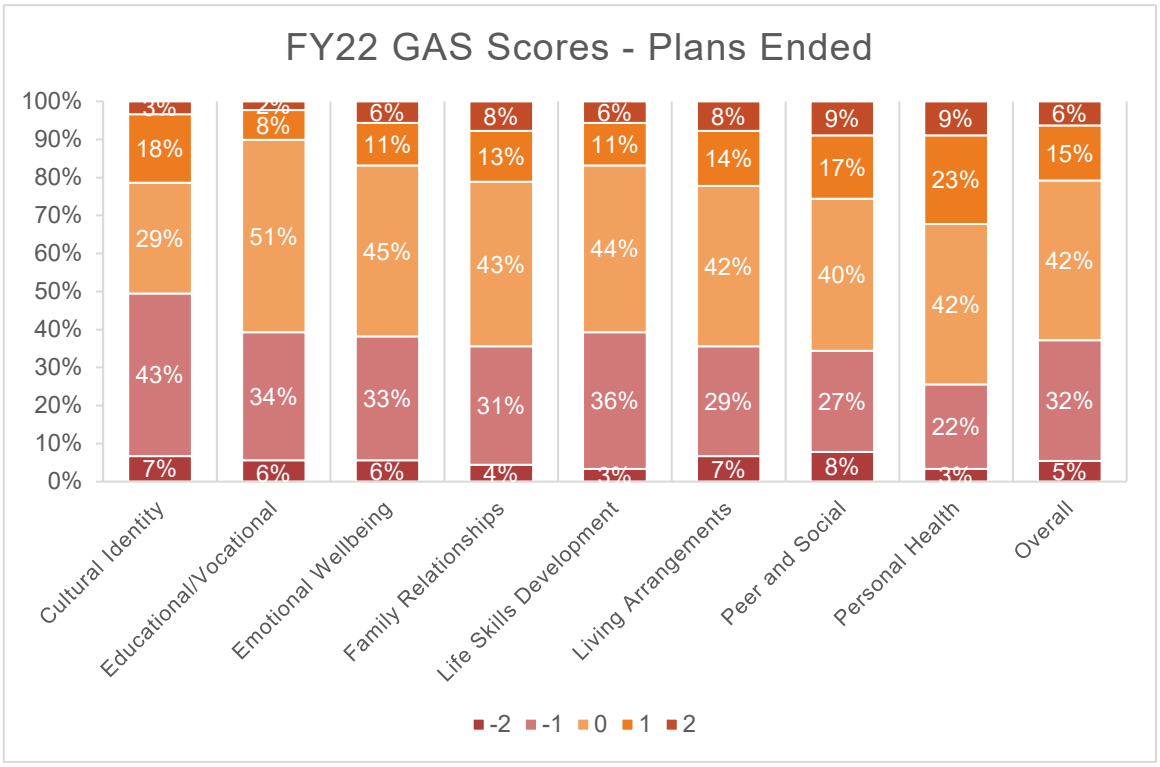
GAS enables individualised goals to be set under each domain on a five-point scale and evaluates effectiveness by measuring the extent to which individualised goals are achieved in a specific timeframe. As shown in the below table, the goal attainment scale is characterised by five levels of achievement. 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.

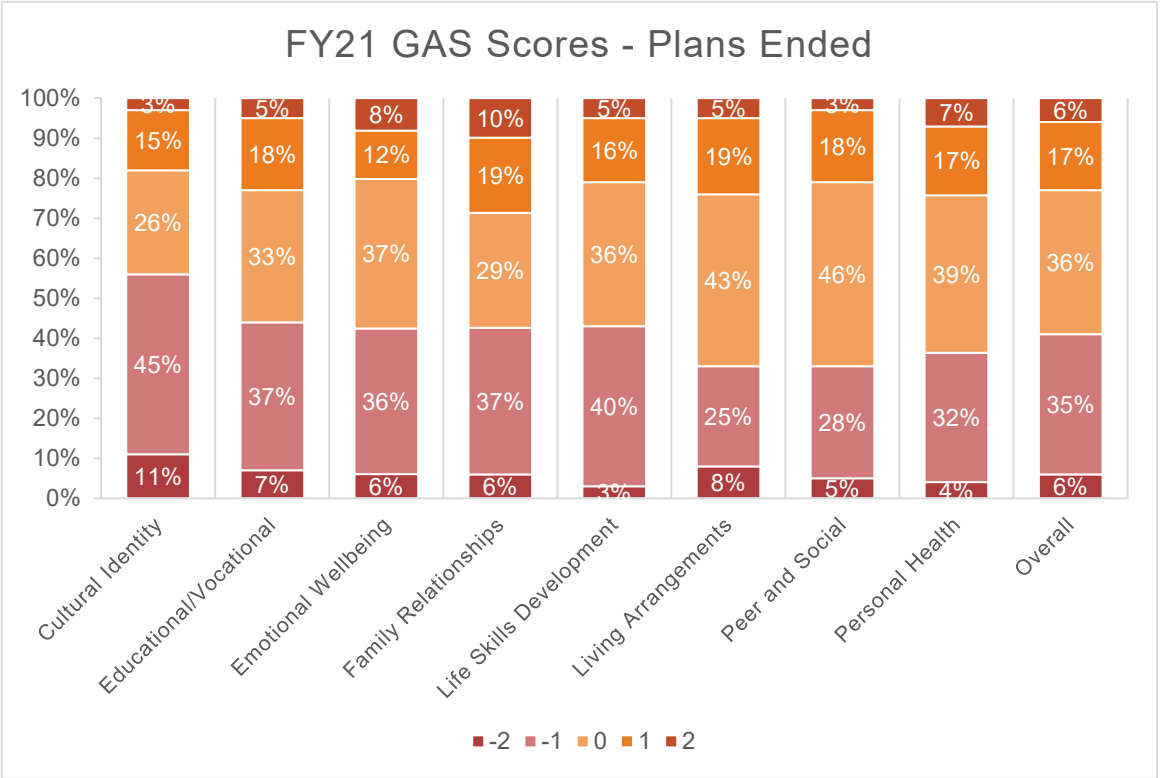
Value	Indicator
2	Much more than expected outcome
1	More than expected outcome
0	Domain goal / expected outcome
-1	Less than expected outcome
-2	Much less than expected outcome

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 FY22, plans ended with higher GAS Scores than in FY21 across most Domains. Goals within the Cultural Identity & Educational/Vocational Domains achieved the poorest scores while goals within the Personal Health Domain excelled. When the GAS Scores are broken down by ethnicity, outcomes for Māori have outperformed outcomes for NZ European in all domains.





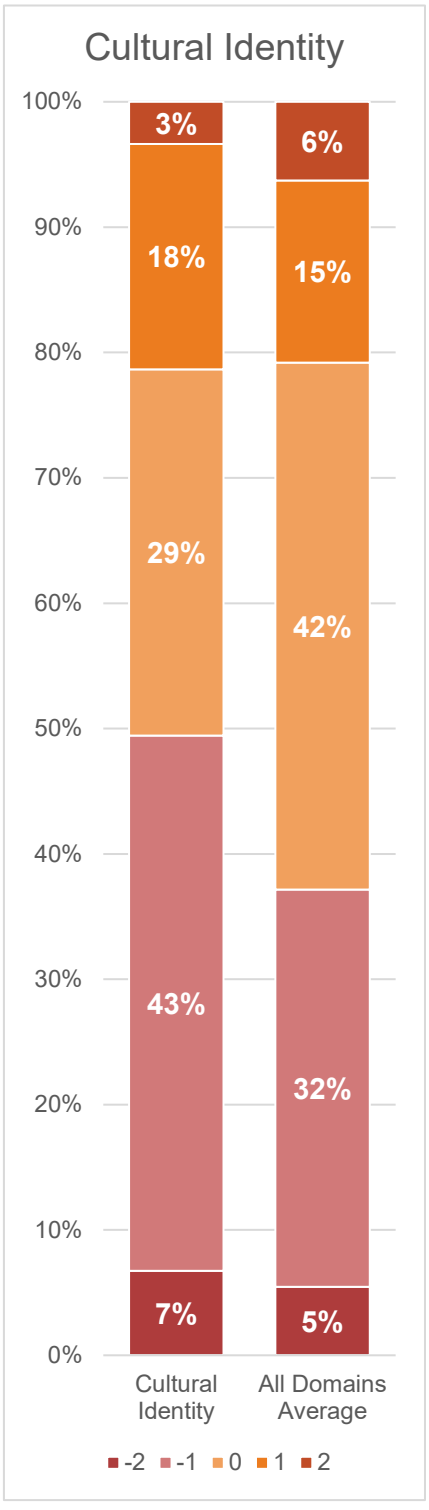
Cultural Identity Domain – Tuakiri ahurea

Domain Descriptor

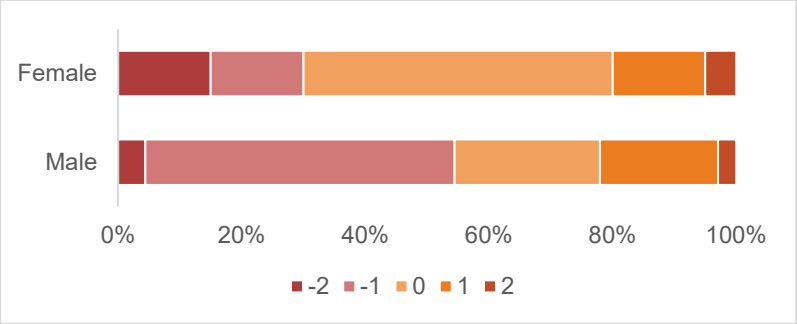
HCN children and young people have a sense of belonging by being positively connected to a culture, heritage, and/or spirituality.

Overall

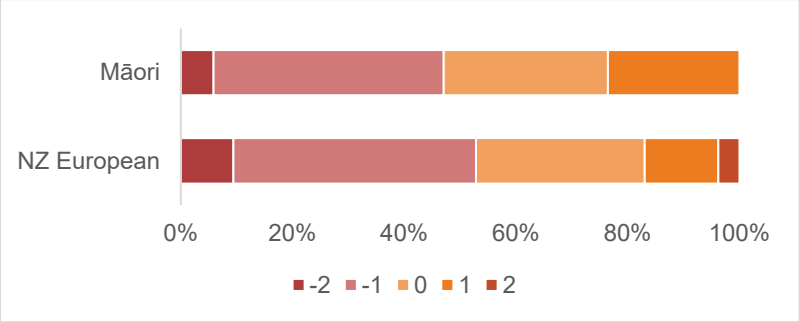
Goals attempted in the Cultural Identity Domain were achieved at a rate of **51%** for plans ended in FY22, a 4% increase from FY21.



Gender



Ethnicity



Educational/Vocational Domain – Oranga mātauranga

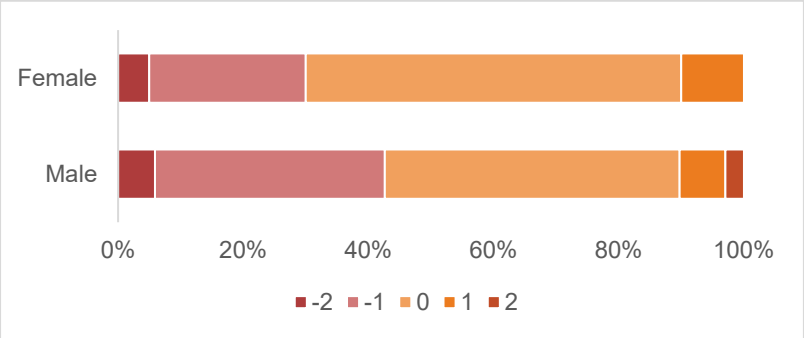
Domain Descriptor

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

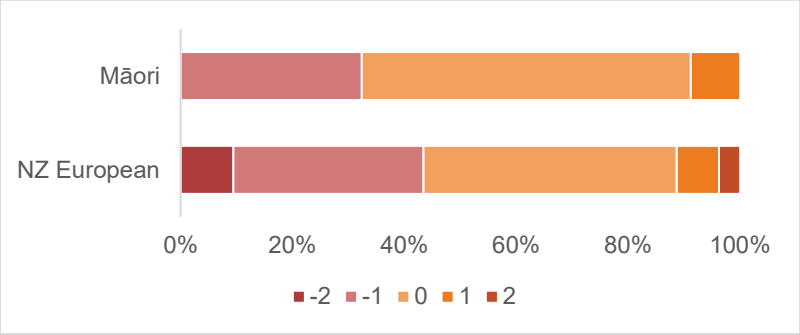
Overall

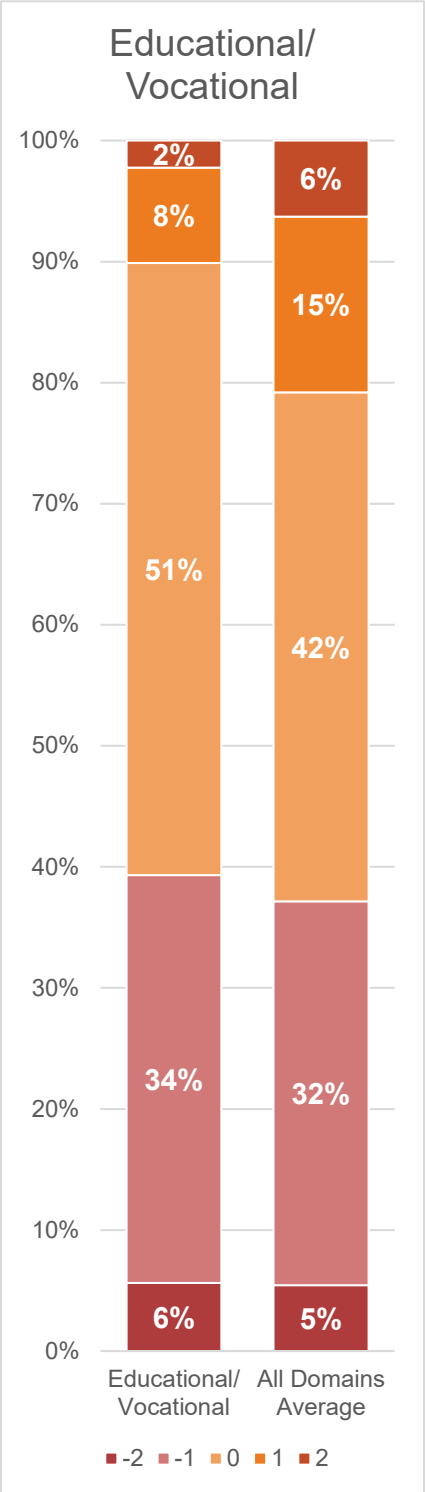
Goals attempted in the Educational/Vocational Domain were achieved at a rate of **61%** for plans ended in FY22, a 10% increase from FY21.

Gender



Ethnicity





Emotional Wellbeing Domain – Oranga hinengaro

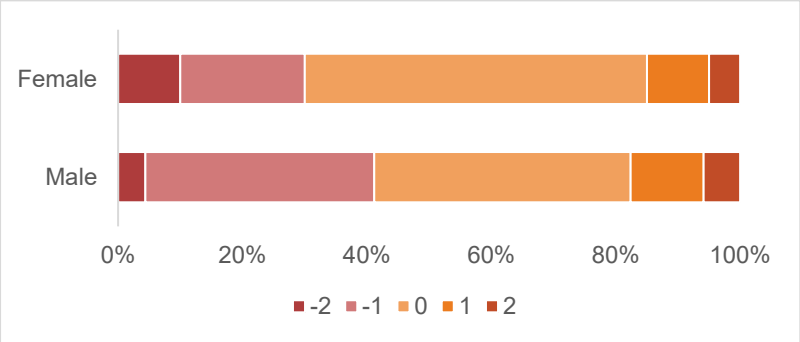
Domain Descriptor

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

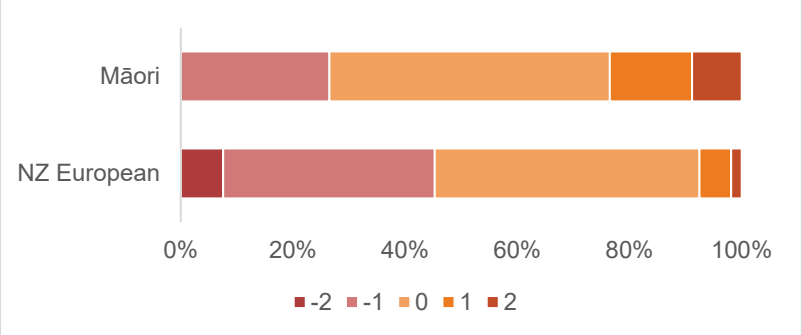
Overall

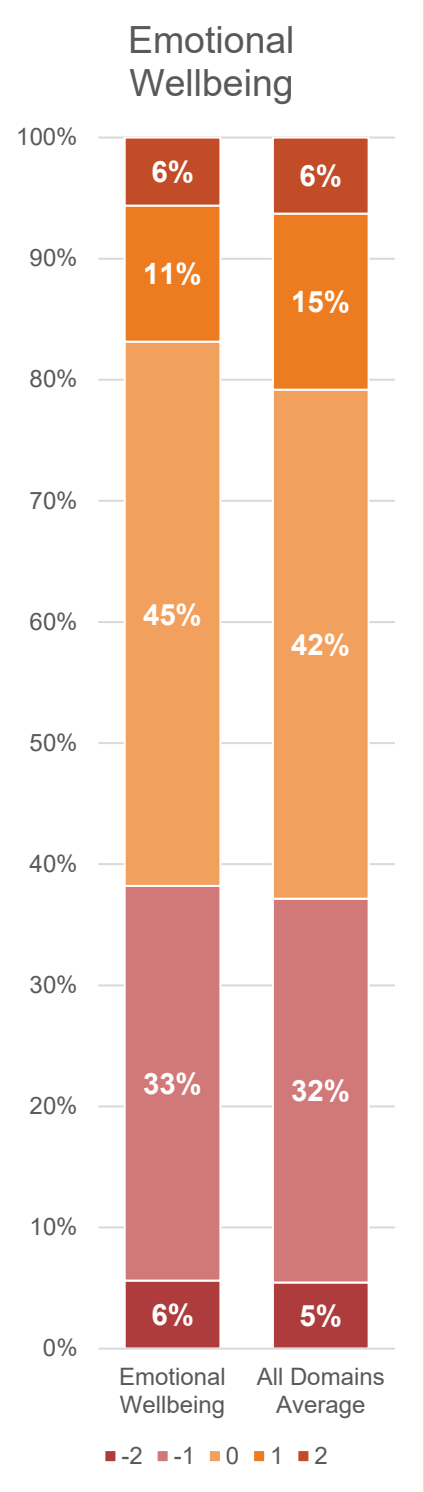
Goals attempted in the Emotional Wellbeing Domain were achieved at a rate of **62%** for plans ended in FY22, a 3% decrease from FY21.

Gender



Ethnicity





Family Relationships Domain – Hononga ā-whānau

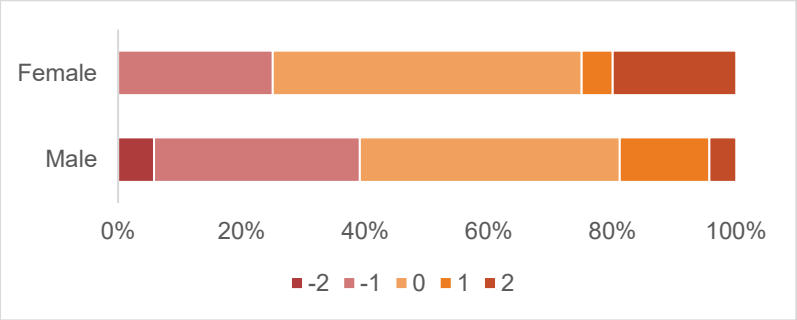
Domain Descriptor

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.

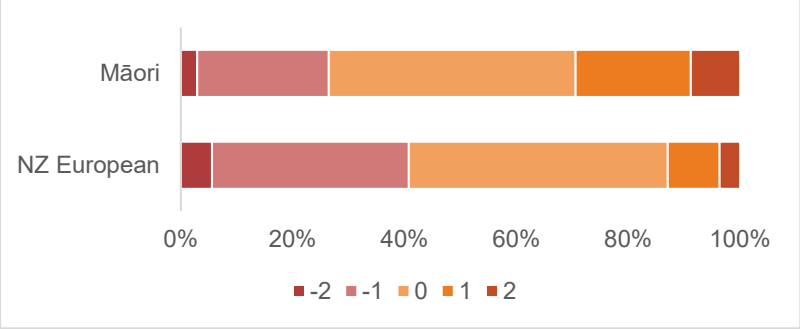
Overall

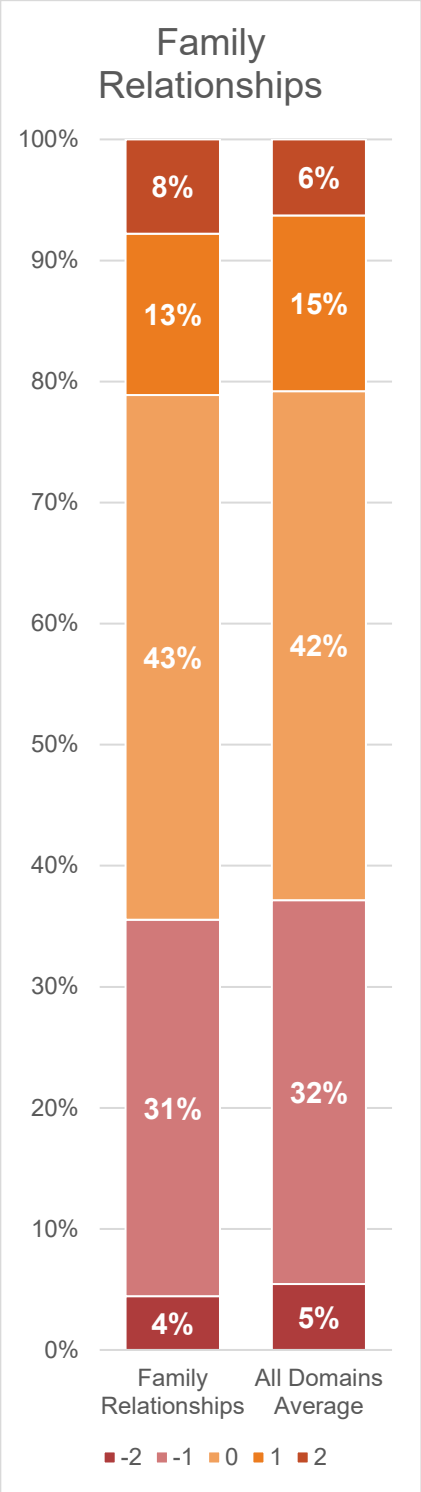
Goals attempted in the Family Relationships Domain were achieved at a rate of **64%** for plans ended in FY22, a 1% increase from FY21.

Gender



Ethnicity





Life Skills Development Domain – Whakawhanaketanga pūkenga ora

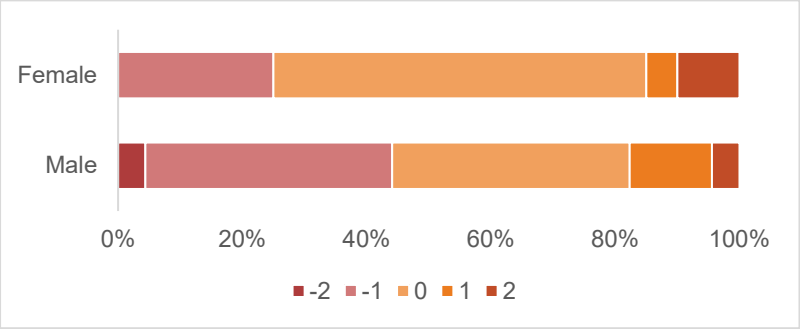
Domain Descriptor

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 **61%** for plans ended in FY22, an 8% decrease from FY21.

Gender



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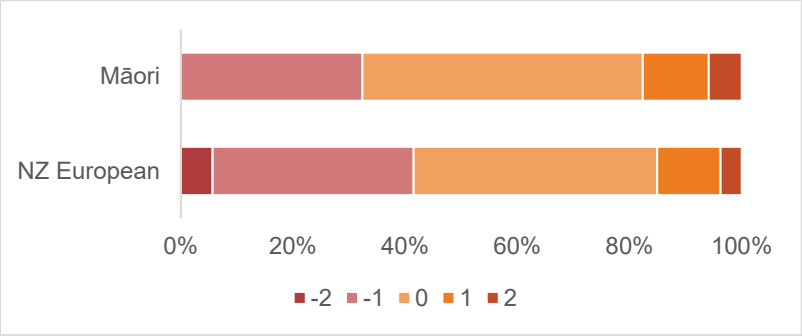
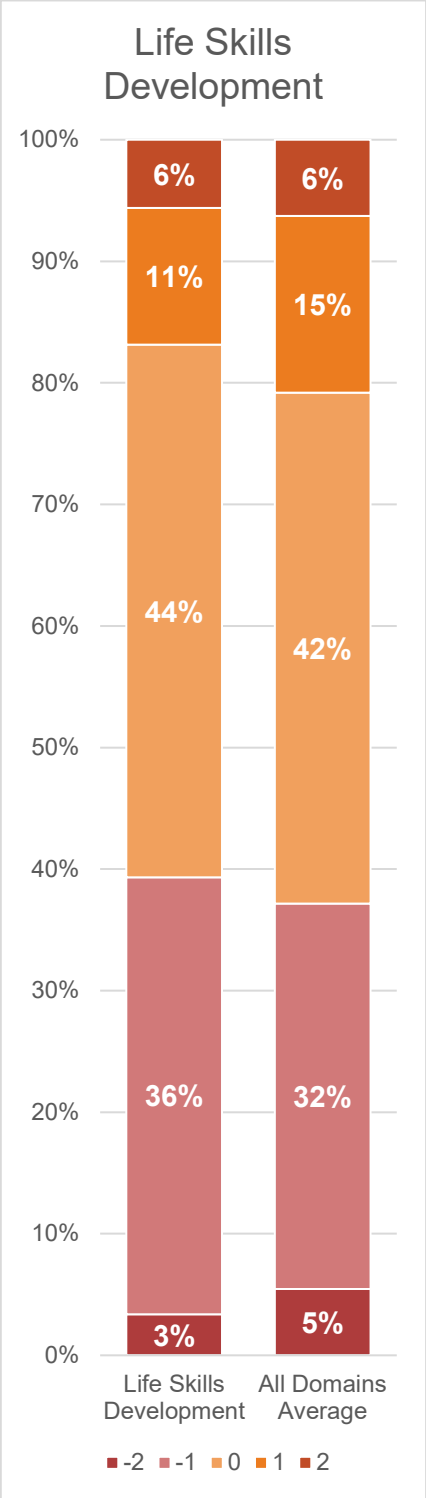




Living Arrangements Domain – Tūāhuatanga noho

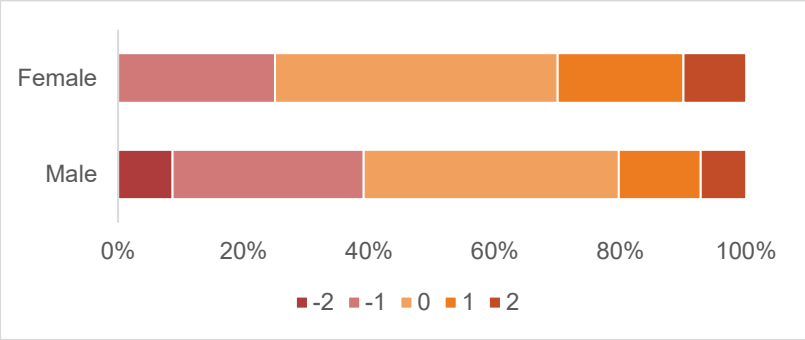
Domain Descriptor

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 FY22, the same achievement rate as FY21.

Gender



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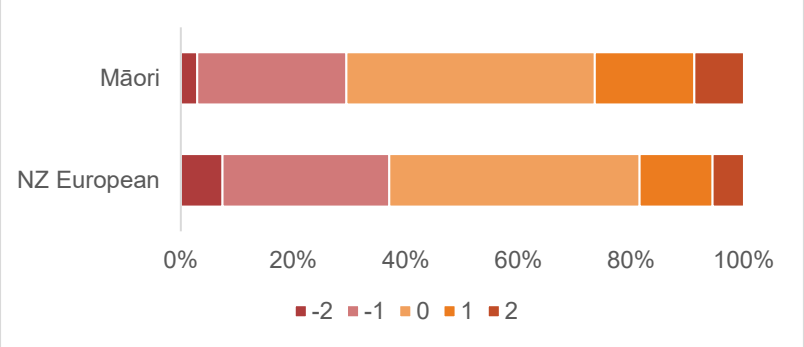
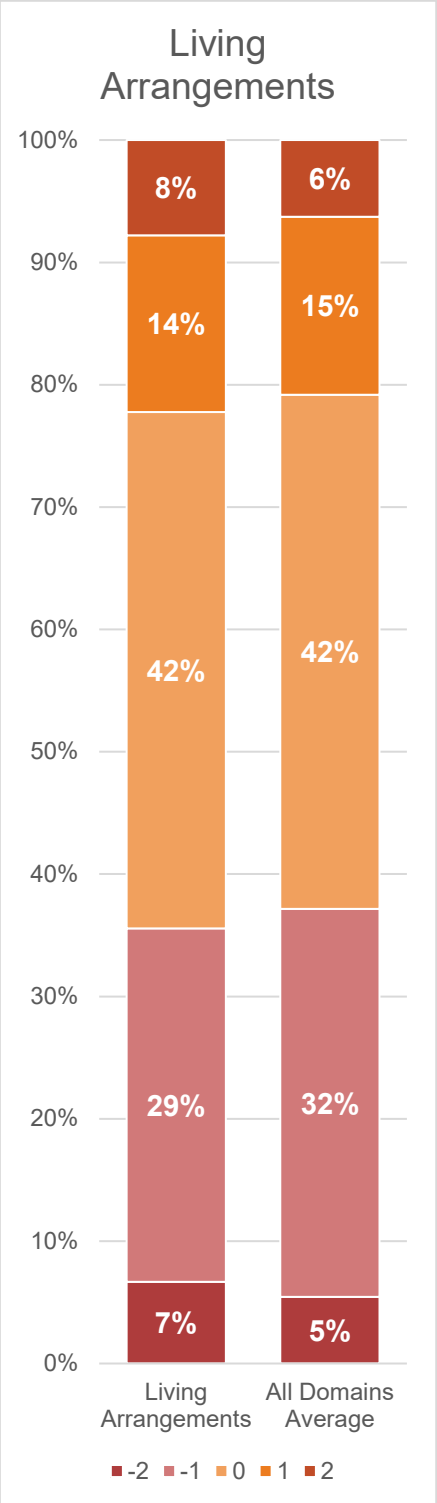




Peer and Social Domain – Hononga ā-hoa, ā-pāpori

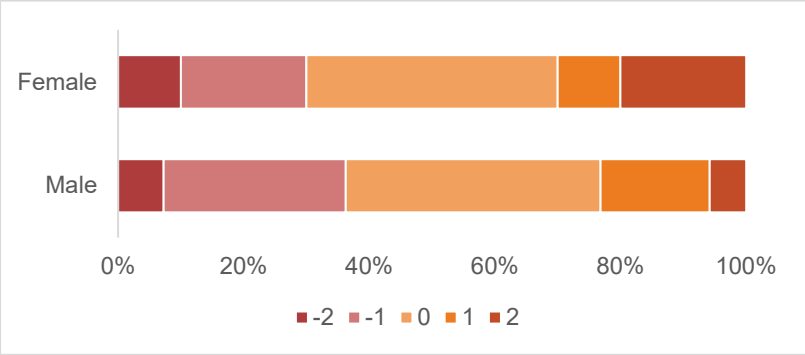
Domain Descriptor

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 **66%** for plans ended in FY22, a 2% increase from FY21.

Gender



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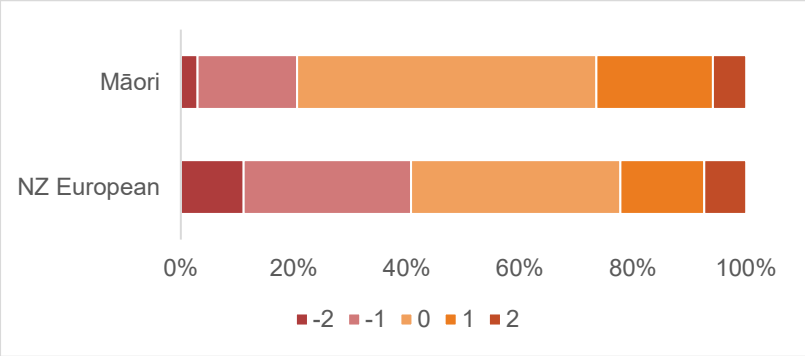
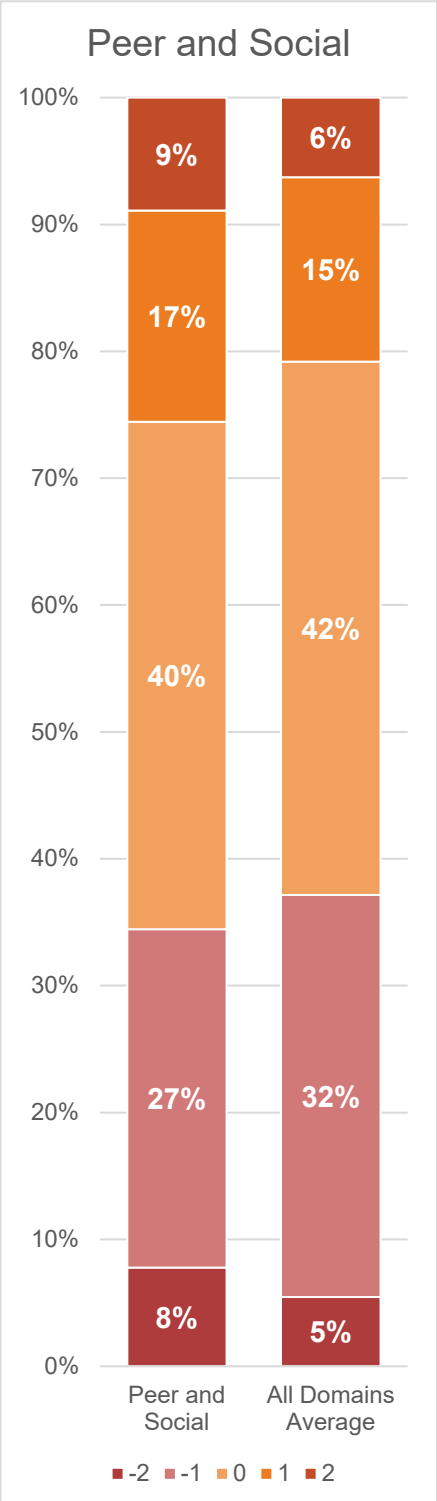




Personal Health Domain – Oranga tinana

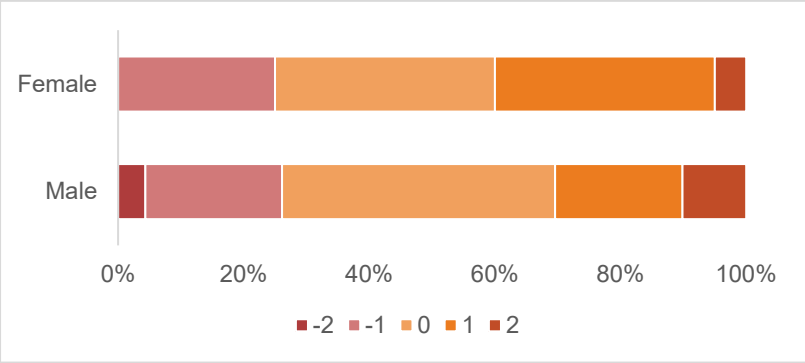
Domain Descriptor

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

Overall

Goals attempted in the Personal Health Domain were achieved at a rate of **74%** for plans ended in FY22, an 11% increase from FY21.

Gender



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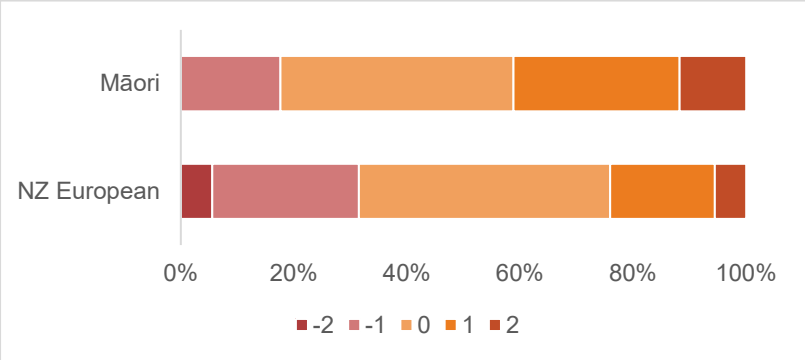

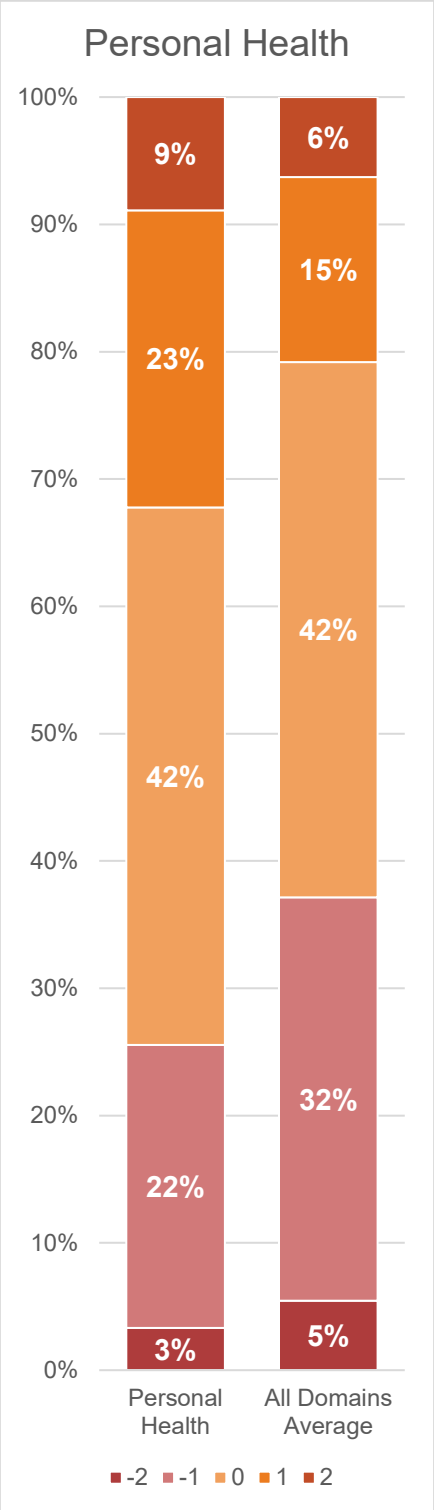

Indicators of Complexity – Diagnostics Tables

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.

	FY22	FY21	FY18-22 AVG
% Neurodevelopmental Disorder(s) Present	**80%**	**78%**	N/A
% Attention Deficit Hyperactivity Disorder (ADHD)	64%	56%	54%
% Autistic Spectrum Disorder (incl. Asperger Syndrome)	29%	33%	26%
% Intellectual Disability	24%	28%	26%
% Communication Disorders	15%	17%	8%
% Global Developmental Delay	13%	16%	9%
% Specific Learning Disorder	9%	11%	7%
% Disruptive, Impulse-Control, and Conduct Disorder(s) Present	**53%**	**46%**	35%
% Oppositional Defiant Disorder	40%	37%	34%
% Conduct Disorder	13%	11%	11%
% Intermittent Explosive Disorder	6%	11%	3%
% Anxiety Disorder(s) Present	**36%**	**43%**	38%
% Separation Anxiety Disorders	11%	17%	8%
% Selective Mutism	3%	4%	1%
% Social Anxiety Disorder (Social Phobia)	11%	10%	4%
% Panic Disorder	5%	2%	2%
% Generalized Anxiety Disorder	16%	22%	13%
% Trauma and Stressor-Related Disorder(s) Present	**46%**	**37%**	45%
% Reactive Attachment Disorder	20%	14%	24%
% Posttraumatic Stress Disorder	24%	20%	18%
% Adjustment Disorder	3%	5%	3%
% Acute Stress Disorder	3%	1%	1%
% Sleep-Wake Disorder(s) Present	**19%**	**22%**	11%
% Insomnia Disorder	8%	5%	3%

% Elimination Disorder(s) Present	**15%**	**19%**	9%
% Enuresis	8%	10%	4%
% Encopresis	9%	12%	6%
% Foetal Alcohol Spectrum Disorder (FASD)	**15%**	**16%**	13%
% Eating Disorder(s) Present	**14%**	**15%**	7%
% Anorexia Nervosa	1%	1%	0%
% Binge-Eating Disorder	3%	4%	1%
% Sensory Disability(s) Present	**-14%**	**11%**	9%
% Vision	9%	4%	6%
% Hearing impaired	6%	6%	4%
% Depressive Disorder(s) Present	**14%**	**11%**	10%
% Disruptive Mood Dysregulation Disorder	3%	2%	2%
% Major Depressive Disorder	6%	4%	2%
% Persistent Depressive Disorder (Dysthymia)	1%	0%	N/A
% Physical Disability Present	**10%**	**7%**	5%
% Obsessive Compulsive Disorder(s) Present	**5%**	**4%**	3%
% Obsessive Compulsive Disorder	3%	0%	2%
% Neurocognitive Disorder(s) Present	**6%**	**4%**	4%
% Traumatic Brain Injuries (TBI)	4%	1%	2%
% Substance-Related and Addictive Disorder(s) Present	**5%**	**2%**	3%
% Substance-Related Disorders (Alcohol, Drugs of Abuse)	5%	2%	3%
% Non-Substance-Related Disorders (Gambling)	1%	0%	1%
% Bipolar and Related Disorder(s) Present	**3%**	**1%**	1%
% Psychotic Disorder(s) Present	**1%**	**1%**	1%
% Dissociative Disorder(s) Present	**3%**	**1%**	1%
% Brain Injury	**0%**	**0%**	1%

Adverse Life Experiences – Plans Started

	FY22	FY21	FY18-22 AVG
% Stand-down /suspension/exclusion from education	**75%**	69%	51%
% Parental separation	**76%**	69%	72%
% Family violence	**64%**	60%	68%
% Multiple school placements/enrolments	**62%**	56%	55%
% Parental alcohol or other drug abuse	**58%**	54%	61%
% Substantiated reports of abuse*	**64%**	54%	67%
% Parental/caregiver mental illness	**52%**	53%	57%
% Multiple caregiving situations	**60%**	53%	58%
% Poor attachment	**57%**	52%	65%
% Parental benefit dependence	**44%**	44%	26.54
% Known exposure to alcohol or drugs prenatally	**45%**	41%	44%
% Parental offending	**41%**	37%	40%
% Family/whanau placements	**40%**	33%	29.06
% Family transience	**30%**	28%	32%
% Non kin caregivers	**32%**	26%	21.05
% Parent in prison	**23%**	22%	15.79
% Exclusion/stand-down from early childhood facilities	**15%**	20%	14%
% Premature birth/low birth weight	**9%**	12%	12%
% Exposure to Gang culture during formative years	**9%**	10%	17%
% Significant accident or injury	**7%**	7%	12%
% Non-enrolment in early childhood facilities	**9%**	6%	16%

** Substantiated reports of abuse subcategories – Plans Started*

% Neglect	48%	42%	37%
% Emotional	**46%**	36%	37%
% Physical	**35%**	31%	28%
% Sexual	**10%**	9%	8%

Presenting Problem Behaviours – Plans Started

	FY22	FY21	FY18-22 AVG
% Social difficulties with peers	96%	94%	93%
% Physical aggression (people, animals, property, arson)	92%	91%	73%
% Verbal aggression	88%	85%	86%
% Excessive fear, anxiety (separation, phobia, panic attacks, obsessions, compulsions)	60%	69%	47%
% Deficits in adaptive functions (activities of daily life)	48%	60%	38%
% Hyper or hypo reactivity to sensory input	55%	58%	42%
% Mood (lability, elevated, depressed)	54%	58%	39%
% Deficits in intellectual functions (reasoning, planning, problem-solving)	58%	57%	45%
% Absconding	49%	52%	53%
% Non-suicidal self-harm	37%	44%	34%
% Inappropriate sexualised behaviours	35%	37%	34%
% Restrictive food intake	27%	30%	19%
% Theft	29%	25%	25%
% Truancy from education	27%	25%	21%
% Abnormal motor behaviour (restrictive, repetitive, disorganised)	25%	23%	19%
% Delusions (fixed/false beliefs)	13%	19%	13%
% Use of alcohol or other drugs of abuse	15%	10%	13%
% Suicide attempts	11%	10%	12%
% Hallucinations (false perceptions)	9%	7%	6%
% Sexually abusive to others	8%	7%	8%
% Non-attendance at school	2%	6%	17%