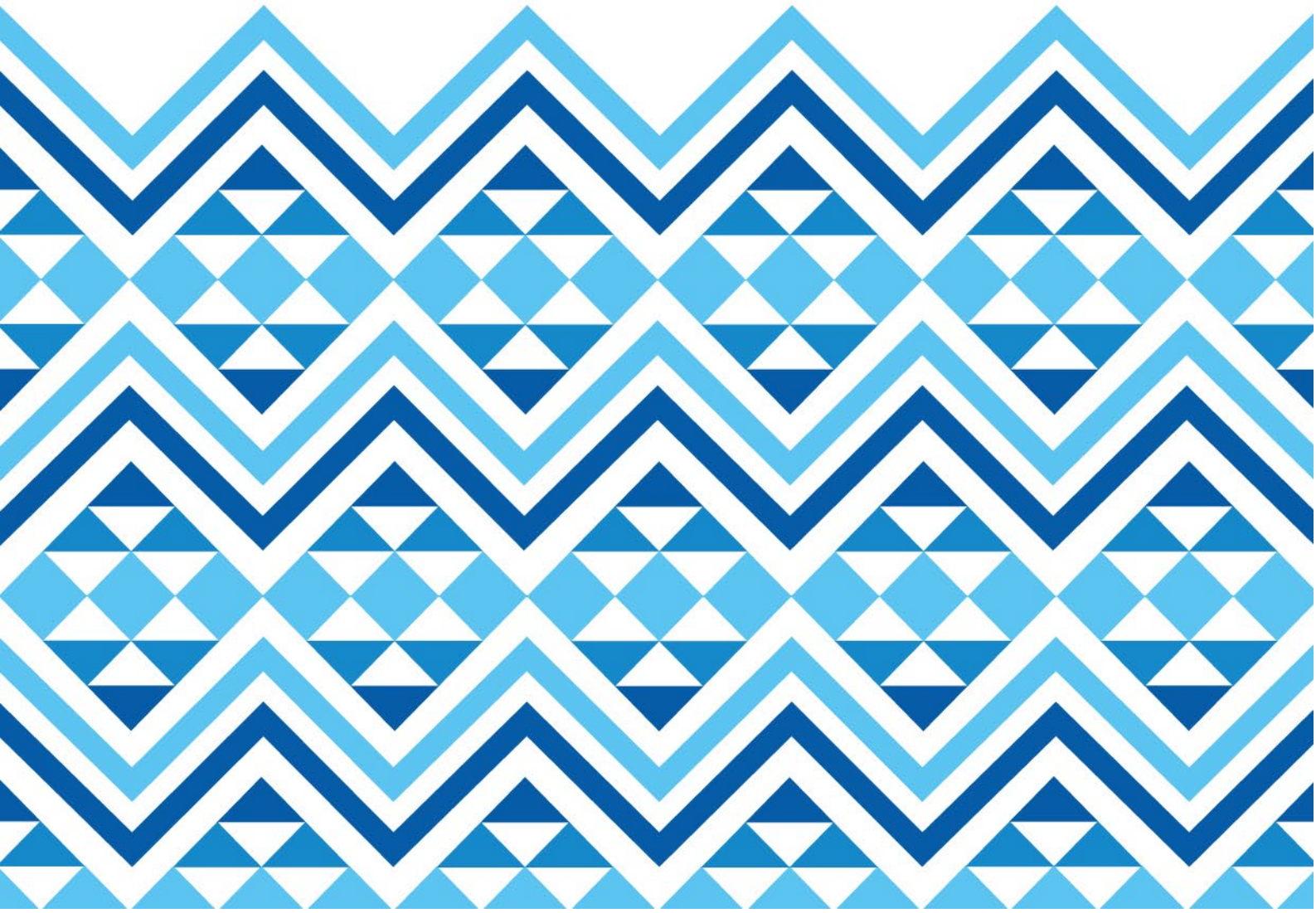
ORANGA TAMARIKI
Ministry for Children

New Zealand Government

# Gateway Assessment Review: Key Findings



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ORANGA TAMARIKI
Action Plan

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# List of Acronyms

| | |
|---|---|
| ACC | Accident Compensation Corporation |
| ADHD | attention deficit hyperactivity disorder |
| ADL | Adventure Therapy |
| CAFS | Child, Adolescent and Family Services |
| CAMHS | Child and Adolescent Mental Health Services |
| CDS | Child Development Services |
| CDA | Child Disability Allowance |
| CYP | Child or young person |
| DHB | District Health Board (Te Whatu Ora – Health New Zealand) |
| DSS | Disability Support Services |
| ECE | Early Childhood Educator |
| FGC | Family Group Conference |
| GAA | Gateway Assessment Administrator |
| GAC | Gateway Assessment Coordinator |
| GLSW | Gateway Liaison Social Worker |
| GP | General Practitioners |
| HERA | Health and Education Recorded Assessment |
| IAP | Integrated Analytics Platform |
| ICAFS | Infant, Child, Adolescent and Family Service |
| IDI | Integrated Data Infrastructure |
| ISA | Interagency Service Agreement |
| IT | Information Technology |
| MDD | Major Depressive Disorder |
| MDM | Multidisciplinary Meeting |
| MDT | Multidisciplinary Team |
| MOE | Ministry of Education |
| MOE SE | Ministry of Education Service Manager |
| MOH | Ministry of Health |
| PACEs | Positive and Adverse Childhood Experiences |
| PTSD | Post Traumatic Stress Disorder |

| | |
|---|---|
| RTLB | Resource Teachers: Learning and Behaviour |
| SENCO | Special Education Needs Co-ordinator |
| SOGIESC | Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics |
| SLT | Speech Language Therapy |
| SW | Social Worker |
| UNCRPD | United Nations Convention on the Rights of Persons with Disabilities |
| YJEA | Youth Justice Education Assessment |
| YJES | Youth Justice Education Screen |
| YJHEP | Youth Justice Health and Education Programme |
| YJHA | Youth Justice Health Assessment |

# Executive Summary

## Introduction

The purpose of this report is to provide an understanding of the Gateway Assessment (Gateway) process and detail the key findings identified through the Gateway Review (the Review). This report provides evidence for the recommended areas of improvement identified in the briefing to the Minister for Children, Minister of Health and Minister of Education[1].

Gateway was introduced in 2011 as a joint programme between Child, Youth and Family (now Oranga Tamariki) and the Ministries of Health and Education. Gateway provides a specialist assessment, which aims to comprehensively assess the physical, mental, disability, educational, and social well-being needs of children and young people engaged with Oranga Tamariki[2].

Children who are engaged with Oranga Tamariki are more likely to be diagnosed with a disability and to experience poor or inequitable health (including mental health) and education outcomes. They are also more likely to have unrecognised and unmet needs and require additional supports. Gateway helps Oranga Tamariki meet the needs identification requirement of the National Care Standards.[3]

Each year, an average of 3,698 children are expected to receive a Gateway, with an average of 2,443 Gateway Assessments completed[4]. Currently, children and young people are eligible to receive Gateway if they are:

- entering care
- at risk of coming into care[5]
- already in care
- attending a Family Group Conference (FGC) under Section 18AAA

It is estimated that at least 56 to 86 percent[6,7] of children in care have a disability and over 70 percent are of Māori and/or Pacific descent.

In December 2022, recommendations were made to the Minister for Children, Minister of Health, and Associate Minister of Education to undertake a review of

[1] Briefing number B-0096, provided to Ministers on 10 May 2024.
[2] The Treasury. (2011, June). *Budget 2011 information release*. https://www.treasury.govt.nz/sites/default/files/2018-02/b11-2042441.pdf
[3] Oranga Tamariki (National Care Standards and Related Matters) Regulations 2018, cl 7
[4] Gateway administrative data, average over six years (2018 – 2023).
[5] Oranga Tamariki seeks to engage with families through Family Group Conferences (FGC) the aim of which are to avoid children and young people coming into care.
[6] This estimate depends on the dataset, age of children, and the definition of disability used. Oranga Tamariki Action Plan In-Depth Needs Assessment on the primary health needs of children and young people in care, 2024. Oranga Tamariki – Ministry for Children (n.d.). *Disability and children's system issues*. Internal paper: Unpublished.
[7] Oranga Tamariki—Ministry for Children. (2020). Children and young people with impairments. Wellington, New Zealand: Oranga Tamariki—Ministry for Children.

Gateway in response to collaborative cross-agency efforts to better meet the needs of children and young people involved with Oranga Tamariki.

The Review was initiated in March 2023, under the Oranga Tamariki Action Plan, and has been led by Oranga Tamariki, the Ministries of Health and Education, and Health New Zealand, with support from the Māori Health Authority and the Whaikaha - Ministry of Disabled People (Whaikaha). This is the first comprehensive national review of Gateway since it was launched.

The Review included engagement with key stakeholders through focus groups and surveys, as well as analysis of administrative data.

# Gateway review key findings

***Gateway should be more child, family, and community centred***

Gateway is most effective when children, families, and caregivers actively participate in the process. Currently, Māori and Pacific families feel disconnected from the process and improvements could be made to better meet the needs of these communities given their overrepresentation within the care population. Overall participation in Gateway could be improved by shortening timeframes and holding meetings in child and family friendly locations.

When children, families, and caregivers do participate in Gateway, their voices should be prioritised within reports and decision-making. Many families struggle to understand Gateway reports. Community providers could have a larger role in supporting children and families to understand Gateway information and outcomes.

Gateway works well when community providers, especially Māori and Pacific providers, are empowered to work in innovative ways to meet the needs of children, young people, and families. Culturally responsive assessments and services take a holistic approach, value relationships and the voices of children, young people, and families in the process.

Many community providers are willing and able to play a larger role in Gateway, with some providers expressing an interest in taking a leadership role within the Gateway process in their region. Some providers are already equipped to deliver the Gateway service from start to finish and could enable Gateway to be culturally responsive and alleviate needs quickly.

There are current examples of Māori and Pacific providers engaging in cross-agency collaboration and these examples could be used to improve the Gateway process at present. This approach would further improve the outcomes for children, young people and families.

***An enhanced Gateway could benefit more children and young people and ensure their needs are followed-up and met***

Many children and young people do not receive the services recommended through Gateway, due in part to gaps in the Gateway follow-up process. More work is

needed to ensure systematic follow-up of health and education recommendations until all identified needs have been met.

Some groups of children and young people miss out on Gateway and its services due to narrow eligibility criteria. For example, young people transitioning out of care often do not receive continued access to the services they need. Young people in the Youth Justice system who 'have no care and protection concerns' experience a different set of needs assessments. More work is required to better align Gateway with the Youth Justice system.

### *More work is needed to better identify and meet the needs of children and young people*

Needs identified through Gateway require services to meet them. There is significant regional variation in service availability, especially in rural communities. Engagements highlighted a particular lack of services to meet needs associated with trauma, mental health, and disability. Many schools struggle to manage children with significant unmet needs, this in turn puts their education at risk.

Primary health needs are often identified; however, Gateway timeframes often mean children wait long periods for treatment of straightforward primary health needs. Some sites have streamlined primary health service pathways, and these could be rolled out nationally to improve primary health service delivery across the motu.

High quality needs data is essential to understand and meet needs, identify service gaps and fulfil agency reporting requirements. Issues with the Gateway Information Technology (IT) Tool and inconsistencies in practice are currently impacting Gateway needs data recording. Identifying and recording disabilities in the Gateway population is also an issue, leading to unmet needs in this population.

By adequately identifying and addressing the health, disability and education needs of children and young people, engagement in education and wellbeing can be significantly enhanced and have positive impacts on longer-term social outcomes. This supports Government Targets to reduce serious and persistent child and youth offending, and increase education attendance.[8]

### *Some systems are supporting Gateway well while others need improvement*

Gateway has been designed to support collaboration between Oranga Tamariki, Health, and Education frontline staff, care and community partners, and children, young people, family, and caregivers. This review found examples of systems supporting good collaboration through Gateway as well as areas for improvement. Critical functions of the system that need improvement to better support Gateway include: the Gateway IT Tool, information sharing, consent process, funding, governance and accountability.

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[8] Department of the Prime Minister and Cabinet. (2024, April). *Government targets*. https://www.dpmc.govt.nz/our-programmes/government-targets

# Context

## Gateway Assessment Process

The Gateway process based on the service specification is outlined below, noting there have been variations made within regions since 2011 (see Figure 1).

The programme's main components include coordination, health assessments, service agreements, and referrals to health and support services. The process for completing the assessments and making referrals are outlined in Gateway Guidelines[9], including roles, consent procedures, and documentation.

Gateway is typically a one-off event, with two components – a health assessment and an education assessment. The first step is for a social worker to obtain consent from the young person or their guardian, and to make a referral to a Gateway Assessment Coordinator (GAC)[10].

Health assessment:

- The GAC is responsible for organising the medical checks and gathering the medical history of the child or young person.
- Detailed medical assessments are completed, typically by a paediatrician or in some instances by a nurse-practitioner or registered nurse.

Education assessment:

- The social worker for the child is responsible for obtaining the education profile from the child's early childhood education service or schoolteacher.
- Once the education profile is received, this is added to the child's medical file and health assessment.

The GAC then organises for the case to be reviewed in a monthly Multi-Disciplinary Team meeting (MDT), where various professionals from health, education, Oranga Tamariki and external providers meet and agree to recommendations, which form an Interagency Service Agreement (ISA). The ISA outlines the referrals and services to be provided to meet the needs of the child or young person.

The GAC then compiles the Final Gateway Report to be shared with the child's social worker. The report includes the recommendations, along with a detailed summary of medical, education, or other wellbeing needs.

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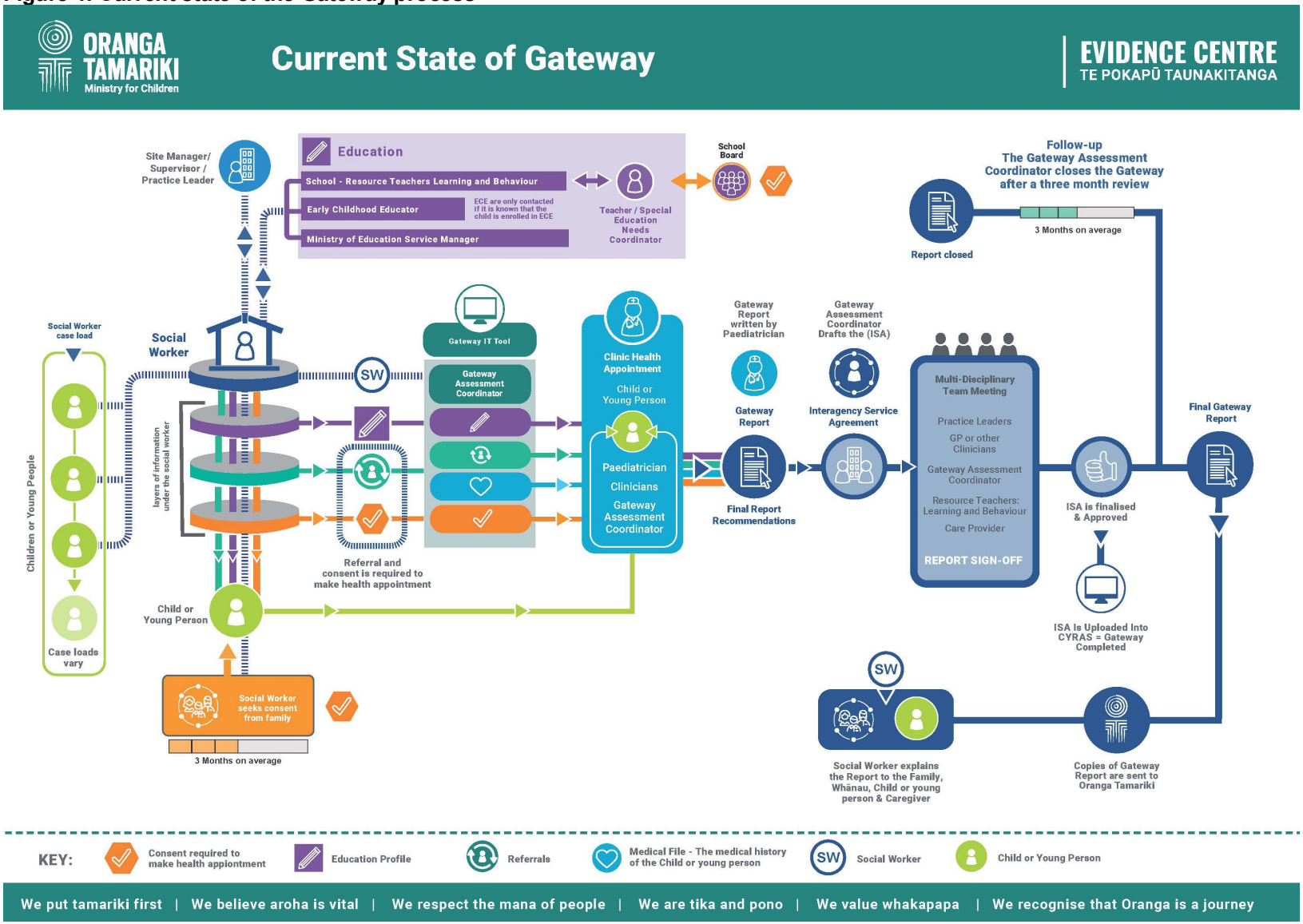
[9] Oranga Tamariki – Ministry for Children. (2018). *Service specifications: Gateway Assessment*. Internal document: Unpublished.

[10] A GAC is employed by Health New Zealand to manage the programme and provide case management. A range of Oranga Tamariki, health and education professionals contribute to the programme, including social workers, teachers, Resource Teachers Learning and Behaviour (RTLB), early childhood education providers, nurses, general practitioners (GPs), other clinical services, disability services, family and community service providers.

**Figure 1. Current state of the Gateway process**



# Gateway Review

A comprehensive national review of Gateway has not been completed since it was first launched despite its operational challenges, and previous attempts to commission an overall review.

Operational reviews conducted in 2013-14 and 2018 aimed for a 100 percent completion rate of Gateway for children and young people in care, however, this remains unmet.

Oranga Tamariki, the Ministries of Health and Education, Whaikaha, Health New Zealand, and the Māori Health Authority have come together to review Gateway under the Oranga Tamariki Action Plan.

**The goal of the review was to understand the issues and opportunities that exist in Gateway currently along with what's working well.**

A mixed methods approach was utilised[11], that included:

- conducting 80 regional engagements with over 40 individuals and groups (predominantly in Auckland, Bay of Plenty, Te Tai Tokerau and the Lower South Island) with frontline cross agency staff, partners, providers, care experienced young people and whānau care groups with experience of Gateway
- two national surveys (one for sectors and partners, and one for care experienced young people, whānau and caregivers) with over 300 responses
- other data analysis and insights collected.

The main review questions were:

- What is the current experience of Gateway?
- What is working well and what is not working well?
- What system improvements are necessary?

Engagement with stakeholders followed a semi-structured approach, with a set of questions asked about the challenges, practice changes and local approaches which could be applied nationally. These questions formed the staff survey.

A set of tailored questions regarding the experience of Gateway and how needs are met formed the survey for care experienced young people, whānau and caregivers.

Local reports and approaches informed this review, including relevant national[12] and

[11] Creswell, J., & Plano Clark, V. L. (2018). *Designing and conducting mixed methods research*. CA: SAGE.

[12] Wylie, C. (2022). *Highest needs review: What matters to stakeholders*. New Zealand Council for Educational Research. https://assets.education.govt.nz/public/Documents/our-work/changes-in-education/Highest-Needs-Review-What-matters-to-stakeholders-NZCER.pdf

local[13] reviews.

These methods captured key issues, aspirations, and options for a future system. Qualitative insights were analysed and tested with key stakeholders. Findings from the quantitative analysis of needs, cost, and administrative data on how Gateway is currently delivering on the desired intent, were assessed against engagement and survey findings.

From these insights, a set of clear recommendations were derived and designed with stakeholders.

# Structure of the Report

This report is the final product of the Gateway Review and is intended to provide detailed supporting evidence for the recommendations made to Ministers for proposed enhancements to Gateway.

The report is written using a combination of descriptive and analytical styles aiming to immerse the reader in the workings of Gateway and its issues.

From here, the report is split into three chapters:

1. What We Learned
2. Gateway Innovations Making a Difference
3. Research Design

**What We Learned** summarises the most important issues currently limiting the effectiveness of Gateway as identified through the review.

**Gateway Innovations Making a Difference** explores examples from regions that show how frontline staff are making things work despite the current challenges with Gateway.

**Research Design** briefly explains the research framework utilised.

[13] South Auckland Social Wellbeing Board (2023). *Te Huarahi Ngaa Tahi: Connecting Pathways* [Prototype learnings report]; Viner, A. (2022), *Review of Te Puaruruhau (Auckland) Gateway service*. Puawaitahi.

# What We Learned

From the engagements, surveys and other data analysis, four overarching themes were identified which comprise the four main sections of this chapter:

1. Building a more family and community[14] centred process
2. Enhancing the process to better meet needs
3. Addressing the needs of child and family[15]
4. Enabling the system across agency frontlines

These overarching themes are broken down into subthemes within the four main sections.

## 1. Building a more family and community centred process

The review identified that Gateway needs to be more family and community centred. To do this, Gateway needs to:

1.1 Respond to and meet cultural needs
1.2 Reduce the wait times for Gateway
1.3 Include the voices of families and communities
1.4 Be conducted in child and family friendly locations
1.5 Ensure information is accessible for families

### *1.1 Respond to and meet cultural needs*

The Crown's commitment to Te Tiriti o Waitangi and the multi-culturalism of New Zealand's society requires Gateway to be culturally responsive, particularly to priority communities[16]. This can be done by:

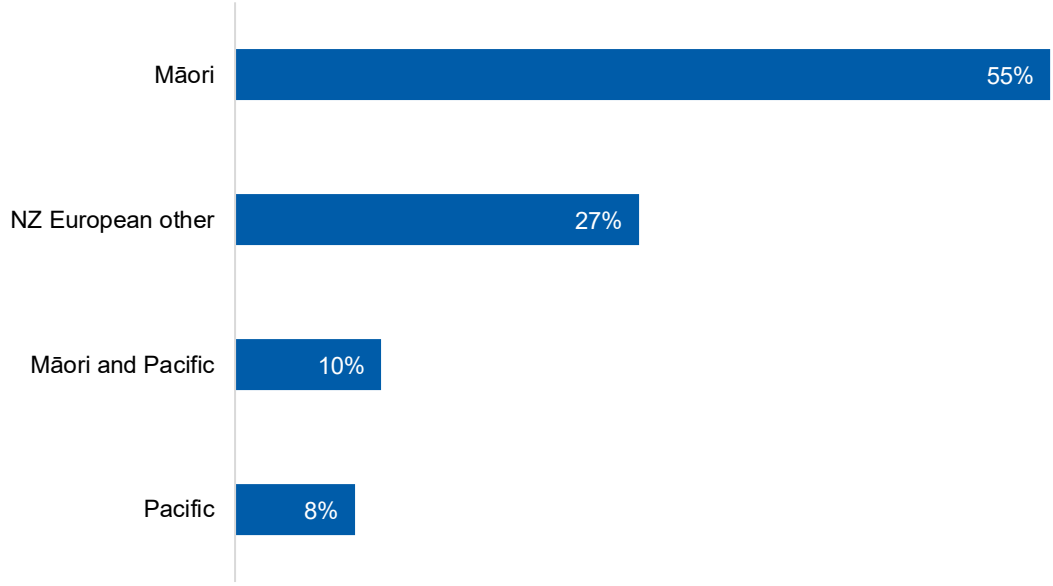
- Providing culturally appropriate pathways of care
- Utilising Kaupapa Māori, Tikanga Māori and/or Whānau Ora based services
- Ensuring service staff are culturally capable and can respond to cultural needs throughout the assessment process.

The Oranga Tamariki Practice Approach is framed by Te Tiriti o Waitangi and draws on Te Ao Māori principles of oranga. The overarching principles of oranga focus on practice that is relational, restorative and inclusive which supports the notion that Gateway must be culturally responsive.

[14] 'Family and community' is inclusive of children, young people, whānau, families, caregivers and social workers, reflecting a holistic view of social support and interdependence.
[15] 'Child and family' includes children, young people, whānau, families and caregivers.
[16] Priority communities include Māori, Pacific people, ethnic minorities, disabled people, Sexual Orientation, Gender Identity, Gender Expression and Sex Characteristics (SOGIESC) diverse, and children and young people in care.

Figure 2 provides a breakdown of Gateways delivered by grouped total response ethnicity[17]. Grouped total response means if a person's identified ethnic groups fall within a main designated ethnic category, they are only counted once in that category. Majority of children and young people who receive Gateway identify as Māori or Pacific or both (n=13,301).

**Figure 2. Proportion of Gateway assessments delivered by grouped ethnicity 2017 to 2023 financial years**




Māori and Pacific communities and staff mentioned that cultural needs are not being met, despite agencies' commitments to these populations. Māori providers expressed feeling that the Western and clinical approach of Gateway prevents whānau Māori and Pacific families from seeing their values reflected in its process.

> *It is difficult for whānau Māori to see themselves in the Gateway process. Very clinical, diagnosis, and deficit focussed… [we] liken tamariki to different atua, each with their different strengths and personalities. – Māori Provider*

Pacific providers acknowledged that Pacific leadership is required, that there is not enough representation of Pacific people within Gateway, and that advocating for cultural support for families means advocating for increased Pacific leadership.

> *The whole process of Gateway is fitted for a community that is not Pacific. Some of our traditions are different to what is designed in*

[17] Stats NZ. (n.d.). *2018 Census ethnic group summaries.* https://www.stats.govt.nz/tools/2018-census-ethnic-group-summaries/

*Gateway. It doesn't look like us, it doesn't feel like us.*
*– Pacific Provider*

Government processes, policies, and practices sometimes sideline the needs and expectations of tamariki, rangatahi, and whānau Māori. Some Māori providers said that there is a lack of guidance and support for implementing frontline policy.

*The experiences that we've had, for people who have been here [from] years ago, the policies come from there, tick the box, and then when it comes to us, we're all muddled. What are we going to do? How are we going to execute all these policies? – Māori Provider*

To ensure the Gateway process is culturally responsive, services could be provided through Māori providers, many of which have the capability and capacity to provide these services. Māori providers want to have more control of their mahi with their communities, enabling services to be for Māori, by Māori.

*Why can't this work be devolved to community in its entirety? We have the capacity and capability to complete the end-to-end process and the ability to navigate their internal networks in the community to get the access to service once the Gateway Assessment is complete. – Māori Provider*

Whanaungatanga[18] is a culturally responsive practice that builds relationships between children, young people, family, and social workers. Frontline kaimahi emphasised the importance of cultural responsiveness, especially when working with whānau Māori and Pacific families.

Moreover, social workers recognise the importance of applying a cultural perspective in presenting essential information such as rights to services and medical recommendations, to ensure understanding and acceptance among diverse children, young people, and families. Social workers suggested redesigning Gateway brochures to use more inclusive language and to engage with children and their families in a culturally responsive manner.

*I think the key is having the right people in those spaces [appointments], so having a cultural advisor, as an example […] in terms of cultural [we need to] provide some type of cultural*

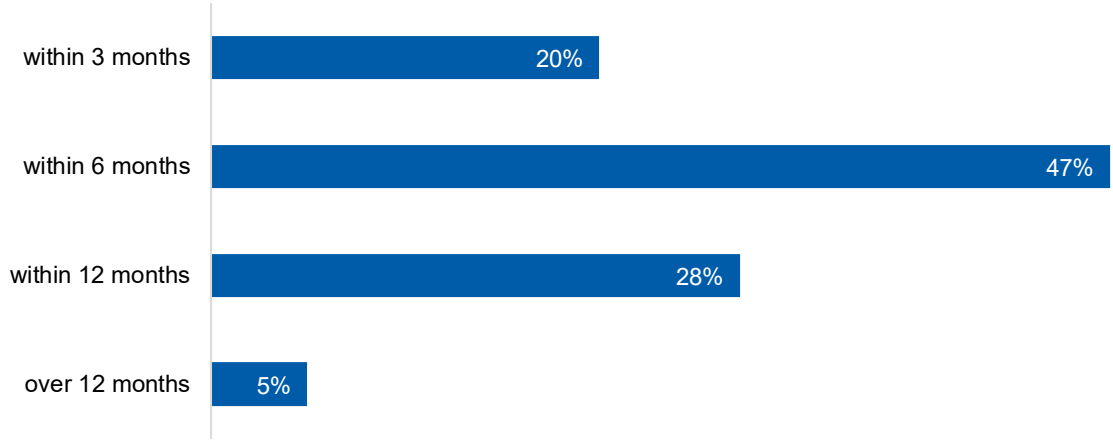
[18] In relation to a person, whanaungatanga means the purposeful carrying out of responsibilities based on obligations to whakapapa.

*recommendation or align the recommendation from the clinician from a cultural lens. – Social Worker, South Auckland*

## 1.2 Reduce the wait times for Gateway

Lengthy wait times are an issue, with most Gateways taking up to six months to complete (according to administrative data). Completion means a medical appointment, ISA, and the Final Gateway Report have been uploaded to the system. However, completion does not necessarily indicate that the child or young person has received the recommended supports or service, or that any proposed action was followed up (Figure 3).

**Figure 3. Gateway Time from Referral to Completion (n=13,301)**




Engagements outlined several reasons behind Gateway's lack of timeliness, including the consent process which involves a social worker explaining the process to the family. Social workers' high caseloads and the family's own schedule can delay this. Social workers must accommodate the family and work at their pace, while balancing the need for timely completion.

Once consent is received, it usually takes between three months to six months to schedule a health appointment. This can be exacerbated in rural areas, where access to services can be limited. Some rural areas have also seen a rise in referrals to GP's, contributing to longer waiting times for services in those areas.

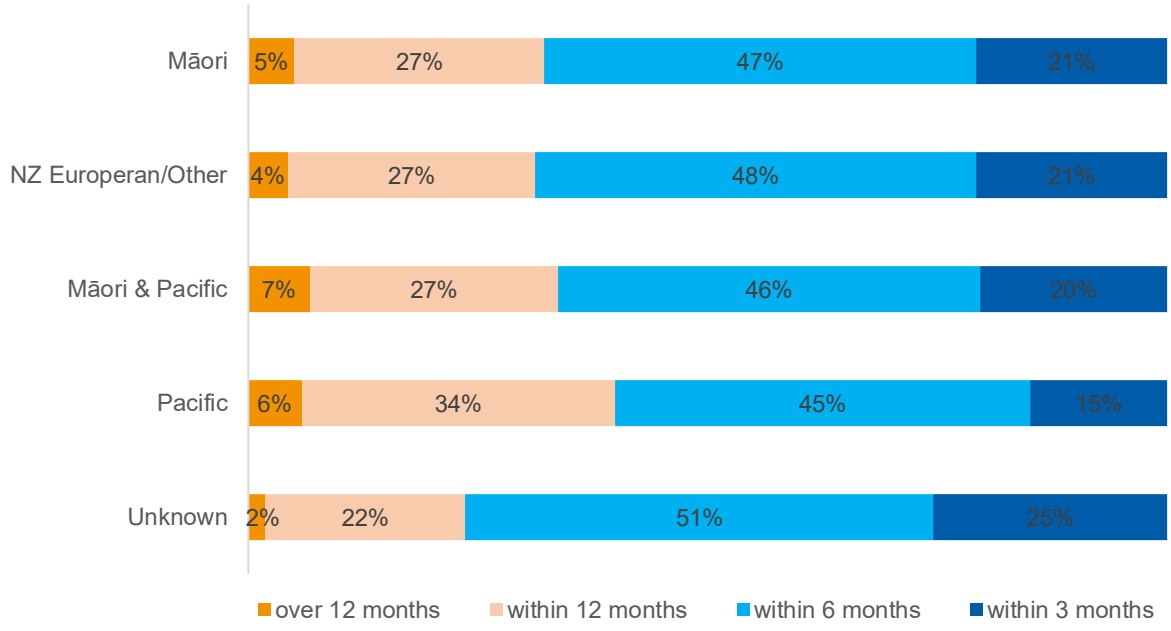
*We have huge wait lists to get into a GP [appointment]. If you ring a GP today, you might get an appointment in four or five weeks' time. – Care Provider, Lower South*

The child must see a GP prior to getting referred to specialist care. The situation appears to be worse for referrals to specialist appointments, where wait times can exceed six months.

*Wait times for specialist health appointments average six months. Often, by the time a child gets a specialist appointment, they have moved to a new location or care placement, are no longer in care, or the FGC intervention has been completed or closed. This makes follow-up more complex, as it appears no one is accountable if Oranga Tamariki are no longer involved, and some are forced to restart the waiting process due to a lack of coordination regarding medical appointments. It's hit and miss because of the waitlist to get into other agency's referral to secondary services. Once the Gateway actions have been identified and services recommended, there can be significant delays and lack of services to refer the tamariki on to. The waitlist to gain access to specialist care can be between 2-3 months currently. – Māori Provider*

Figure 4 gives a breakdown of time to completion by grouped ethnicity. Most notably for Pacific children and young people, 34 percent of Gateways can take up to 12 months, while only 15 percent were completed within three months compared to other groups.

**Figure 4. Time from referral to completion by grouped ethnicity (n=13,301)**




The difference in timeliness noted for Pacific children and young people could be due to the lack of culturally responsive services for Pacific families.

## 1.3 Include the voices of families and communities

The participation of children, young people, their families, and caregivers in the process is crucial to ensuring Gateway achieves the best outcomes for them.

Historically, a power imbalance has existed between Crown entities and whānau Māori and Pacific families that has commonly excluded them from conversations about issues concerning them. As a result, Māori and Pacific communities are not always involved in important decision making. This denies them the opportunity to express their primary needs, expectations, aspirations, and to negotiate how these can be met.

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*It is important for te tamaiti and their whānau to be around the decision table to be clear about support and to manage their expectations. – Māori Provider*

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In some cases, children, young people, family members, and caregivers may disagree on needs and appropriate treatment options for the child or young person. In these cases, professionals must carefully ensure the child or your person's voice is included, and they participate in the process before making decisions that can have lasting impacts on young people and families.

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*I think the interest of the young person should take priority. My parents were very against us receiving psychological support. This could have been why I never received any therapy while in care. – Māori, Care Experienced Youth, Auckland*

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Sometimes social workers engage families in the process without having sufficient knowledge of the Gateway process themselves (due to high staff turnover) or lack the ability to explain the process in a way that families will understand.

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*In at least 30-40 percent of patients there is a brief referral and/or the social worker who has arrived has recently been allocated the case and knows little. – Clinician, Te Whatu Ora, Waitematā*

*We're trying to explain to them how the process works and it is just so confusing because […] we've got to understand that some of our whānau don't read and can't comprehend what's in there [and] whether they truly understand that or not is another question. […] I guess trying to figure out how to bridge that gap. And that Gateway [consent] form, it's just a lot of words and we end up just taking the last page out and just kind of going "here, you take this, can you just sign this?" and talk through it because otherwise they're not going to*

*engage or want to hear about it at all.*
*– Social Worker Supervisor, Auckland*

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When families are unclear on the purpose of Gateway, their engagement with the process often declines or withdraws completely. In doing so, they forfeit their input on service referrals.

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*I may have been offered counselling once or twice but didn't know much about it. Looking back, I wish I was given more information about counselling or clinical therapy. I would have benefited from it as a young person in care. – Māori Care Experienced Youth, that recalled having Gateway, Auckland*

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Frontline staff have reported that Gateway recommendations frequently appear over-simplistic and do not fully capture the child or young person's needs. In addition, input from social workers (social worker's voice), who often deeply understand the child or family's circumstances and can assess the appropriateness of a recommendation, is often excluded.

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*[Social workers] are met with the ISA with these recommendations …and they're like oh, you know, these probably won't work.*
*– Social Worker, Auckland*

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Education frontline staff emphasised the importance of improving communication with families and youth, respecting their input and providing mechanisms for meaningful involvement in the process.

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*Just want to share my experience with a couple of the Gateway students who have come to [our school] and Oranga Tamariki have been involved. The difference for the child seeing all parties at the table before they start school is just so powerful. And then the kōrero is also controlled by them. Their narrative is also controlled by them because they're in the room. We then ask, is it okay to share this? …there's autonomy given to them straight away. So, I don't think we can underestimate how powerful it is when Oranga Tamariki are there when the child is there, and the school is present.*
*– High School Teacher, Auckland*

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The barriers to including their voice in the decision-making process have included the time available, quality of engagement and discussion with family, and the accessibility of written information. For further perspectives on the inclusion of voice gathered from the cross-agency staff survey refer to Table 14,Table 15 and Table 16 (Appendix II – *Cross-Agency Survey Themes and Responses*).

## 1.4 Be conducted in child and family friendly locations

Gateway health assessments are often administered in clinical settings, such as hospitals, which can often be very institutional and not child friendly. These settings sometimes have a re-traumatising effect on children and families, impacting the quality of interaction with medical staff during appointments.

> *We've had lots of discussions about where should the Gateway be, where's best for the whānau, for the young person. If we're looking at [our region], we all know that building. It's also the same building that we would take our tamariki and rangatahi in for an evidential video. What's an evidential video? So, if there's been a sexual assault, then a child or young person will go and have a formal video with Oranga Tamariki staff and the police. But that's in the same building, and they can also go there for therapy. They could also in that same sense of physical or sexual assault, go there for a physical examination, which is evidential. So, when we look at that building, it is not fit for Gateway in so many different ways. I just wanted to throw that in when we're talking about looking at alternatives, more appropriate spaces, places, marae, et cetera. That would be for the whole whānau, not just for the medical team and social worker and the rangatahi.*
> *– Senior Advisor Education and Health*

Whānau Māori and Pacific families question whether they can trust the system due to the history of Oranga Tamariki and its predecessor Child, Youth and Family, and also due to negative experiences that other family members have had, particularly with Gateway. Not only is there stigma behind the agency, but the locations in which assessments are carried out.

> *[There is] stigma that whare holds. So, it's hard to get whānau through the room when you're saying, 'oh we're doing a Gateway Assessment', fully explaining what it is but they just won't do it because they know what the place used to be. Well, that place is where you go and get checked out by Police. So, the whare itself [holds stigma]. – Māori Provider*

Health assessments can often require travel to the assessment location, which can be difficult for working families, making it impossible for some to attend, especially for those who need transport assistance or rely on public transportation.

> *They will travel. Some of our whānau come from Tūrangi, which is a good two-hour drive [from] here to Rotorua. So that's a significant ask when we're asking families to travel that far for appointments.*
> *– Practice Leader, Bay of Plenty*

*Whānau can't get to this appointment because it's too far. They don't have a waka to travel in, [and] that's another challenge for our kaimahi here on site. – Social Worker, South Auckland*

In one district, 62 Gateway health appointments were missed by children or young people in a quarter[19]. While reasons these were missed include COVID-19, family accessibility was a critical issue.

*This becomes even more significant when it occurs out of the Dunedin or Invercargill facility as there is the car travel, driving time (for example up to 3 hours each way) and an inability to do other work due to being away from the office.*
*– Provider Narrative Report, Te Whatu Ora, Southern*

In some cases, families require support from their social worker to provide transport to the clinic. If the social worker cannot take the family to the appointment, another social worker (who is not assigned to the family) may step in and take them. The site must then provide more support for social workers to manage these aspects of the Gateway process especially if there are high caseloads.

*[If a] relationship is not there between [a] social worker and the whānau, the expectation for the social worker to transport can be a safety risk and the hospital expecting social worker to transport is not necessarily a safe one. – Social Worker, Canterbury*

Some social workers expressed that the process of arranging health appointments could be better coordinated with health staff to streamline the workload.

*Pressure [is] on social workers to arrange the admin around visits. Responsibility is put on Oranga Tamariki where health should be responsible e.g. letting people know when the [appointment] is.*
*– Social Worker, Taranaki*

Frontline staff across Oranga Tamariki and Health, aware of these obstacles, have suggested changing the service specifications to allow for conducting assessments in local and familiar locations (i.e. Oranga Tamariki sites, community centres, marae, or churches) for families and children.

[19] Southern District Health Board. *Quarterly Report for period 1 July 2021 to 30 June 2022*. Internal document: unpublished.

*A lot of our assessments are done at hospital, and we get the whānau to travel there. You know the accessibility, it would be good to have it in the local marae, in our Pacific churches, you know. Some place that [is] familiar with whānau where they feel safe and able to speak up. Somewhere normalised for children. So yeah, in terms of having a paediatric assessment or assessment done in the cultural setting. Not in the setting that's clinical. So they're able to engage with the whānau or connect with the whānau at the very least anyway, because most of the times when trying to support the whānau - if you can't create the positive relationship or positive connection with our whānau then trying to support them right through the processes will be very difficult.*
*– Social Worker, South Auckland*

However, there are advantages to offering a clinical setting, including proximity to blood tests and radiology if needed, and the equipment required for specialist health assessments. This is why it is important to streamline the service to allow efficient access to health facilities. Having a whānau navigator alongside the process would alleviate some of this workload on both health and Oranga Tamariki frontline.

## 1.5 Ensure information is accessible for families

Information about services and recommendations are sometimes difficult to understand and access.

Part of the service provided by Health New Zealand is assisting Oranga Tamariki social workers in informing families, whānau, and caregivers about upcoming medical appointments. Sending reminder calls or messages and appointment notifications falls under this shared obligation.

This coordination between Health New Zealand and Oranga Tamariki in engaging with whānau is an important consideration to ease the burden on social workers and health professionals. We heard that delivering explanations of the process to families in a manner in which they can understand, inclusive of providing explanation of printed information such as brochures, consent forms and medical information, often falls to the social worker involved.

Following the assessment, a Final Gateway Report is produced. Written by paediatricians or the lead clinician, the report should also summarise needs and provide recommendations for further action.

A copy of the Final Gateway Report is issued to Oranga Tamariki, and the social worker is then responsible for sharing the report with the young person, family, whānau, or guardian caregiver. However, sometimes they don’t get access to the written report, unless they request it.

*I remember being told about the assessment, but don't remember much else. I didn't know I had a Gateway report until I was out of care. – Care Experienced Youth, Wellington*

Some sites do share the report with young people, families, and whānau and allow education professionals to see it while other sites do not. This issue is variable and underscores an important theme about information sharing (refer to section *Provide clearer guidance on information sharing*).

*[The Final Gateway] Report is not consistently reported to whanau although it is directed to Social Worker and family are told to expect a copy. [The] report is long. Most relevant part is the recommendations at the top…would be great to be able to feed back to families [and] invite their involvement with use of trusted community person of their choice, or navigator, or use of Zoom/phone/in-person discussion depending on preference and complexity of recommendations. [We need] more engagement of primary care/NGO partners [and] multiple versions of report geared to audience would be ideal with co-production. – Paediatrician, Te Whatu Ora, Counties Manukau*

In most cases the social worker meets with the family, whānau, or guardian to explain the recommendations made on their behalf and for their child or young person. Social workers have said this is a difficult task because often the reports are lengthy, filled with medical terms and are not written in an accessible way for the family, whānau or young person and with no cultural lens.

*Another challenge for our social workers is that [we] almost need an interpreter or translator […] because you know as much as we pretend that we're paediatricians or mental health workers or counsellors or lawyers, the honest truth is that we just social workers. That could be lost when attending these MDT hui in terms of what does that exactly mean for whānau? And the social worker could go there unassisted and just nod and say "okay, yeah, that sounds good." And then they actually carry that out. And they meet up with the whānau and the whānau might disagree and think that may not provide a solution for the issue or concern for the child […]. On top of a cultural lens [needs] to be applied in that space, when working with whānau. […] If you don't understand [the conversation], that alone is a challenge. – Social Worker, South Auckland*

Additionally, providers expressed their frustration with language barriers and the general lack of cultural competence when Oranga Tamariki works with whānau Māori and Pacific families and communities. Engagements with Māori and Pacific

providers highlighted that English is a second language for many families and whānau are having trouble understanding the terminology and paperwork for the Gateway process.

> *Simplify the language, some of our Pacific families just arrived in Aotearoa. They need to be supported, add Pasifika words.*
> *– Pacific Provider*

By working together with Health New Zealand, community and local service providers could deliver this support to families, in a culturally responsive way, to ensure they understand what professionals and documents are saying. This could further lighten the workload for social workers and clinicians involved.

> *We know that working in silo does not work for us or for our whānau, especially for our tamariki. Therefore, we need our partners to walk alongside [us] together at the same time [in] a shared space not on separate ends of the telephone. That doesn't work. We've seen it. It doesn't work. That's why Gateway[s] fallen over, telephones, emails… we need our partners all together in one space for an hour or two a week so that we can have those kanohi-ki-te-kanohi, because that is where it's important.*
> *– Senior Advisor Education and Health*

# 2. Enhance the process to better meet needs

Findings from engagements and surveys suggested ways of enhancing Gateway to better identify and meet the needs of children and young people. We consolidated these into four sub-themes for this section:

2.1 Include children via hui-a-whānau and those identified by social workers
2.2 Include young people transitioning out of care
2.3 Align the Gateway and Youth Justice programmes
2.4 Address the gaps in follow-up of recommendations

The primary recipients of Gateway are children and young people[20] who are:

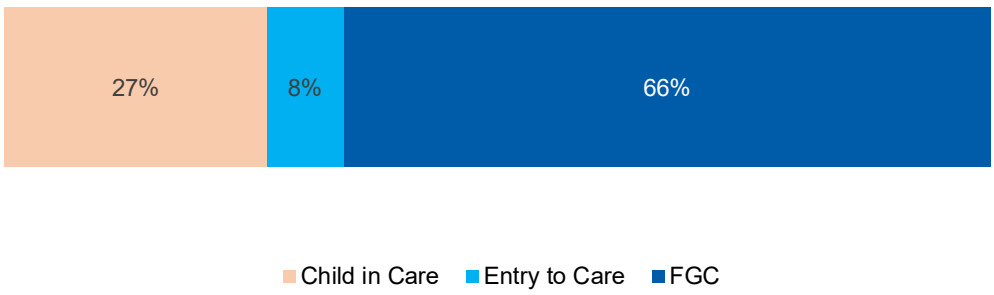
- entering care (Entry to Care)
- at risk of coming into care[21] (Entry to Care)
- already in care (Child in Care)
- attending a Family Group Conference (FGC) under Section 18AAA of the Oranga Tamariki Act 1989

Gateway service delivery may include:

- identifying family, whānau, and caregiver health and parenting needs
- responding to needs by providing information and making referrals to services as agreed with the child and family.

The national breakdown for the 2017 to 2023 financial years is shown in Figure 5. Total number of children and young people eligible to receive a Gateway was 21,931.

**Figure 5. Reasons children and young people are eligible for Gateway services (n=21,931)**




However, only 13,301 from the total count received a Gateway from this period (Table 1). Those referred to a Gateway (i.e. 3708) can either be cases that have

[20] The Oranga Tamariki Act 1989 defines Children and Young People as those between the ages of 0 to 17 years (up to their 18th birthday).
[21] Oranga Tamariki seeks to engage with families through Family Group Conferences (FGC) the aim of which are to avoid Children and Young People coming into care.

remained ‘Open’ as described in Figure 20, or cases that have been referred but are still waiting to have the clinical appointment.

**Table 1. Gateway status category breakdown and count 2017 to 2023 financial years**

| Gateway Status Category | Count | Total |
|---|---|---|
| Already engaged with service | 453 | |
| Completed | 13,301 | |
| Consent not obtained or withdrawn | 344 | |
| Not Referred | 4,125 | |
| Referred | 3,708 | **21,931** |

## 2.1 Include children via hui-a-whānau and those identified by social workers

We heard from frontline staff that the scope of eligibility for Gateway is too narrow, although some areas have worked to widen the scope where capacity permits. Many more children and young people would benefit from the scope being widened.

> *I'm also really excited about the opportunity of a gateway review and what more we can do in that space to expand probably out furthermore into a proactive space of other tamariki and rangatahi who might not be in Oranga Tamariki care right now, but who run that risk of being there and needing the same support and the same response as we're giving those others at the moment.*
> *– Senior Advisor Education and Health*

More specifically, we heard that Gateway should include families who attend a hui-a-whānau[22].

> *We're quite keen to open up to families that are doing Whanau Hui [Hui-a-whānau], rather than just going to FGC.*
> *– Gateway Coordinator, Te Whatu Ora, Northern*

Frontline staff currently employ legislative measures and creative approaches to extend Gateway to children and young people, even when there is no immediate concern for their care and protection. Their intention is to use Gateway as a tool for collaboration and meet the child’s or young person’s health and education needs to prevent an intervention.

[22] A hui-ā-whānau is a whānau meeting using tikanga ways of thinking to assess the needs of a child. The aim is increased focus on early and ongoing engagement with whānau, hapū and iwi.

Social workers utilise Section 18AAA of the Oranga Tamariki Act 1989 to provide for children on the periphery of care who otherwise would be left out of the service. Some children and young people may have been identified to have needs but do not have care and protection orders in place. Rather than close the case, some social workers may try to steward resources to that child and family in need, however complicated the task might be to apply.

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*It is red tape because it has to go through our regional manager, but I make it really clear, that if we don't do this, this is what's gonna probably happen. You're better to push this work now rather than waiting, [because] then we're potentially at a situation where we're having to do more intervention, but it's also about working with the whānau and getting them to understand this is going to help them. Because as soon as you hear FGC people think it's that step-up [fear]. But if we could get involved with Gateways earlier on like in the initial assessment phase, I think we would be doing more service to whānau than we are doing now. – Social Worker Supervisor*

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Social workers verify the child or young person's safety in their family's care while facilitating Gateway to identify their needs and provide necessary support for sustaining their family care environment. The utilisation of s18AAA via a wellbeing FGC is an example of collaborative effort, as it requires engagement with health and education leads.

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*Say for example if you've got a grandmother who's looking after her moko, but her moko, through whatever circumstances has got some educational and health needs. So there's no actual care and protection concerns with nan's care, but there are some things that are happening in her moko's life which will need ongoing support and so social workers have tried to navigate that wellbeing FGC so that there is still some robust support in place under a legal framework which supports our whānau because what we see is whānau will take care of the children. But later on, the children end up coming back to our attention. Maybe because the whānau members are really struggling to care for them and so we're trying to prevent that from happening by really putting in the right support for whānau before it even gets to that stage.*
*– Practice Leader, Auckland*

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Social workers have found this method valuable for children who have needs but are in a stable and safe family environment. The purpose of Gateway becomes to support their needs and prevent them from coming into care.

Widening the scope of Gateway to including families receiving a hui-a-whānau and supporting social workers to strategically utilise wellbeing FGCs via s18AAA has the potential to benefit more children and prevent them from coming into care.

## 2.2 Include young people transitioning out of care

Children and young people technically exit the Gateway service following a review of its recommendations. This typically occurs three months after the ISA is issued and referrals to other services have been made, regardless of their condition or progress. Many cases likely require additional reviews to assess, for instance, if the referred service has been engaged or if the ISA needs adjustments.

A significant issue arises when children and young people referred to Gateway leave Oranga Tamariki custody, ending the Health District's engagement remit. This group and their families require additional support to ensure the Gateway-recommended services are enacted, even if they have left care.

Some care experienced young people, having gone through an assessment process, cannot recall whether they had an assessment follow-up, let alone having access to a recommended service that met their needs.

> *I have severe trauma. As well as all the health needs I'm recently learning about which was not attended to during my time in care. That's just a very brief summary.*
> *– Pākehā Care Experienced Youth, Canterbury*

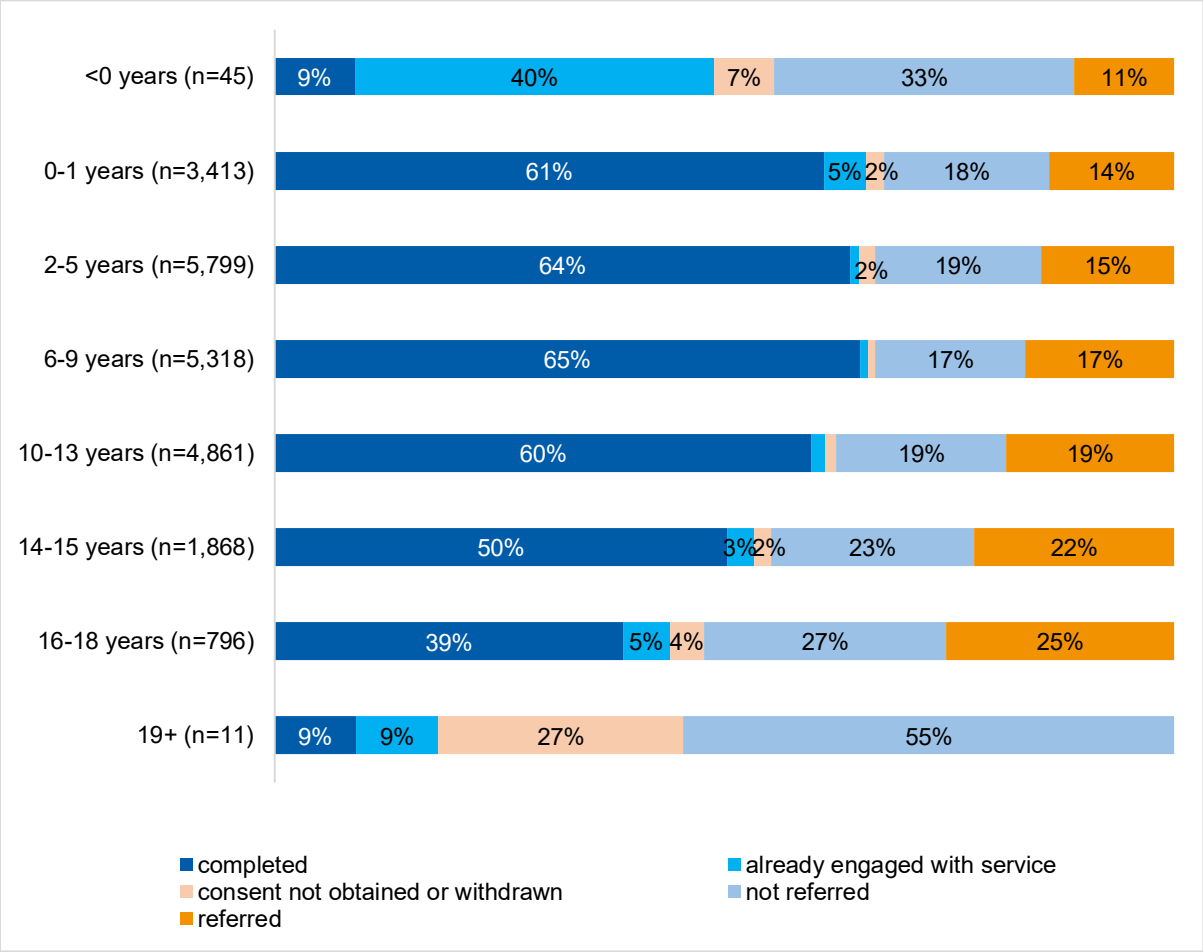
For young people transitioning out of care, typically between 16 to 18 years of age, Gateway concludes once the three-month reviews are finalised and all necessary referrals (with consent) for additional assessment and treatment have been processed and accepted.

While any unaddressed needs due to service gaps should be reported to the local Governance Group[23] and documented in the quarterly narrative report, there is no mandate to continue to provide service to any unaddressed needs for young people transitioning out of care. We see this as a core gap in the Gateway specifications.

Figure 6 shows a decreasing completion rate and an increasing referral rate for age groups above 13 years.

[23] Also referred to as the Local Leadership Group, is a multidisciplinary group that meets quarterly to discuss and resolve issues impacting the Gateway process.

**Figure 6. Gateway status breakdown by age – 2017 to 2023 financial years (n=21,931)**




## 2.3 Align the Gateway and Youth Justice programmes

To give a brief overview of the youth justice system in New Zealand, it addresses the behaviour of children (ages 10 to 13) and young people (ages 14 to 17) accused of committing offences.

Minor offences are often handled by Police through alternative measures, while more severe cases are managed by Oranga Tamariki involving a family group conference for youth justice (YJ FCG). The Family Court and Youth Court may play a role in certain situations.

Our review reveals that the Youth Justice system has a distinct protocol for assessing the educational and health needs of children and young people involved with the Youth Justice system.

The Youth Justice Health and Education Programme (YJHEP) consists of three assessments:

- Youth Justice Education Screen (YJES)
- Youth Justice Education Assessment (YJEA)
- Youth Justice Health Assessment (YJHA)

*So, there are three different assessments that happen in the Youth Justice space. We have a health assessment which requires consent like the Gateway. We also have an education screen which doesn't require consent and then we've got an education assessment. There are also different criteria or eligibility for the health assessment and education assessment. – Senior Advisor Youth Justice*

The YJES screening gathers details about the child or young person's school attendance, academic achievement, interests, and potential health issues that affect learning. It includes their school history and any current or proposed educational plans, which Oranga Tamariki can obtain from schools or the Ministry of Education (MOE) without needing consent from the child, young person, or their guardians.

The YJEA is conducted by educational psychologists when significant concerns are identified. This in-depth assessment aims to discover factors that can enhance the young person's educational or vocational engagement. Recommendations from this assessment, require the consent of the child or young person and their guardians, and are presented at the FGC to guide decisions.

The YJHA is a primary health screening by registered nurses which checks for physical, mental, social, or substance use issues, along with any disabilities. It aims to identify the developmental needs and health risks of the youth, offering recommendations to support their well-being and reduce re-offending risks. Consent is needed from the child or young person and their guardians before proceeding.

Certain children and young people in the Youth Justice system might also qualify for Gateway if they are under the care of Oranga Tamariki due to alleged offences or have pre-existing care or protection orders. The decision between proceeding with Gateway or the YJHEP is made after a case consultation before the FGC, focusing on the most suitable approach for the child or young person’s needs.

For some youths facing charges in Youth Court, a psychological assessment, as per section 333 of the Oranga Tamariki Act, may be required to assess whether further evaluations are needed for any significant findings.

The YJHEP highlights several challenges in addressing the health needs of children and young people involved in youth justice. There is opportunity for a redesigned Gateway to better meet the educational and health needs of children and youth in the care and protection and youth justice systems. Effective use of a redesigned Gateway to coordinate health, mental health and educational interventions could significantly enhance school engagement and behaviour, helping these youths

transition into adulthood[24]. Without such interventions, the youth may face persistent health, educational and social challenges, impacting their long-term outcomes[25].

### *2.3.1 Gateway and Youth Justice assessments share similar challenges*

Similar challenges to Gateway also exist within the Youth Justice assessment procedure. Critical shortages of health assessors and education support was mentioned.

> *We need to review our health assessment programme. There are a lack of nurses or health assessors that are trained specifically to do youth justice health assessments in the various regions. We've also got some work that needs to be done in our education assessment process with MOE. MOE is a specialist in education. They basically take the lead in that process, and whether or not we are able to have psychologists that can do those education assessments in the region, they're really struggling to have skilled people to be able to refer to. There are some regions that don't have any health nurses or education assistance. So a lot of kids from what we know about are actually missing out on those key assessments.*
> *– Senior Advisor Youth Justice*

The YJEA, YJES, and YJHA are primarily conducted within specific Oranga Tamariki sites as part of the YJHEP. When children or young people are in custody and housed in a Youth Justice (YJ) residence or community home, they might still be referred to or be undergoing one of these assessments.

A significant distinction between the YJHEP and the Gateway process is the role of the youth justice coordinator and the process of referral. Referrals are initiated before a YJ FGC occurs. Given the legal requirements[26] to conduct a YJ FGC within specific timeframes, there's a strong push for health assessors and educational psychologists to complete their assessments promptly.

The focus on conducting health and educational assessments early on—right when a child or young person enters the YJ system for an FGC, irrespective of whether the referral came from the police or was directed by a Youth Court—is designed to address their needs from the outset.

The YJ system emphasises immediate assessment and intervention for health and education needs. In contrast, the Gateway process is triggered by concerns about a child's or young person's safety or well-being, leading to care and protection actions.

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[24] Malatest International. (2023). *The four-year evaluation of Oranga Tamariki Transition Support Service*. https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Research/Latest-research/Transition-Support-Service-four-year-evaluation/TSS-Evaluation-report.pdf

[25] Rice, S. M., Baker, D. G., Purcell, R. & Chanen, A. (2024). Offending behaviour and mental ill-health among young people: Reducing recidivism requires integration with youth mental health care. *J Global Health*, *14*. https://doi.org/10.7189/jogh.14.03001

[26] Oranga Tamariki Act 1989 s255 and s259(A)

### *2.3.2 There is regional variation of Youth Justice education assessments*

The process for conducting educational assessments within the MOE framework varies regionally, presenting challenges in the delivery and effectiveness of these assessments for youth in the justice system. Referrals for educational assessments are directed to the MOE Regional Office, where the execution of these assessments and provision of Learning Support can differ significantly.

In some regions, MOE-employed psychologists carry out the assessments directly. Other areas may outsource this to a third party, which then subcontracts independent psychologists. This outsourcing can lead to delays due to the additional layers of coordination required, impacting the timing and effectiveness of FGCs.

Significant delays in the assessment process can result in FGCs proceeding without crucial information, leading to the creation of plans that do not meaningfully address the child's or young person's needs. Subsequent revisions to these plans, incorporating recommendations from later-received assessments, can reveal previously unnoticed needs complicating the situation further.

The availability of educational psychologists varies by region, with some areas facing a shortage. This scarcity can prevent some children and young people who need assessments from receiving them.

Addressing these challenges requires collaborative approaches between Oranga Tamariki and MOE to overcome obstacles, such as the shortage of educational psychologists, by building strong relationships with local service providers.

### *2.3.3 Challenges for Youth Justice assessments include no obligation for follow-up*

The YJHA approach emphasises the involvement of community-based health professionals, distinguishing it from other health assessment frameworks.

YJ site managers are tasked with identifying and contracting health professionals within their communities to conduct health assessments. These professionals must be registered nurses but are not required to be affiliated with any specific organisation, practice, or Health District. They can operate independently.

To this end, various regions have encountered difficulties in recruiting health assessors. Some concerns include:

- perceived inadequate compensation for conducting assessments within the time and effort required
- lack of substantial support and resources from YJ sites for independent health professionals
- lack of comprehensive access to a child or young person's historical health data, crucial for making informed and accurate assessments
- conflicts in recommendations between health and educational assessments complicating decision-making.

The YJHA focuses on identifying primary health issues, with assessors making recommendations for secondary services when necessary. However, there's no obligation for health assessors to ensure these recommendations are acted upon,

under the current setup. This can lead to situations where essential follow-up services are identified but not implemented, much like the gap in follow-up services for the current Gateway process.

### *2.3.4 The MOE participates in the YJHEP but Ministry of Health does not*

The involvement of MOE-employed psychologists or contracted providers signifies a structured approach as part of the broader strategy to address factors contributing to offending behaviours. Education is recognised legislatively as a critical area for intervention, with the understanding that educational disengagement and failure can be both a symptom and a cause of wider social and behavioural issues. MOE's active role in YJ reflects a legislative acknowledgement of the importance of education in preventing re-offending and supporting rehabilitation.

There is a need for Ministry of Health (MOH) involvement in a similar capacity that is currently lacking for the YJHEP. This contrasts with the Gateway process, where the MOH is more involved and MOE involvement is lacking.

Further research is needed to explore and learn from the YJ process and its similarity to the Gateway. From engagements we found that common issues exist across both processes, such as the importance of cross-agency involvement and the availability and appropriateness of health and education assessors who can effectively interact with children, young people, and their families.

## *2.4 Address the gaps in follow-up of recommendations*

Currently an explicit mandate to follow up on the recommendations and whether the child or young person received or continues to receive these services while in care after the three-month 'review' is not required within the Gateway service specifications.

The current situation reveals a lack of systematic data on follow-up procedures. The only data available on follow-up is a ‘tick box’ for initiation of a three-month review. This appears within the Gateway IT Tool, and the GAC initiates this task.

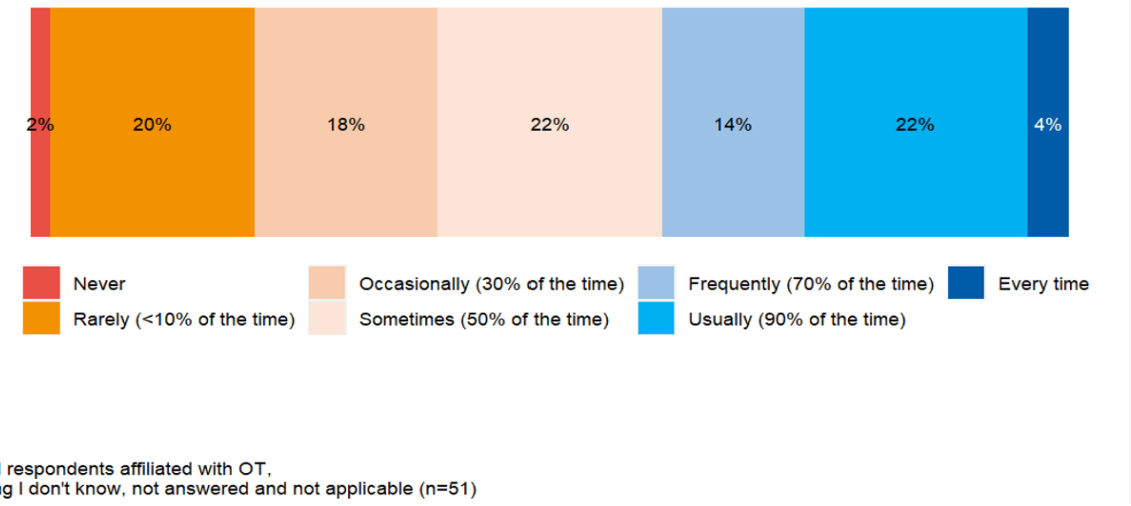
Three months after the ISA is issued, the GAC will schedule a review of the services recommended. Gateway service specifications state the objective of the three-month review is to keep track of developments and, where necessary, update any unfinished business or recommendations. At this time, participating professionals and the GAC may decide that a second review or a revised ISA is necessary or decide to close the Gateway if all tasks have been completed.

> *ISA is approved. […] in three months’ time […] we will review that to see whether engagement has occurred […], and all of the tasks are completed […]. However, meantime, if Oranga Tamariki close, under the current guidance of Gateway, […] we have no mandate to follow that up. – Gateway Social Worker, Manawatū-Whanganui*

Inconsistencies remain as to whether or not the child actually receives the services recommended after the ISA is issued (Figure 7). Responses refer to the question:

*Q: To your knowledge, how often is the ISA followed-up and reviewed?*

**Figure 7. Oranga Tamariki staff perceptions of follow-up after ISA**




Base:all respondents affiliated with OT,
excluding I don't know, not answered and not applicable (n=51)

Responses from Oranga Tamariki frontline staff highlighted the critical issue of follow-up in the process. They also provided suggestions such as engagement of supervisors into this part of the process and providing staff training on the importance of reviewing the Gateway final report and ISA for social workers (Table 18, Appendix II).

The three-month review can be challenging because waitlists can exceed three months or there can be delays in seeking consent for referrals to be made. In some cases, long term supports may be required, or they may only be appropriate once a stable placement is made.

Insights from regional engagement and qualitative survey responses indicate that social workers also conduct follow-ups which are documented in CYRAS[27] case notes. However, some social workers fail to initiate follow-up on critical medical and education service recommendations. This could be due to a lack of capacity, awareness or knowledge of who is responsible for managing follow-up.

> *I have seen that some children have had multiple assessments and recommendations that haven't been followed up because as an organisation we need to be better at communicating from one social worker to the next. I have seen four or five Gateway assessments now on record just saying the same thing with no interventions [having] taken place. – Oranga Tamariki, Psychologist*

To confirm if social worker follow-up is systematic, verification of social worker case notes is necessary.

[27] Oranga Tamariki case management system

*Sometimes there were excellent recommendations made in the report, but when I read the report and follow up, putting the next plan around the kid – some of those recommendations haven't occurred even though the date saying that they would be [followed-up] was quite a long time ago. – Social Worker, Lower South*

There needs to be clearer guidance on who is responsible for following the recommendations and ensuring that service given after Gateway is deemed completed.

Responses on follow-up from health frontline staff echoed similar themes to those mentioned by Oranga Tamariki staff (Table 19, Appendix II). Some GACs and Nurses felt more positive about the process of follow-up suggesting that they were already working together to ensure follow-up was happening in their practice.

We heard similar themes from education frontline staff regarding follow-up (Table 20, Appendix II).

Social workers, clinicians, and provider partners on the frontline have suggested that more robust follow-up procedures would better ensure that a child or young person receives the recommended services. Several points of the Gateway process were suggested to require a follow-up.

Follow-up should happen after an initial Gateway has commenced. This should include checking how the initial assessment went and following up with the child or young person about their experience.

Follow-up should happen after services are recommended and the Final Gateway Report is written and distributed to the social worker to ensure the child or young person is on track to receive the recommended services or take action if a service has not been identified. If there is a lack of service, it should be escalated to the site manager or service provider.

Follow-up should happen after services have been provided to understand whether the service met the needs of the child or young person. It is imperative to document progress on the recommendations to understand what further actions or services may be needed.

Frontline staff agree that this is a concerning gap in the process. Follow-up is required to understand:

- the experience of tamariki, whānau, caregivers who engaged in the process
- whether the service met their needs or to help identify any improvements needed.

Given the challenges with follow-up in the current process, there are significant opportunities for re-design to support practice that is whānau-centred, promote improved health outcomes and earlier intervention. This finding on implementing a robust follow-up protocol is also supported by the Te Puaruruhau review.

# 3. Address the needs of child and family

Findings from the engagements and surveys suggested more services and supports are needed, along with consistent recording of needs data. Seven sub-themes are discussed further in this section:

3.1 Provide better access to services and support
3.2 Address trauma, mental health, and disability needs
3.3 Address health primary care needs early on
3.4 Provide support for neurodevelopmental needs
3.5 Support schools to meet the needs of children in care
3.6 Ensure consistent recording of needs data
3.7 Improve the recording of disability data

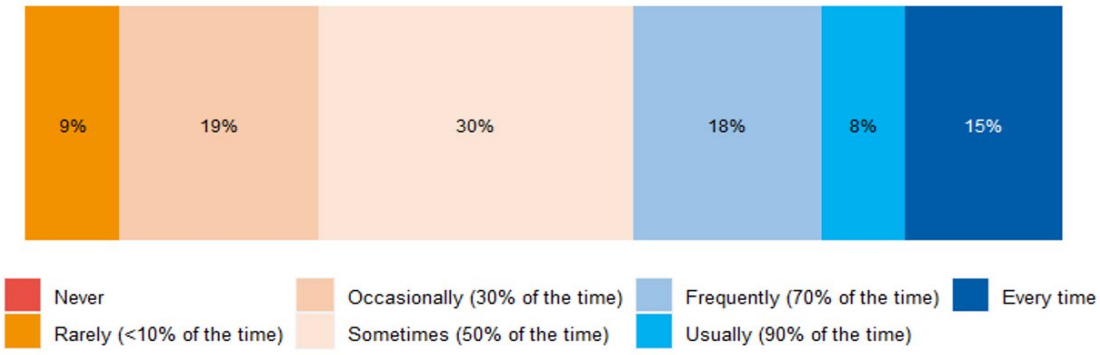
Findings on the gaps in services and supports available align with the recent report *Meeting the mental health needs of young New Zealanders*[28]. Controller Auditor-General's recommendations include working more effectively between agencies on guidance, integrated care pathways and strengthened system leadership to improve youth mental health outcomes.

## *3.1 Provide better access to services and support*

Many regions report insufficient access to required services. Based on all respondents to the staff survey across all regions, 58 percent reported that services were available less than 50 percent of the time (Figure 8).

*Q: When needs were identified, how often are there services available to support these needs?*

**Figure 8. Cross-agency staff perception of service availability**




Base:all respondents, excluding not answered, prefer not to say and not applicable (n=212)

Our review uncovered various reasons for this perception. For instance, critical gaps exist in the provision of mental health, education, disability, and behavioural support

[28] Office of the Auditor-General. (2024). *Meeting the mental health needs of young New Zealanders.* https://oag.parliament.nz/2024/youth-mental-health/docs/youth-mental-health.pdf

services. Moreover, in some rural regions, only a limited number of GPs, dentists, and schools were reported to be available.

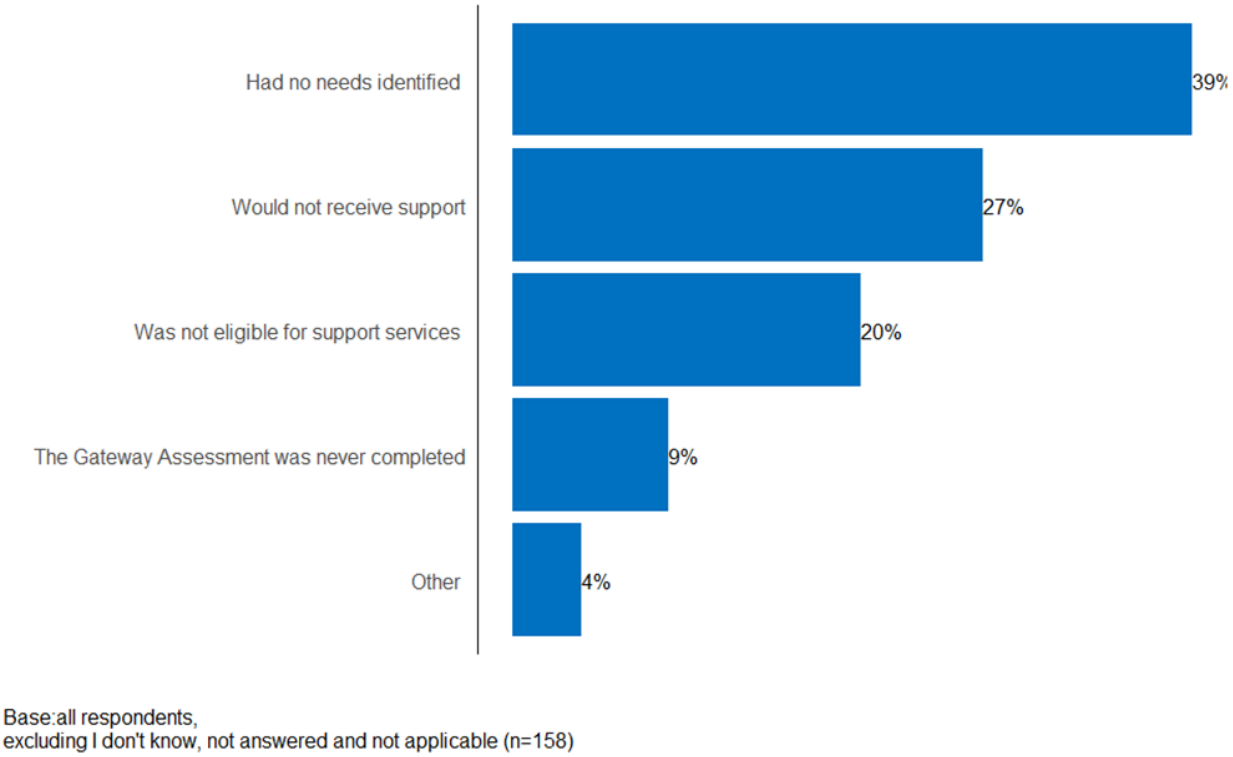
> *Invercargill's quite peculiar in terms of the number of schools, there's just no schools available, it's just like we said earlier on, there's no GPs, even less dentists, I understand. – Anonymous*

However, despite these challenges frontline staff underscored the value of the Gateway, emphasising improvement required and that all agencies involved should make a concerted effort towards addressing these longstanding service gaps.

Figure 9 shows staff perception of reasons why the child or young person didn't receive support after a Gateway was completed. Of the reasons, 39 percent said this was primarily because the child 'had no needs identified' via the process.

*Q: In the event that a child or young person does not receive support through the Gateway Assessment, what might be the reasons?*

**Figure 9. Cross-agency perceptions of why Gateway supports were not received**



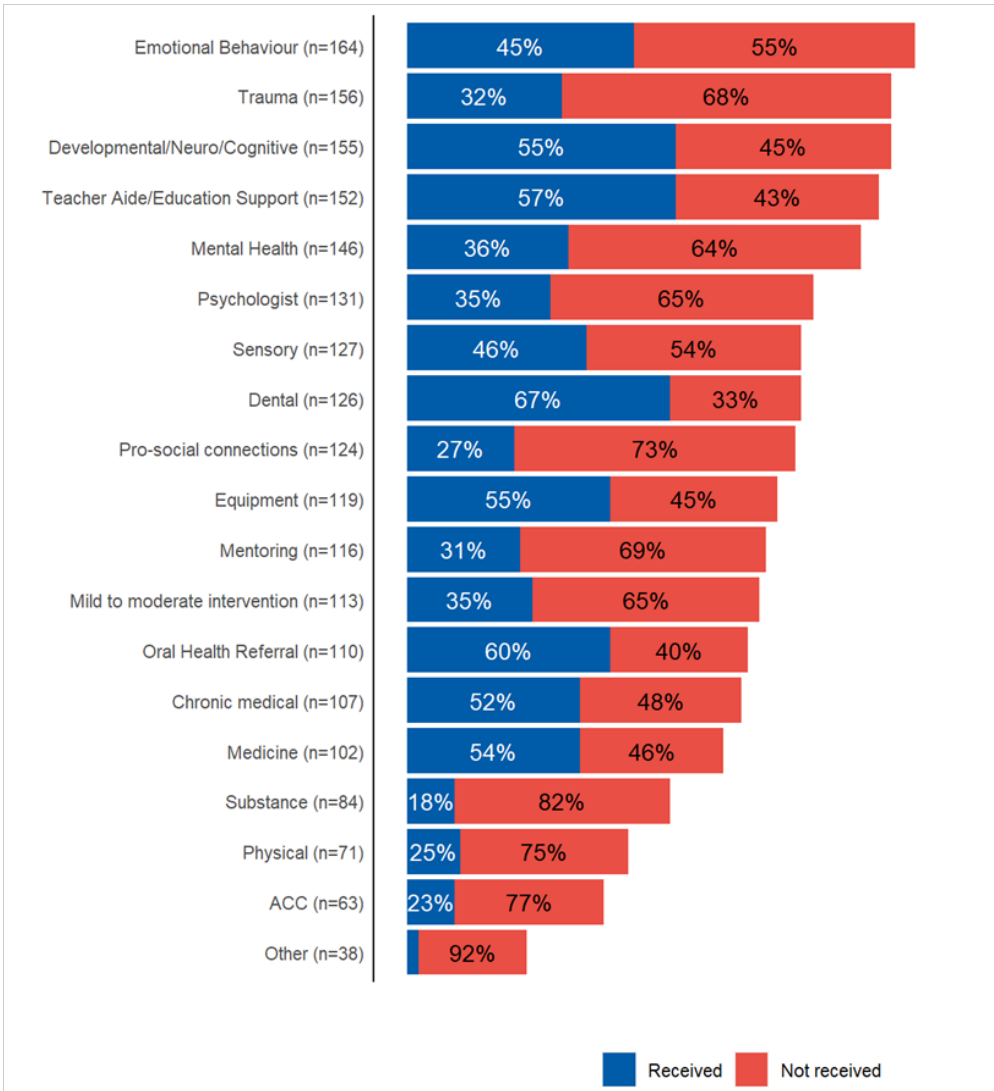

Looking deeper into this finding from the survey, Table 21 (Appendix II) presents some of the quotes explaining why they felt the child *'Had no needs identified'*. Reasons range from their needs were already met to cases being closed prior to follow-up happening. These survey responses align with themes drawn from regional engagements.

Figure 10 visualises results from two survey questions about common needs

identified and whether supports were received. A list of 19 commonly identified needs were selected and the proportion of supports 'received' for that need (in Blue) versus 'not received' (in Red).

*Q: In your experience, what needs have you identified for the child or young person in the Gateway process? And what supports are actually received for the child or young person resulting from the Gateway Assessment?*

**Figure 10. Cross-agency staff perception of needs identified versus supports received**

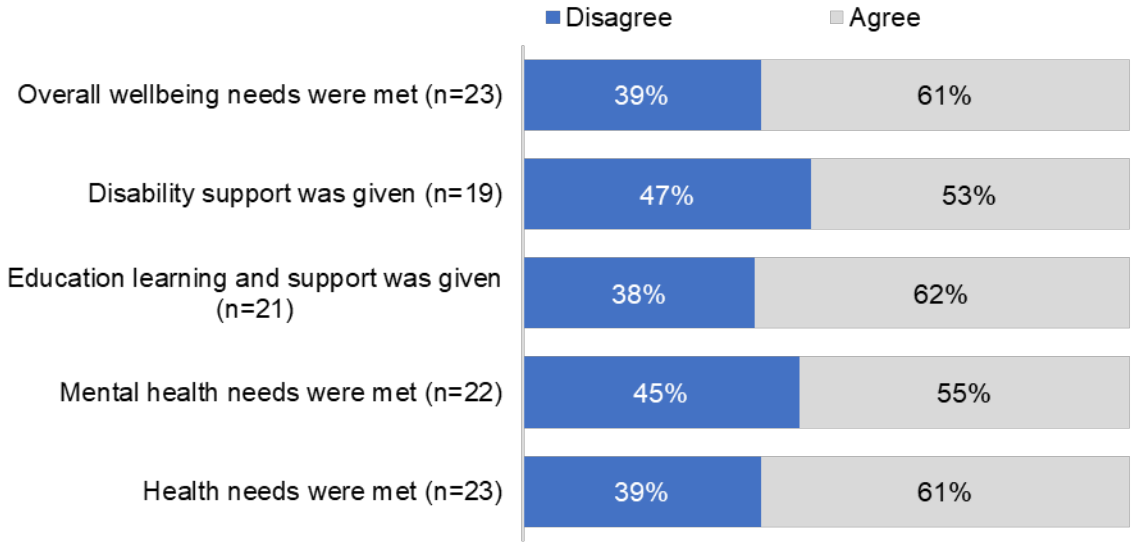



From the above commonly identified needs we can see that gaps exist that are not being met in the current service provision across-agency.

However, family and caregivers' perspectives from the survey suggests a slightly more positive finding. Figure 11 presents the perceptions from family, whānau and caregivers on whether holistic needs were met for the child in their care. Between 53 and 62 percent agreed that the child's needs were met overall.

*Q: We would like to understand how well the child or young person's needs have been met through contact with Oranga Tamariki.*

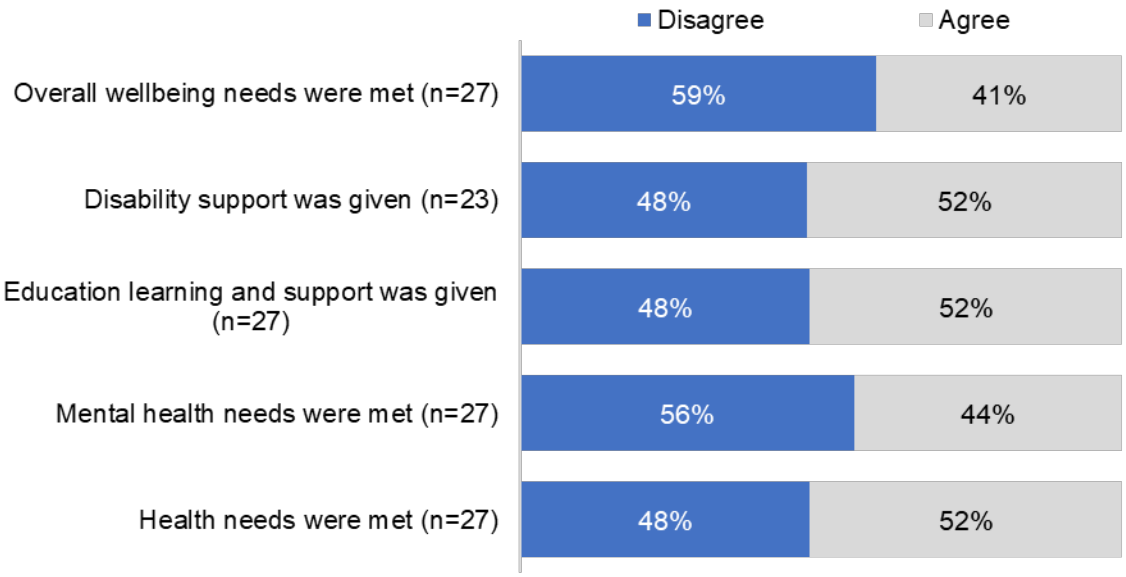
**Figure 11. Family, whānau and caregiver perceptions on needs met for the child in their care**




While Figure 11 suggests a slightly positive outcome from the perspectives of family and caregivers, Figure 12 shows the perceptions from care experienced young people and parents. Results show 59 percent disagreed that their overall wellbeing needs were met during their time in care.

*Q: We would like to understand how well your needs were met through contact with Oranga Tamariki.*

**Figure 12. Care experienced young people perceptions of their needs met**



Considering the population of children and young people involved with Oranga Tamariki are known to have a high proportion of complex and multi-layered needs, it is a critical situation when the child has undergone a health assessment process and does not receive services.

Involvement of community providers in the process, being more suited to overcoming participation barriers with families, could alleviate this pressure by providing much needed wrap-around services earlier.

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*The last thing that you want is people waiting six months for a Gateway assessment only to find that there are no services available to be referred to. – Anonymous*

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For further information on the issue of service availability from the perspective of cross-agency frontline refer to Table 22,Table 23 andTable 24 (Appendix II).

## 3.2 Address trauma, mental health and disability needs

We heard from care experienced youth about their experience of struggle while in care, with some mentioning not receiving enough supports leading them to discover disability and mental health issues later in life.

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*[My] eyesight was only tested 6 months before being 'aged out' of care at 17yrs old - received glasses for vision, and as an adult I have recently found out I am dyslexic. I struggled all through school and was led to believe I was slow due to my level of learning. I am recently learning that I am very likely on the ASD/ADHD spectrum - all my life in care, I was told that I was naughty/troublesome/[had] behavioural problems. I struggle to love and build any kind of relationship with others, I have no sense of stability, I have experienced long-term homelessness as well as long term complex health issues. I feel like I wouldn't have to go through this amount [of] other things, had I had the appropriate support and care. – Pākeha Care Experienced Youth, Canterbury*

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Not every child or young person with a disability has a formal diagnosis but many present with some combination of:

- adverse childhood events (including trauma)
- social, emotional, and behavioural problems, or
- neurodevelopmental issues.

Issues presenting under any of these domains may, or may not, reach the threshold either for diagnosis or for formal treatment and support. Even so, these issues can

give rise to disability-related needs including psychosocial disability[29]. In particular, mental health issues stemming from trauma are widely undiagnosed.

> *I think I should have been regularly seeing a counsellor or even a psychologist whilst under Oranga Tamariki's care. The level of trauma I experienced as a child was severe. Since leaving Oranga Tamariki I have been diagnosed with PTSD and MDD, as a result of my childhood experiences. Had I had known this as a teenager in Care, I could have navigated early adulthood easier with the help of therapy. – Māori Care Experienced Youth*

Across the regions, limited access to mental health services was highlighted and even more notably lacking in rural settings. Frontline engagements noted significant delays in referrals to Child and Adolescent Mental Health Services (CAMHS and ICAFS).

> *Some of the things that aren't working in our region is we have a significant lack of mental health resources here, lack of psychological and counselling services. And the specification limitations on the Gateway service. Although we're stretching them and finding ways around them. They are a bit of a barrier that we try and work through, but yeah, mental health and the psychological counselling services here, sadly, the waitlist are up to three years. – Practice Leader, Bay of Plenty*

Some regions are dealing with the shortage of mental health services by working with community providers, such as Kia Puāwai, Adventure Development Therapy (ADL), Functional Family Therapy (FFT) and other local providers.

> *We refer to Adventure Development down here which is for teenagers. […], but if they get declined, that is quite often because it's a Gateway child. They do have a lot of high needs, so when we refer to them, they say to us, "we think they're too high needs for our service." So they'll ask us to refer back to ICAFS and sometimes even having heard them say that [they] will refer [the child] to ICAFS, and then, ICAFS will accept them… we refer them on to mentors like youth mentors. But the main services we would try, and use would be ICAFS or Adventure Development or get them seen by FFT . – Gateway Coordinator Clinical Nurse, Lower South*

[29] NSW Health. (2023, February 6). What is psychosocial disability? https://www.health.nsw.gov.au/mentalhealth/psychosocial/foundations/Pages/psychosocial-whatis.aspx

It is prevalent for children and young people involved with Oranga Tamariki to be declined services due to the large proportion having multi-layered needs.

For the Lower South region, from 1 July 2021 to 30 June 2022, a total 299 appointments were made for Gateway. The main area of referral has been to primary mental health services (approximately 66 percent of the children seen by Southern Health District) through Gateway for this region alone. Referrals to mental health services surpass referrals to see GPs (35 percent) and paediatrics (12 percent).

The following quote highlights the lack of services for mental health support and getting the right supports for issues that underlie emotional and behavioural challenges. Local providers (i.e. Mirror Services) are being utilised to fill this gap.

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*I would have to say it's quite tricky cause anything that might have an emotional tie [is] tied to behaviour. Because we don't have a lot of mental health support down here, that's probably the trickiest area. But if they're on the wait list to be seen by CAFS for a behavioural problem, well I suppose it would be more emotional for CAFS, but there's a lot of behavioural stuff that comes along with that, we do have Mirror Counselling service and our Mirror Councillor does try and work on a lot of behavioural strategies with the young person. – Gateway Coordinator Clinical Nurse, Lower South*

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We also heard from a GP about the importance of paediatricians appreciating the trauma experience, especially when working adolescent age groups. She suggests many clinicians give a diagnosis without fully reflecting the young person's background. The GP interviewed also expressed the need to include the child, young person, and family's voice in the process of assessment and recommendations.

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*I think the teenagers are kind of complicated. Because they have now got a lot of history. […] They've also got a whole lot of so-called mental health files, […]. They've ended up with a whole lot of letter labels, you know, ADHD, […] But they've also got their own point of view. And I go to a lot of bother to try and understand their whole timeline which [some] roll their eyes at me for trying to make sense of it because for me, it's trying to work out what happened when. It's actually quite important and I've had some conversations with some family members too. Where kids go in and out of their whānau and then into kin or non-kin placements and the communication across those timelines is very varied and they're understanding, and the kid doesn't know stuff and the whānau don't know stuff that happened when they were in different placements. So, there is often a real need to understand where and what happened when in those different places. And sometimes when you take the big picture lens to it you can actually start to work out that actually, back then was someone's sort of idea that maybe that was the diagnosis, but it was*

*just a trial medication and a possibility that that could be the condition and by the time we got to the next placement, it was an official diagnosis. And the kid was now permanently labelled. – General Practitioner, Te Whatu Ora, Manawatū-Whanganui*

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We heard that it is necessary to view the child holistically, within the context of their family, whānau, and who they are as individuals, rather than being deficit focussed. Clinicians must consider how the child or young person has coped with their situation, in a mana-enhancing manner.

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*The description of a kid's behaviour at the time is not a diagnosis. We all have trauma. We're allowed to have trauma. Trauma is normal and our responses to trauma is how we get through it. But we've got to recognise that the survival of trauma could become kind of a chronic response. And working out when we have this kind of [response], to stop assuming that that's a condition. And to me, there are parallels with intergenerational trauma as well. I need to be strength based when I'm working with young people. And I can always find the positives. So, I think the young man that you know stormed out on me. I know that he's incredibly intelligent and he can hear perfectly well. – General Practitioner, Te Whatu Ora, Manawatū-Whanganui*

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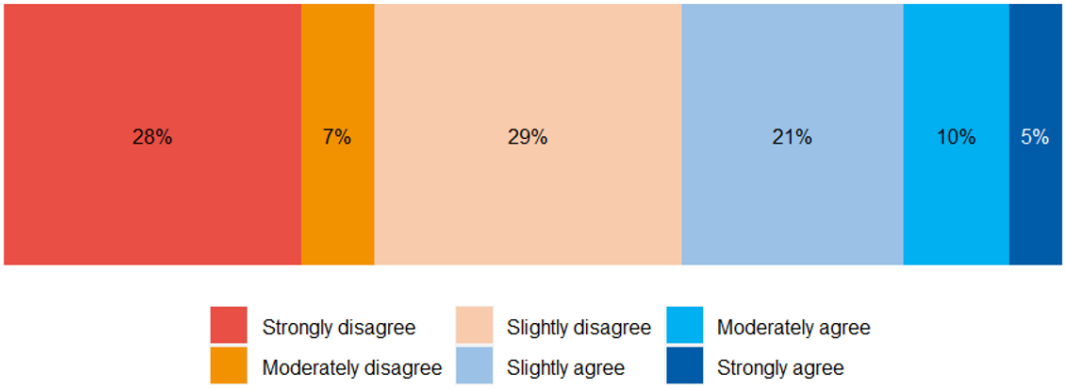
The ongoing response to trauma can be challenging, particularly within the short time frames for the Gateway process, as well as the often complex and challenging living situations for children and young people in care placements. For many, trauma is something that is better worked through once they are in a stable, caring environment, and at a stage in their lives when it is possible to engage with the trauma they are experiencing.

Findings from the cross-agency staff survey also validate the gap in trauma supports provided. Figure 13 shows 64 percent from cross-agency frontline (n=114) generally disagreed that enough support was provided related to trauma identified needs.

*Q: Please rate your degree of agreement to the following statement. The Gateway process and related support services meet the needs of children and young people who have experienced trauma.*

**Figure 13. Cross-agency staff perceptions of trauma support provided**




Base:all respondents, excluding I don't know, not answered and not applicable (n=114)

Findings on the needs gaps pertaining to mental health, trauma, disability and behavioural needs are also validated by the survey responses from education sector frontline staff (Table 22,Table 23 andTable 24, Appendix II).

## 3.3 Address primary health care needs early on

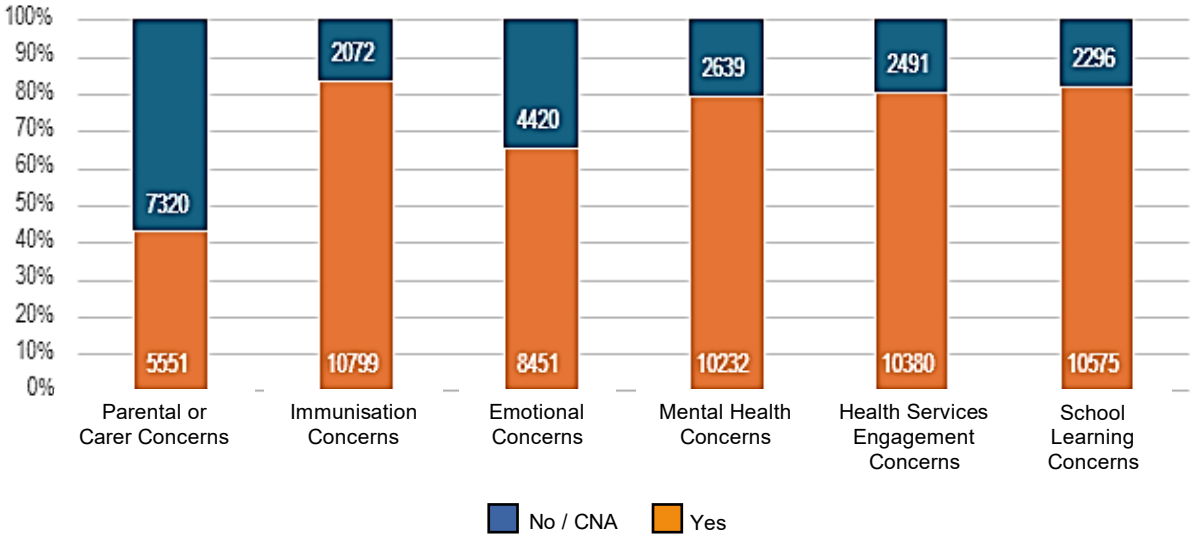
Gateway identifies a child or young person's primary health needs as a starting point, including whether treatments are required for dental care, eyesight, and hearing. However, not just primary care needs are identified through the Gateway process. Many needs identified at the primary care stage require referrals to specialist care and even to services from community providers.

Figure 14 gives a breakdown of the most commonly identified needs specific to primary care and those identified that may require a triaged service pathway (i.e. Primary care, Specialist care, Community provider – refer to section *Needs Codes Data*), for completed Gateways between 2018 to 2023 financial years.

For example, Immunisation and Health Services Engagement and to a certain extent Mental Health are concerns that are addressed by primary care, while Parental / Carer and Emotional concerns could be addressed by community providers. School Learning concerns are addressed by Ministry of Education Service Managers or education partners.

Referring to Figure 14, 'Yes' signifies that the need was assessed which suggests the child received a recommendation for that need as a result of their Gateway; 'No / CNA' refers to 'Not Assessed' or 'Could Not Assess' suggests there were needs identified for which a recommendation was not given due to various reasons (i.e. lack of time or follow-up, specialist availability, or left blank – no data found).

**Figure 14. Commonly identified needs categories for completed Gateways 2018 to 2023 financial years**




As mentioned, the Gateway process can be long and culminate in over-simplistic recommendations. In the context of primary health, we heard that Gateway often identified issues that could have been treated earlier by a visit to the local nurse[30].

> *We need nurses on all our sites […]. They can ask - have they had their immunizations? Have they done this? Have they done that? That little stuff is a lot of why we do Gateway. The stuff that actually doesn't need to go to Gateway. – Senior Advisor Education and Health*

To this end, three sites in South Auckland and one site in the Bay of Plenty have begun to streamline their primary pathway by staffing a nurse or Gateway Social Worker Liaison to work alongside the assessment to schedule appointments and administer check-ups (refer to *Gateway Innovations Making a Difference*).

> *A streamlined primary health pathway would ease the number of referrals being made to specialists for health issues easily treatable by primary care nurses. In turn, this would ease the demand on specialist resources, which are limited, especially in rural areas. So what we're seeing is kids that really need referrals on to specialist services like maybe ear, nose and throat or audiology, they're not actually able to get into GP appointments to get the referral that gets them on the wait list for those clinics. So, we have a huge need in our community to be doing things a little bit differently.*
> *– Practice Leader, Bay of Plenty*

[30] Oranga Tamariki Quarter 3 Performance Report 2022/23, pg 14.

A streamlined primary pathway is already happening in some regions, but it is inconsistent across the motu.

While primary and specialist pathways may be able to address health related issues, other needs commonly identified (i.e. Mental health, trauma from abuse, or homelessness) may be best addressed by engaging with a community provider.

Providing a streamlined primary pathway for Gateway as a starting point would:

- ease the number of referrals to specialists for otherwise highly treatable issues via primary care nurses
- support an ongoing health relationship with a primary care provider
- enable access to community primary care providers that are more responsive to the needs of these children, young people, and whānau.

The examples we found of triaged practice and collaboration happening in spite of the existing challenges are what makes the Gateway a valuable service. By learning from these examples to assist the process of streamlining primary care pathways across the regions could drastically increase utilisation of Gateway.

## *3.4 Provide support for neurodevelopmental needs*

Many of the paediatricians we spoke to have specialist capabilities in assessing developmental needs, as well as understanding the complex relationship between trauma and developmental needs. This is a strength of involving paediatricians in the process, particularly given the prevalence of developmental needs among the population.

Neurodevelopmental assessments are often recommended, but the delay in accessing these can be a significant cause of stress. Publicly provided neurodevelopmental assessments are very limited, and cost is a significant barrier to accessing these assessments.

Developmental delay as a disability suggests a lifelong impairment which may include mild to severe developmental difference. However, for children and young people with milder symptoms, developmental delay can be difficult to diagnose. Developmental needs falls under the category of learning and behaviour needs, which was mentioned as a gap in the Gateway.

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*I also think bringing in that neurodiversity, neuro-disability lens to Gateway has been extremely important. So many of our young people that come through these doors are not one thing or the other thing, right? I think we can get really fixated on "it's trauma or it's this or it's this". And I think so many of our young people are not pieces of this or that, we've got trauma and neurodiversity and mental health and these things compound upon each other. If we're not looking at that very holistic lens then we're missing some key aspects. So being able to offer those sorts of neuropsychological, neuro disability kinds of assessments within the Gateway on the*

*same day, has been super important for the whānau and the tamariki. – Clinician, Te Whatu Ora, Northern*

Allied Health is a key part of the response to developmental needs, including Speech Language Therapy (SLT) and behavioural supports. During engagement we heard that more could be done to include a range of allied health supports in the process, including SLT engagement in the assessment process.

This has been piloted in Auckland at Te Puaruruhau[31], where SLT was used as part of the triage process and identified children and young people with clinically significant communication difficulties, the majority of whom had not accessed SLT services. Based on this trial, we have evidence on the value of SLT engagement in the Gateway process. The pilot also developed resources that could be usefully shared with other practitioners, including the development of communication passports for those with speech and language challenges, and training modules.

While valuable, these supports and services are limited and accessing them can be a challenge with significant wait times, particularly through the public system.

## 3.5 Support schools to meet the needs of children in care

Several gaps identified relate to the challenge of schooling for children and young people in care or on the periphery of care. In terms of support for school, tensions exist between Oranga Tamariki, MOE and schools, and the child or young person.

*I work in the children-in-care team, what tends to happen is that when the child is misbehaving or being a little bit difficult in class then because they [schools] know they're in our custody, they go straight to request for student aide funding […]. So, we are getting a bit more involvement with RTLB. But it's for those kids where RTLB has been exhausted. They're onto their sixth round of student aide funding and we just can't go anywhere and it doesn't meet the criteria for the MOE to step in and do something. The child's diagnosed with ADHD and has medication, so there's nothing more that health is able to offer and its specific within education and then the kid's behaviours are just becoming more and more complex. But they might not be quite at the level to get a high and complex needs plan in place. So, they're sort of just in limbo.*
*– Senior Practitioner, Lower South*

[31] South Auckland Social Wellbeing Board (2023). *Te Huarahi Ngaa Tahi: Connecting Pathways* [Prototype learnings report]; Viner, A. (2022), *Review of Te Puaruruhau (Auckland) Gateway service*. Puawaitahi.

In many cases, children and young people in care have multilayered needs, disability due to trauma[32], emotional trauma, and may be frequently absent from school or severely behind in their learning. We heard that communication of needs with school is not consistent, which is critical for schools to be able to provide adequate support.

> *I think any need that's a current need for the child needs to be communicated to us – learning yes, absolutely. But also, social, and emotional […], if we don't know these needs, it's hard to put support in place for the child, but also for those around them as well. I mean as you know, some behaviours trigger other students, et cetera. So, if the proper clear picture isn't painted for the school, the risk is too high. – SENCO, Auckland*

In addition, there is the challenge of negotiation of responsibilities and communication between the social workers, RTLBs and school.

> *If children are behind in their learning and it may be because they haven't been at school, allowing them to be at school with really good teachers is what they need to be able to make the progress. They're still behind, bringing an RTLB in or throwing a specialist at them isn't going to magically fix them. And sometimes things that are offered are not necessarily the best placed, so I'd also like to advocate that people understand each other's roles. And that in education you know, we're meeting children where they're at and then we're progressing them and growing them. And if a student is behind, if they're making normal progress, they're going to be behind for a little while as they make their normal progress and climb that ladder […]. So, I guess roles are really important. – RTLB, Auckland*

Many schools are not equipped to handle this and require additional resources. Obtaining funding for teacher aides was mentioned as another challenge.

> *What I find with schools is that their ability to fund what they need to fund is quite [limited] schools and MOE, they are not always on the same page when it comes to funding young people.*
> *– Social Worker, Auckland*

We heard from frontline staff that some schools would not accept a child or young person associated with Oranga Tamariki due to stigma about the needs and

[32] Trauma can affect memory, cognition, emotion and behaviour in a disabling way. See: Tumlin, K. I., Crowley, A., Turner, B., Riley, E. & Lyons, J. (2023). Detection of traumatic stress in the presence of traumatic experiences: the role of resilience factors in foster care children five years or younger. *International Journal of Mental Health Systems, 17*(39). https://doi.org/10.1186/s13033-023-00610-w

resources that child may require. We heard about some young people being stood down from school, partly because the school could not access the resources to support them.

Care experienced youth say the stigma associated with being in-care impacts their experience at school.

> *Just normalise kids in care so it's not an uncomfortable topic when talking amongst your peers. – Māori and Samoan Care Experienced Parent, recalled having Gateway, South Auckland*

Engagements with local service providers emphasised the importance of giving the child or young person the learning, mental health, therapy or emotional supports they need early in their school life. They stressed that these interventions were crucial for supporting better life outcomes for them.

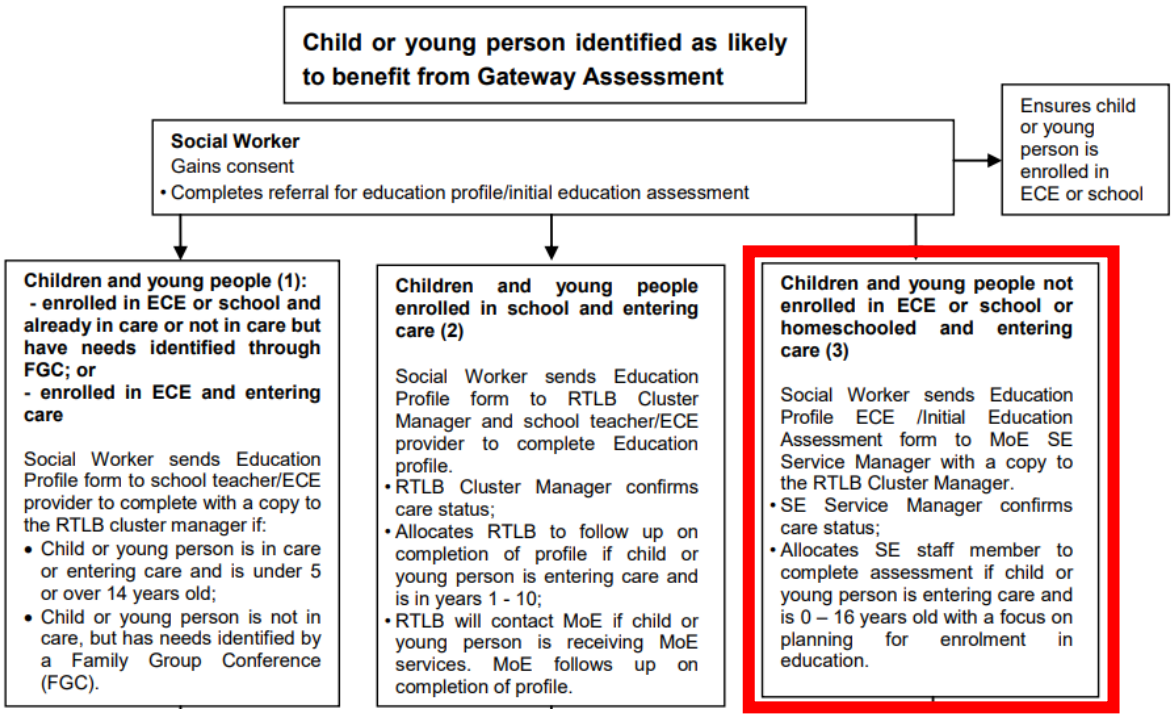
> *Look at the community the child lives in … What supports are in that community... Target the support to what can be given in the community, especially rural communities […]. These kids get one shot in life, and you can provide the resources to support them through the tough times they have experienced […]. The issues don't sort themselves out. Quicker intervention is needed. – Education Support Provider, Lower South*

Figure 15 shows the MOE protocol for Gateway and gives a brief description of responsibilities for social worker and education roles involved. Under these guidelines the social worker is responsible for gaining consent and referral for the education profile.

For children under school age, an Early Childhood Education centre (ECE) is only contacted if the child is enrolled in ECE. If the child is not enrolled (which is usually the case), the social worker contacts an RTLB who liaises with an MOE Service Manager (MOE SE) directly responsible for the education-related needs of children under five not enrolled in ECE[33]. We did not hear of any engagement with an MOE SE about these needs. Our review reveals that learning needs for very young children in care remains a gap.

[33] Ministry of Education. (2013). *RTLB Gateway Guide.*

**Figure 15. Ministry of Education – Gateway assessment flowchart**




## 3.6 Ensure consistent recording of needs data

High quality needs data is required to understand and meet the needs identified through Gateway. Currently needs data is not consistently recorded, making understanding and reporting on needs identified through Gateway difficult.

We reviewed the surface-level aspects of the Gateway IT Tool and liaised with GACs about the data discrepancies found between the Integrated Analytics Platform (IAP) and the tool. Discrepancies were primarily due to coordinators not entering structured data, meaning needs codes are being omitted from records. This is likely a result of challenges with the codes and usability of the system.

Missing structured needs data compromises most reporting on Gateway needs. The inconsistency of needs coding also results in varied interpretations and coding outcomes from the data. This will continue until remedial actions, such as proper frontline training and data quality enhancement on the IT Tool, are undertaken.

Through IAP data analysis, we identified further gaps in coding practice and multiple issues around the recording of needs. The impracticality of the existing needs codes list is likely the biggest reason why GACs fail to input structured needs data. GACs noted they do not input the needs codes because the list is lengthy, difficult to use, and contains redundant categories of needs.

Another reason could be the lack of services available to address the identified need. Why input complex needs codes for each Gateway report when those streams of specialised services are simply not available for the child or young person? This highlights the need for a community of practice among Gateway practitioners, specifically for coding needs in reporting and potentially a revamp of the tool itself.

Another issue is that reporting inconsistencies are prevalent across agencies. The reporting measures employed by Health Regions[34] and Oranga Tamariki can vary significantly, further complicating data matching and reconciliation efforts. For instance, the criteria for considering a Gateway 'complete' differs across Oranga Tamariki and Health Regions, leading to inconsistencies and potential delays in case closure. Investigation is required to determine whether these discrepancies hinder referrals or access to specialist services for children and young people.

We found potential for data mismatch between formal and funding reporting. Service agreements with Health Regions report that a Gateway is deemed delivered once a Final Gateway Report and ISA is uploaded into the Gateway IT Tool for administrative purposes. However, this does not align with the actual practice definition of what a 'completed' Gateway is. This discrepancy may lead to funding mismatches and does not account for follow-up processes undertaken.

Table 2 shows approximately 25 percent of Gateways completed between 2018 – 2023, did not have structured needs data associated with them. The regional variation by Health Region likely requires investigating.

**Table 2. Completed Gateway assessments with no needs data recorded**

| Financial Year | Completed Gateways with No Structured Needs (Count) |
|---|---|
| 2018 | 189 |
| 2019 | 403 |
| 2020 | 296 |
| 2021 | 564 |
| 2022 | 487 |
| 2023 | 648 |
| 2024* | 351* |

**Count does not represent a full financial year.*

## 3.7 Improve the recording of disability data

Accepted definitions of disability[35] are poorly operationalised in the administrative data. Accessible structured data is limited and, where it is available, does not align to disability concepts. The recognition of specific disability related needs and documentation is a complex problem across Oranga Tamariki. Currently, the agency does not have a method of identifying different disabilities among children or young people in care. As such, knowledge about disability prevalence within the care population is limited[36].

[34] Previously known as District Health Boards (i.e. DHBs), which are local regions currently under Te Whatu Ora – Health New Zealand
[35] Such as those given by the UNCRPD or New Zealand Disability Strategy
[36] Oranga Tamariki - Ministry for Children. (2020). Children and young people with impairments. https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Research/Data-analytics-and-insights/Children-and-young-people-with-impairments.pdf

Potential identification of the disability population involved with Oranga Tamariki can be gathered through existing data from the Integrated Data Infrastructure (IDI) regarding the payment of cross-agency social supports. These are the:

- Child Disability Allowance (CDA) – Ministry of Social Development (MSD)
- Ongoing Resourcing Scheme (ORS) – MOE
- Disability Support Services (DSS) – MOH

The primary challenge linked to data from administrative sources is that it only captures the needs of children and young people that are recognised and addressed through their interactions with services. It overlooks those whose needs are either unidentified or unmet, including those with undiagnosed conditions, those who do not qualify for financial support or those who need to be engaged with service providers.

Previous evidence suggests that these indicators point out areas where there may be a greater need rather than encompassing all existing needs. For instance, the number of families with disabled children facing financial difficulties may surpass those receiving income support due to differences in service availability and issues such as eligibility, accessibility and avoidance of stigma.

Findings from previous evidence echoed findings from our regional engagements. For instance, not every disabled young person will have accessed the aforementioned services. Some may receive general health care from Health Regions or alternative organisations such as the ACC for disabilities stemming from accidents or injuries. Again, some people may have yet to use services for various reasons, such as not being aware of them.

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*I think our young people might have quite significant unmet health and neuro-disability needs and we found in our cohort that we just have really, really, really high rates of disability.*
*– Clinical Nurse Specialist, Te Tai Tokerau*

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# 4. Integrating the system across agency frontline

Our engagements and analysis identified Gateway's system enablers that support service delivery, which have been consolidated into the following seven sub-themes:

4.1 Address funding and utilisation issues
4.2 Provide clearer guidance about information sharing
4.3 Reduce barriers to family involvement in Gateway
4.4 Address issues with education profile completion
4.5 The Gateway IT Tool is crucial and needs significant improvement
4.6 Improve the function of cross-agency governance
4.7 Clarify and improve accountability on roles and responsibilities

It is crucial for Oranga Tamariki to work with service providers at a local level to ensure their delivery methods are integrated and cooperative. This encompasses the entire process, from when a child or young person is referred through to follow-up of final recommendations. Ideally the Gateway programme should also keep track of whether their needs are fully addressed.

Several principles have guided cross-agency collaboration for Gateway:

- The wellbeing, interests, and safety of children and young people are the central focus
- To behave with integrity and trustworthiness
- To communicate clearly and promptly
- To exchange information within legal bounds, prioritising the child or young person's best interest
- To cooperate and work together constructively
- To acknowledge and respect the diverse strengths and approaches among health professionals, educators, and social workers while honouring each organisation's duties
- To promote excellence and innovation in pursuit of beneficial results

The regional engagements captured examples of good collaborative practice across agencies and the frontline (refer to section 9.1 *Effective Multidisciplinary Collaboration*). They emphasised the need for on-the-ground multidisciplinary personnel to collaboratively address the needs of children and young people.

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*I definitely think that the multidisciplinary approach that we've taken on here with nursing and Paediatrics and myself and our new role with the Navigator, I think that in itself is massively important. […] it's much more of that kind of holistic assessment for that young person versus having to then sit on different wait lists and different services and all of those things […]. Those relationships and working together is probably one of the biggest strengths that I can speak to the gateway service up here. […] to make sure that we're doing the best thing for that young person is clearly paramount.*
*– Clinician, Te Whatu Ora, Northern*

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Despite being designed to support collaboration, we could do more to enable frontline cross-agency collaboration and integration.

> *Sometimes the processes are a barrier. […] how we get those referrals, how we still have to rely on the IT tool, how we still have to get consent, it still has to come through Oranga Tamariki in some way. Sometimes those are more of a barrier than a support, because support services should actually support rather than be barriers. […] Otherwise, totally agree with the great mahi that we do and the good relationships that we have. We know each other. We pick up a phone, we talk. – Clinician, Te Whatu Ora, Northern*

However, we also heard that many barriers could be overcome by:

- Having people who support local governance and networks as part of their role, e.g. Gateway Liaison Social Workers, GAC, or Gateway champions. These roles support local networks, innovation, and improve monitoring and accountability.
- Strengthening collaborative relationships between respective departments and professionals involved across Oranga Tamariki, MOE and MOH and other agencies such as Whaikaha and ACC.
- Embedding community partners and local service providers into the process.

Further description on current practice examples that provide solutions forward are presented in the section *Gateways Innovations Making a Difference*.

## 4.1 Address funding and utilisation issues

Funding and utilisation present two separate issues for Gateway:

1. Partner Providers are underfunded to complete Gateway assessments.
2. Utilisation of Gateway (i.e. number of Gateways completed) is impacted by several factors which require national-level agency attention.

Between the 2018 to 2023 financial years, Gateway cost an average of $3.75 million per year. The majority (65 percent) was spent on employing GACs, with the remainder (35 percent) allocated to the payment of Gateway Health and Education Assessment Services. Table 3 gives a breakdown of contractual spend expected under each tranche of funding for 2023/24 financial year.

**Table 3. Oranga Tamariki Gateway Costs for 2023/24 Financial Year**

| 2023/24 Financial Year Breakdown | Costs | Percentage |
|---|---|---|
| Gateway Health and Education Assessment Services | $1,363,167.97 | 35% |
| Gateway Health Assessment Coordination | $2,531,351.64 | 65% |
| **Grand Total** | **$3,894,519.61** | **100%** |

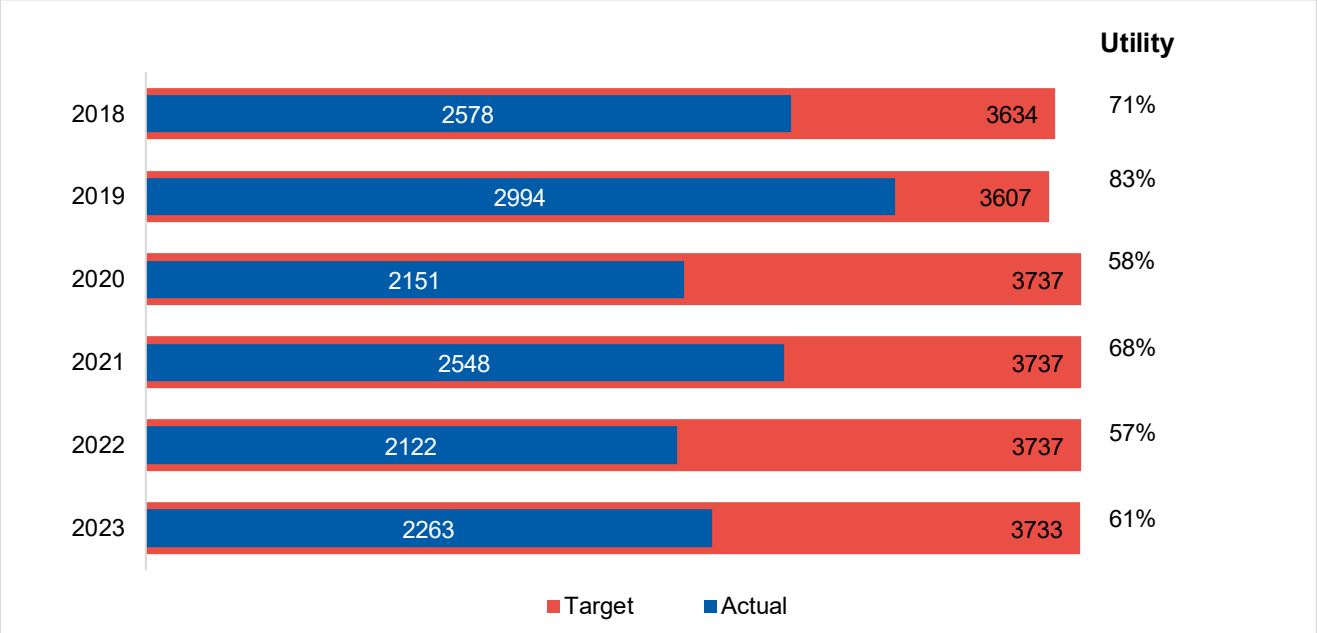
Some Māori providers have expressed feeling under-resourced and believe that increasing funding will contribute greatly to their ability to support tamariki, rangatahi, and whānau. Some providers have had to re-think whether it is worth providing the service.

> *Gateway is significantly under resourced for what it is charged to do. This has forced [us] to review the viability of providing the Gateway Assessment service. The journey from referral to completion is not reflected in the funding arrangements. Court appearances, attending FGCs and whānau hui, tracking whānau is all mahi over and above what Gateway funds. – Māori Provider*

Figure 16 gives an overall picture of Te Whatu Ora national utilisation rate according to Oranga Tamariki cost data. It shows the expected target total versus the actual number of Gateways utilised. The yearly national average utilisation rate ranged from 57 to 83 percent across. We heard that COVID-19 has had a significant impact throughout the period after 2019 and the data reflects this.

According to Oranga Tamariki contract data and utilisation rates by Te Whatu Ora health region, between 2018 to 2023 financial years the average expected target count amounted to 3698, versus an average of 2443 actualised Gateways delivered on a yearly basis for the six years.

**Figure 16. Target count and utility rate of Gateways delivered 2018 to 2023 financial years**




For 2023/24, the regional utilisation rate ranged from 28 to 117 percent of target volume (refer to Figure 41, Appendix V – *Gateway Regional Utilisation*). We can see that Gateway is highly utilised in some regions but not others. As previously mentioned, this is attributed to complex factors such as gaining consent from

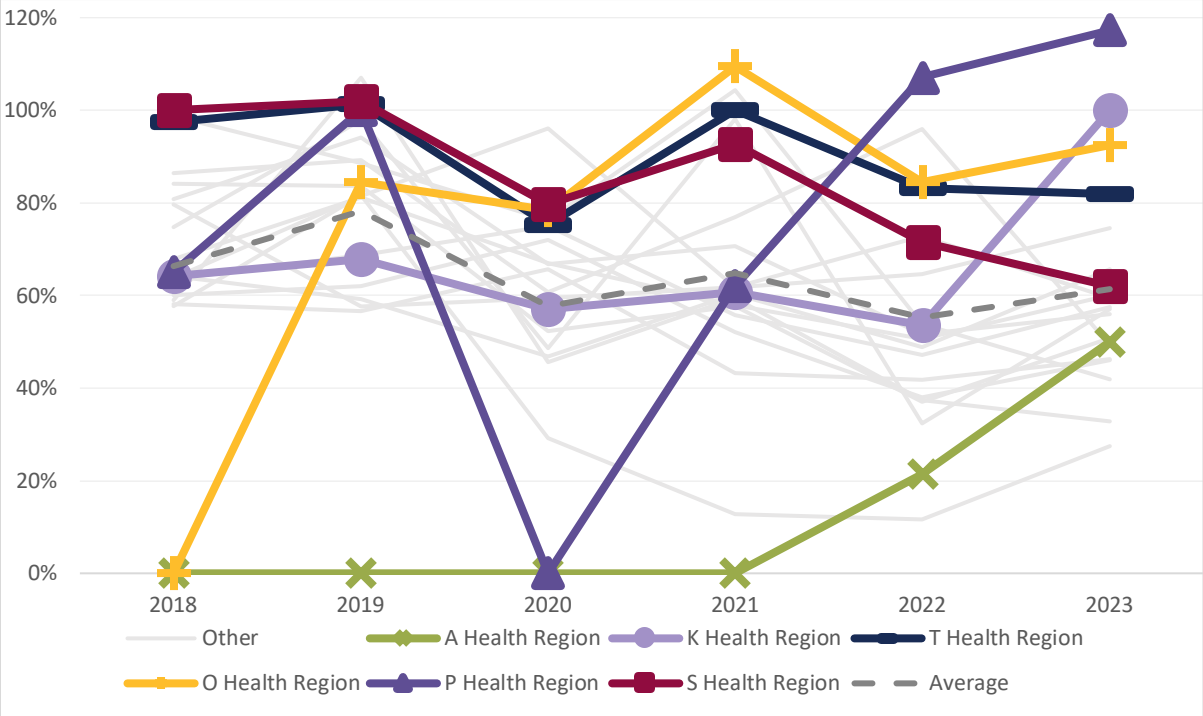
families, lack of services available, shortage of and lack of buy-in from social workers to refer to Gateway.

> *There's […] this perception that we can't do anything until a Gateway is done, no matter what it is. […] I feel sometimes it's a tick-box exercise and that is not what a Gateway is designed to be. – Oranga Tamariki Psychologist*

Taking a deeper look into the regional utilisation rates from 2018 to 2023, we found that some regions were outperforming comparative to the national average. Figure 17 illustrates this breakdown showcasing the utilisation trend for six Health Regions compared to the national average and 'Others' in the background (i.e. other Health regions).

We can see the highlighted five regions have consistently outperformed the national average utilisation rate, except for one region, which while still below the national average was included to showcase a significant positive jump in utilisation. This finding suggests an increasing awareness and value of Gateway across some regions.

**Figure 17. Yearly average utilisation by selected Health Regions**




While we have kept the regions in Figure 17 deidentified for reporting purposes, regional engagements have found that some are applying effective and innovative practices that may explain why some regions have comparatively and consistently higher utilisation rates (refer to *Gateway Innovations Making a Difference*).

We suggest that utilisation rates could be improved by bolstering support in the consent process (refer to *Whānau Navigators and Gateway Coordinator Clinical Nurses*).

## 4.2 Provide clearer guidance about information sharing

Information sharing is necessary for successful cross-agency collaboration and partnership.

Māori and Pacific providers feel they do not have access to enough information to effectively support whānau, they need to be enabled to work with their communities, and supported further by the provision of information, resources, and funding. There is an underlying feeling of frustration due to the lack of collaboration, shared resources, and shared information.

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*Significant improvement around information shared prior to and during assessments is required to support the process. – Māori Provider*

*Sometimes it gets so frustrating for us coordinators and for all the professional and kaimahi (our social workers) because they're the ones that monitor the plans […] sometimes we don't even see the outcome of assessments. – Māori Provider*

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Throughout the Gateway process, a substantial amount of information is gathered about the child or young person. This includes their full medical history, a list of injuries or accidents (including sensitive information about instances of abuse), and their learning or school-related history. Intra-agency information sharing is a complex issue due to the volume and sensitivity of the information collected.

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*Inter-agency Service Agreement, it's meant to just be between the professionals to know who's responsible for following up with what – whānau should be seeing their full report it's their information they shouldn't be given a brief snippet of what's a full health report about them. – Senior Advisor Education and Health*

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In addition, some of the information collected may need to be shared by the GAC to triage referred services and in certain situations information needs to be shared beyond what has been discussed or approved. Information regarding other individuals, such as family members, may be revealed during this process, and the broader use of this information hasn't been approved or discussed. Ensuring the confidentiality of individuals whose details are disclosed during the assessment is crucial. Documenting the information source about others in the case file is also vital.

Our review found that current intra-ministry guidance is unclear on what information should be shared and with who, leading to confusion in the field. For instance, it is

unclear whether health information should be shared with schools. Frontline educators argue that schools should be informed, while social workers are cautious about sharing comprehensive health details about a child, aware that such information could have lifelong implications.

> *Just a question from me, so I am an Associate Principal at [School] and also SENCO, so these come across my desk. [...] Does someone have to give permission for us to be given the results of the assessment back or should that happen automatically? [...] I've never been given back. – Associate Principal, South Auckland*

There are also nuances that need to be addressed, reflected in the comment to Te Puaruruhau review. Updated guidance is required to acknowledge that we need to go beyond a simple sharing or not-sharing dichotomy to instead share information by degrees. Similarly, we have heard that family members often get left out of the loop. More discussion and clearer guidance is needed on what children, young people, and their whānau and family should have access to (i.e. the Final Gateway Report).

> *When whānau are asking about the information and the recommendations and specifically [when] education come to the table at MDT – they [education] would like a full copy of the Gateway report and I've really tried to ensure that the team that I work around also understands the referral process because it could be a difficult one to understand coming into the organisation. […] It's like I'm caught in the middle as a social worker, of being the person that is on the end of, 75 – 80 percent of the recommendations and being told, we're not able to share [the] reports, but then when I'm sitting in an MDT, being told that we need to share and then just the transparency around that aspect of it [the] recommendations. [...] That should definitely be cleared up. [We need to know] what we can and can't share. – Gateway Champion, Auckland*

## 4.3 Reduce barriers to family involvement in Gateway

The process of gaining consent from families and young people is an important aspect of the Gateway process, without consent the health appointment cannot be scheduled.

Gateway is conducted with the explicit consent of the young person and their parent or legal guardian. The process collects data under the condition that the information will be used for the assessment, final report and in adherence to their specific consent form.

In the exceptional situations where the information about the child, young person or family should extend beyond what was initially expected, Gateway healthcare

professionals must obtain further consent, consult legal for guidance or consider potential exceptions under the Privacy Act.

Oranga Tamariki social workers who refer children and young people to Gateway are tasked with gaining consent in the following instances:

- Obtaining the legal guardian's or a capable young person's written permission for the referral and the assessment process, including information sharing and accessing their health records
- Requesting the child or youth's education profile
- Making referrals to a service (e.g. for treatment)

Other tasks the social worker must do relating to consent and information sharing include:

- Informing the GAC about any significant updates, such as changes in the child's social worker, placement, caregiver details, and school transitions
- Pursuing a court order (e.g., when consent is not obtained) if necessary.

Referrals that do not have written consent or a court order will not be further actioned. In other words, families who do not consent do not get Gateway.

Issues arise with gaining consent from family members or parents. We heard that the consent process is the biggest barrier for families not receiving the service. Trust between some Māori and Pacific communities and Oranga Tamariki is fragmented, which can be a challenge for social workers to overcome.

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*As soon as the word Oranga Tamariki is said, there's a hesitation to what support could be. – Pacific Provider*

*The families, being really nervous, really! About what the purpose of Gateway was, what our hidden agenda was, how we were gonna use it against them, and a lot of the times, if we were thinking about kids that were coming into care – the families were pretty angry with us. So then to go out and say, "hey, can we have your consent to gather all this health information?" They were not very forthcoming with that. – Practice Leader, Bay of Plenty*

*I did basically a review of the cases to try and identify where we were sitting in terms of how many children were getting Gateway and how many weren't. It was quite surprising the numbers were significant […], it wasn't because social workers didn't want to refer. There were a whole lot of barriers to the current workloads. – Practice Leader, Bay of Plenty*

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Whānau explained that in the past, information had been misinterpreted during conversations with frontline staff conducting Gateway. As such, some whānau withhold information from government agencies to avoid it being misinterpreted or

used against them. Overall, this has resulted in Māori and Pacific communities feeling fearful and mistrustful towards Oranga Tamariki and the Gateway service.

> *Many of them fear giving information. We've heard that families' information has been used against them through a report of concern being made. – Pacific Provider*

Māori and Pacific providers have the potential to play a crucial role in ensuring that whānau Māori and Pacific families engage with the Gateway process. However, Māori and Pacific providers feel they are brought into the assessment process too late and feel under-utilised.

> *We just become an ambulance at the bottom of the cliff. – Māori Provider*

Utilising Māori and Pacific providers as the point of entrance could be key to improving outcomes for tamariki, rangatahi, and whānau. One provider discussed how utilising them as a point of entrance may increase whānau engagement due to their pre-established relationships.

> *If mandated, [we] can solve [the issue of engagement] i.e., whānau [are] reluctant to give consent for Gateway, the relationships that [we] have can help to bridge that. – Māori Provider*

We heard that creating relationships with whānau Māori and Pacific families is especially important for them to consent to receiving Gateway. Other Gateway roles or provider partners could also be better utilised to obtain consent from whānau Māori and Pacific families, transferring this task from the social worker and improving participation in the service.

## 4.4 Address issues with education profile completion

Education profiles provide insights into the child or young person's learning and developmental needs. For school-aged children, these profiles include details on their academic achievements.

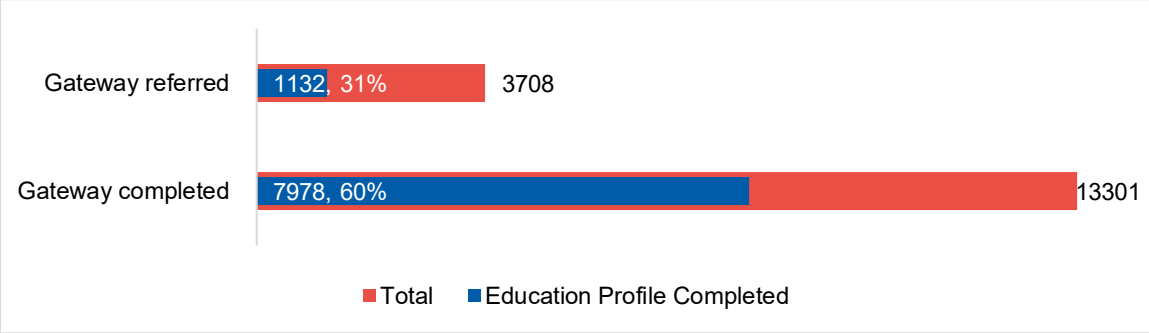
Once the social worker gains consent, they request an education profile from ECEs or schools. In some cases, RTLBs assist schools with this process. These profiles are crucial in formulating a strategy to address education and learning needs.

While most children and young people should have an education profile completed[37], issues with completion persist. We found that over a period of six years, 40 percent

[37] Ministry of Education. (2015). *Gateway Assessments: Supporting information for education professionals*; Ministry of Education. (2013). *RTLB Gateway Guide*.

of the 13,301 completed Gateways did not receive an education profile despite one being requested (Figure 18).

**Figure 18. Gateways with education profiles completed 2017 to 2023 financial years**




For school-age children, MOE Gateway guidelines stipulate that RTLBs are responsible for completing the education profiles or ensuring they are provided to Oranga Tamariki social workers (refer to Figure 43, Appendix VI – *Other Tables and Figures*).

Despite the MOE guidelines, challenges exist in the connection between Oranga Tamariki social workers and RTLBs, schools and ECE to ensure an effective collaborative process. Often, a social worker contacts the school principal or the SENCO, while at other sites the GAC contacts the school.

The Education Profile is another factor behind Gateway untimeliness. Frontline staff also told us this timeframe can differ depending on the relationship between schools and Oranga Tamariki staff. This process is not streamlined, leading to time-consuming back-and-forth communication between education providers, Health Districts, and Oranga Tamariki.

> *Social workers sometimes seem unsure regarding the process which leads to some chasing around after Education Profiles. When students move areas, some time needs to be allowed for the new school to build a relationship with the student […]. It can be very difficult to gather an Education Profile from the previous school.*
> *– RTLB Cluster Manager, Bay of Plenty*

According to administrative data, it often takes up to three months to receive the completed education profile, but in some cases, it has taken over 12 months (Figure 19). Even the three-month time frame is problematic as many children and young people may not spend that long in one placement.

**Figure 19. Education profile time to completion 2017 to 2023 financial years (n=9,110)**


We heard from education staff that completing the Education Profile puts extra time pressure and workload on the schoolteacher or other staff members involved.

> *Different schools have different systems. Some schools it's the Deputy Principal who does it and takes the teacher aside and works with the teacher. And sometimes […] it's, "here's a Gateway - can you fill it in over the weekend?" And again, we're adding workload. One of our schools requested release time and money for that release time from the RTLB service for their teachers to fill those forms accurately and take that time.*
> *– RTLB Cluster Manager, Bay of Plenty*

Questions were raised about who should be ultimately responsible for ensuring a timely completion of the Education Profile especially in cases where the child or young person has not been enrolled at the school for long.

> *The Education Profiles are really good forms to fill out, but they do take a bit of time, but I don't think that my teachers would mind as much if we got something back from it. Often, you know, when our schools are filling in Gateways, they're filling them out for children who have been there for a week, sometimes two weeks, three weeks? It makes them difficult to complete.*
> *– Associate Principal and SENCO, Auckland*

The Te Puaruruhau review, mentioned previously, has led to recommendations for improving the national education profile used in schools. This involves:

- Redesigning the profile to better identify students with cognitive, behavioral, neuro-developmental, and communication needs. This includes ensuring that the needs of very young children are specifically captured and that all questions on the profile are detailed and relevant to provide comprehensive information. MoreTalk, a group of private SLTs, have already begun reviewing the current forms as a preliminary step.
- Reconvene the national working group to further review the educational profile with contributions from SLTs and psychologists involved in the Gateway initiative. Experience from Te Puaruruhau indicates that discussions between

Gateway psychologists and those completing the education profiles can enhance the quality and understanding of the information gathered.

- Increased collaboration across sectors—including MOE, health services, and other providers—to develop detailed, family-centered operational pathways for care. These pathways should be tailored specifically for Gateway and capable of being implemented on a national scale.

## 4.5 The Gateway IT Tool is crucial and needs significant improvement

Frontline staff have told us that the Gateway IT Tool is not fit for purpose, as its design inhibits proper use of the tool itself and the data it collects.

> *The Gateway tool is dreadful. It is hard to believe that any useful data can be obtained from it. Several common issues are not on the tool and very rare ones are. The dropdowns often do not match the actual service or referral that would be made.*
> *– Paediatrician, Te Whatu Ora, Auckland*

Discussions with GACs and observations of the current tool confirm that it does not meet its intended purpose. GACs are bypassing automated functions due to their inaccuracies, opting to input and store information manually outside the tool instead.

This practice, which is likely prevalent across the Health Regions, introduces the risk of human error and inconsistency. A proposed partial solution is developing a dashboarding tool for better data oversight and coordination with Health Regions.

Comprehensive improvements are necessary, as evidenced by the difficulties outlined in the Gateway IT tool's usage, training, reporting, organised data management, and engagement mandate (refer to section *Ensure consistent recording of needs data*). This was the same conclusion reached by a Working Group in 2016 and was reiterated by the review of Te Puaruruhau.

Addressing these issues through improved tool functionality, training, and data quality measures is essential for enhancing the effectiveness of Gateway services and ensuring the needs of children and families are met more efficiently.

As mentioned, a Gateway record is considered complete when it has a referral date, ISA, and Final Gateway Report uploaded in its system. However, when a Gateway record is ‘closed’, it is no longer accessible. This makes updating or following up on report recommendations virtually impossible.

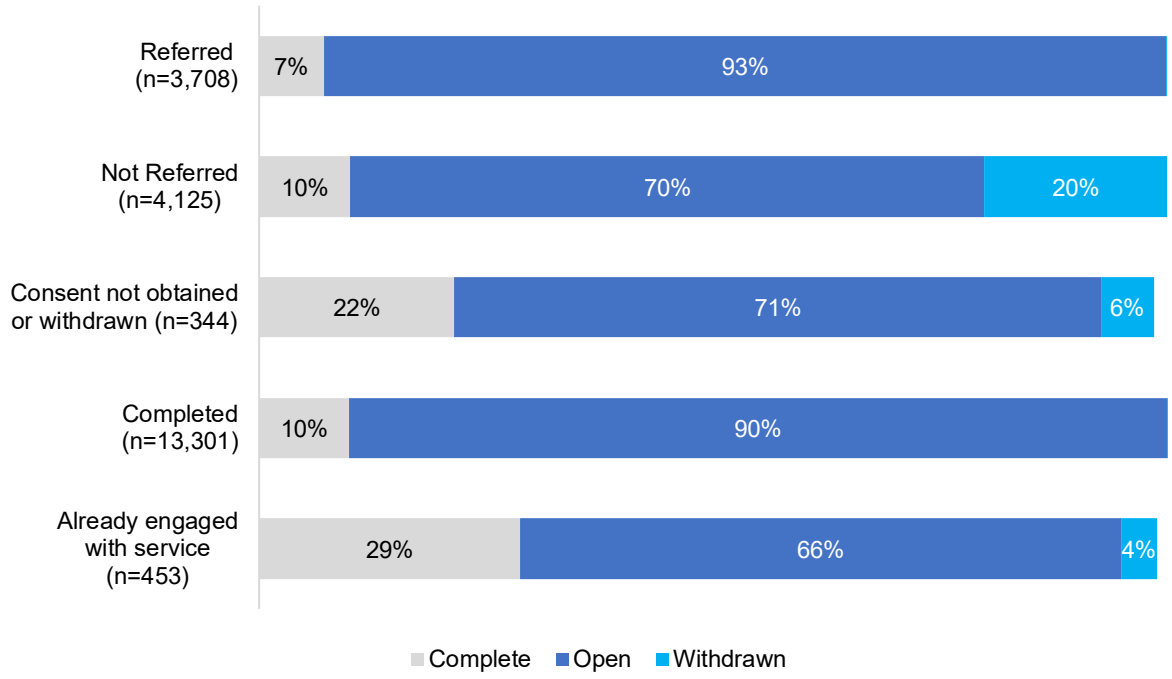
Closing a case prematurely forces a restart of the entire process for the child or young person. Moreover, the process is further complicated if important updates cannot be input after a case is ‘closed’. For instance, changes in living situations of those awaiting Gateway, if a youth is about to age out of care, reunite with family, or relocate, thus impacting their support eligibility from Oranga Tamariki. For these reasons, frontline staff have purposefully kept Gateways ‘Open’.

*We've developed a process now where the cases are staying 'open', we're end dating them, but we're keeping them open for that purpose so the assessment can happen. It is keeping it open for administration purposes. – Senior Advisor Education and Health*

*Gateway cases are being kept 'open' in the system, even if the child or young person has left the care of Oranga Tamariki. […] I think it should be kept open, because it's professional and ethically right to do so. The work hasn't been completed and [they] are asking for a piece of work to be done. – Community Provider*

Figure 20 gives a status breakdown for Gateways between 2017 to 2023 (n=21,931). Gateways are categorised (y-axis) as 'Completed' (i.e. if there is a referral date, an uploaded final report and ISA), 'Referred' (i.e. if there is a referral date), 'Already engaged with service' (i.e. Gateway not required), 'Consent not obtained or withdrawn' (i.e. Gateway not required), and 'Not Referred' (i.e. the rest outside of these reasons). While the status (x-axis) of Gateways can be either 'Complete' (i.e. closed), 'Open' (i.e. active) or 'Withdrawn' (i.e. Gateway not given), across all categories 66 to 90 percent remain Open in the system.

**Figure 20. Gateway Status breakdown after ISA uploaded 2017 to 2023 financial years**




Though the practice of keeping cases open in the system reflects frontline workers' efforts to offer continuous care for children and young people, it also reveals a systemic issue with the Gateway IT Tool. This may have unintended consequences ranging from confusion on data consistency to skewed counts as a key performance indicator for reporting purposes.

Without Gateway, Oranga Tamariki would have little structured data about the needs of children and young people in care. This is an important consideration as there is no other mechanism for Oranga Tamariki to gather this data for any internal or external reporting purposes.

Gateway needs data is currently being used in projects across Transitions, Residences and the development of the Oranga Tamariki Disability Indicator. It has also been used for casefile analysis about disability classifications for children in care with disabilities. Gateway needs data is also used for Oranga Tamariki Quarterly and Annual Reports[38].

## 4.6 Improve the function of cross-agency governance

A Governance Group (also known as the Local Leadership Group) meets at least quarterly and consists of individuals from the Health Districts, the GAC, representatives from local Oranga Tamariki sites (including a liaison officer and typically the Site Manager, Senior Advisors Education and Health) where available, and local education professionals such as the Service Manager from the MOE or the Lead RTLB.

The main functions of the Governance Group include:

- Addressing and solving issues associated with the Gateway service, including streamlining referral procedures to reduce wait times, creating referral routes, pinpointing and addressing training and other areas for quality enhancement.
- Exploring strategies to enhance service accessibility tailored to the individual and collective needs of children and youth.
- Identifying service shortfalls, particularly those arising from Gateway recommendations and ISAs, and seeking solutions.
- Highlighting the problems to be escalated to MOH, MOE, and Oranga Tamariki national offices.

The operation of the Governance Group is based on terms of reference agreed by all participants. The coordination responsibilities are held jointly by Oranga Tamariki and the Health District contracted Gateway Service.

We found that the Governance Group is a key function of Gateway that supports collaborative initiatives in the regions we engaged with. In the quote below, the Practice Leader talks about the culture of collaboration and how their initiative to include children and families identified by social workers via hui-a-whānau and evidential interviews was effectively supported.

> *One of the things that's made some of our ideas happen is our Gateway governance. They're a really supportive group and we're also seeing wider representation on that Governance Group, which*

[38] Oranga Tamariki – Ministry for Children (2023). *2022/23 Quarter 3 Performance Report*. https://www.orangatamariki.govt.nz/assets/Uploads/About-us/Performance-and-monitoring/Quarterly-report/March-2023/2022-23-Quarter-3-Performance-Report_Pub-Accessibility-passed.pdf

*has been fantastic. We're having regular quarterly meetings. […] One of the other things that we've more recently had is the Iwi Māori Partnership Board for [our health district] have asked if they can have a representative on our Gateway governance, which is really welcomed by that group. […] having a really supportive Governance Group has made our proposals a lot easier really. […] a lot of the time we weren't progressing to FGC, so we social workers were identifying at the hui-a-whānau process that the families that we're working with would benefit from a Gateway Assessment. So through the proposals to governance that was accepted, and we started receiving or making referrals under the hui-a-whānau stage and also through evidential interviews. – Practice Leader, Bay of Plenty*

Having a supportive and functioning Governance Group is not consistent for all regions. More could be learned from the regions in which this function is working well to apply to other areas across the motu.

## 4.7 Improve the function of Multidisciplinary Team Meetings and Interagency Service Agreements

After a health assessment, a Multidisciplinary Team Meeting (MDT) is held to determine next steps, including assigning responsibility and timelines for service delivery (Figure 1).

Generally held once monthly and depending on the child or young person, participants in an MDT include, the GAC, an Oranga Tamariki representative or senior staff, Health District clinicians, an RTLB or other education frontline staff, and community providers engaged with the child or young person, where available and applicable.

The MDT focuses on the ISA, which involves a discussion amongst professionals about the recommendations made from the health assessment including the education profile. The ISA contributes to the 'plan' or strategy for the child or young person culminating in the Final Gateway Report.

An Oranga Tamariki social worker reviews the drafted ISA and obtains further consent from the child or young person and their family for the referrals to services.

The GAC oversees the organisation of the ISA, incorporating contributions from health services, the social worker, RTLB or other educational providers, and relevant service providers as needed.

We heard from social workers and provider partners that their input is not being considered enough within the current MDT process.

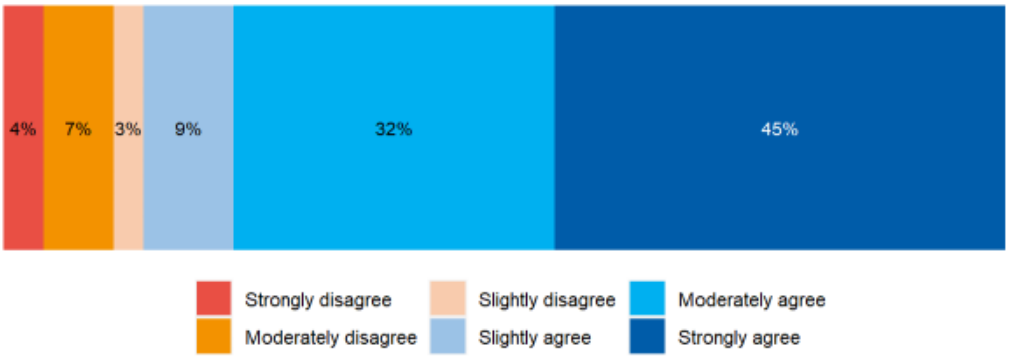
*Sometimes when [our staff] are working with Oranga Tamariki and other partners they don't think their (staff) opinion and experience is being taken into consideration in discussions about the tamariki in their care. They are with some of the tamariki 24/7 in the homes that*

*they operate, so they are in the best position to provide insight. They are not therapist[s], but nevertheless still in a good position to support the korero. – Māori Provider*

While that may be the case, frontline staff cross-agency generally agreed that the MDT and ISA processes was effective in providing recommendations for action and support (Figure 21).

*Q: Please rate your degree of agreement with the statement. The Interagency Service Agreement (ISA) always gives recommendations for action and support.*

**Figure 21. Cross-agency staff perceptions of MDT and ISA process**




Base:all respondents,
excluding partner providers, I don't know, not answered and not applicable (n=152)

We heard that discussion time for each child or youth in the MDT was limited to 15 minutes. As multiple cases are allocated for review during the maximum two hour session, talk time is limited to confirmation of recommendations and services to be referred. Such time limitations make it difficult to have family centred discussions.

*For example, 15 minutes total for one child - around 13 minutes for the presentation, then only 1-2 minutes for questions, any recommendation, boom. No discussion time from us. […] We emphasise about education and health, but not much to discover family dynamics. We need [time] to talk more about that. But often that depends on that person who drives the [MDT] meeting. […] It's set up to just be a confirmation to sign off of an [ISA] agreement. – Community Provider, Auckland*

Furthermore, not including input from relevant and important voices (i.e. social workers, family or caregivers, and the child) suggests that valuable time is potentially spent on recommendations that may not fit the needs of the child or young person.

*ISA not always prepared before MDT - some suggestions are helpful, but some are generic and not specific [nor] culturally appropriate. – Gateway Champion, Auckland*

Health frontline staff strongly advocate redesigning the process and creating guidelines to incorporate input from youth, family, caregivers, and social workers into the development of the ISA and MDT. Their feedback highlights the importance of including the child or youth, family, and guardians in decision-making, along with the social worker's insights, for producing meaningful final recommendations.

*Whānau are not at the centre of how we work, they sit on the periphery. I believe the whānau voice is significantly lacking and we continue 'to do to' whānau instead of working with and partnering with them. The process developed and contracting to do the assessment provides barriers to the way of work. ISA development needs to be developed with whanau present. The health assessment would benefit from having a whole of whānau approach as we know that for Tamariki to thrive whānau needs need to be addressed. – Gateway Manager, Waitematā*

Further perspectives captured from the staff survey across agency frontline called for a redesign of the MDT process to be more family-centred, and to allow more discussion involving the social workers, family, caregivers or young persons (refer to Table 25 and Table 26, Appendix II).

## 4.8 Clarify and improve accountability on roles and responsibilities

The importance of being clear on roles and responsibilities and accountability for actions (or inaction) have been noted in conversations throughout engagements and the survey.

Findings presented in previous sections suggest further discussion is necessary about how agencies should be responsible for enacting due diligence on the follow-up of services received by the child, young person or family and whānau (refer to section *Address the gaps in follow-up of recommendations*).

Communication and transparency between agencies and providers are key aspects of collaboration and partnership. Māori and Pacific providers want this to improve.

*The assessment needs to incorporate what other agencies are doing, what is health doing, education? – Māori Provider*

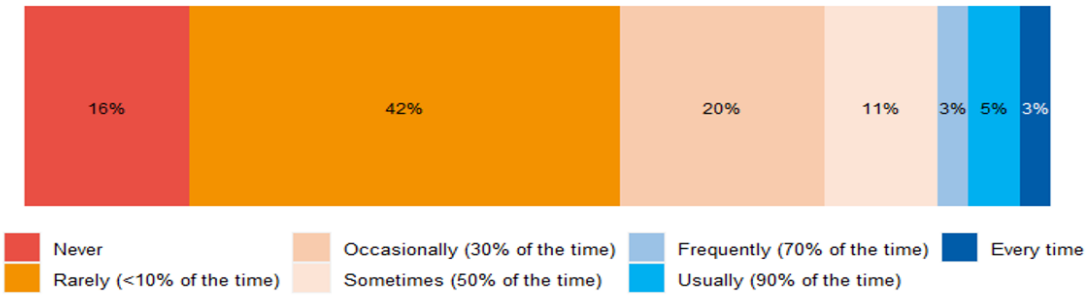
A major theme from discussions is that MOE has not been present enough, from the completion of the Education Profile to the management and delivery of support services (see section *Support schools to meet the needs of children in care*).

While the lack of service and support for disabled children and young people in care has also been an ongoing theme, Whaikaha does not currently have a mandate to collaborate with this effort at all.

Similarly, frontline staff consider ACC involvement to be important for gaining further support for services (Figure 22, and Figure 23), but ACC does not have a mandate to collaborate in the Gateway.

*Q: To what extent is there conversation in the MDT/MDCM about the child or young person's ACC claims and injury related needs?*

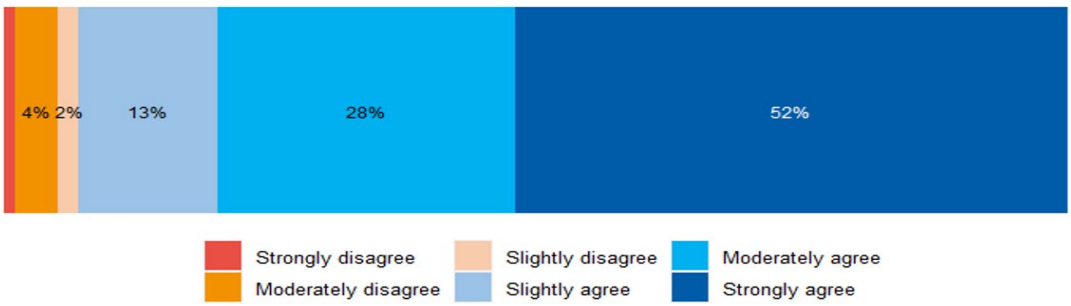
**Figure 22. Cross-agency staff perceptions on ACC claims discussion in MDT**




Base:all respondents affiliated with OT or health agencies, excluding I don't know, not answered and not applicable (n=80)

*Q: Please rate your degree of agreement with the statement. The child or young person's ACC claim history and their injury related needs should be consistently reviewed and discussed as part of the Gateway process.*

**Figure 23. Cross-agency staff perceptions on ACC involvement in Gateway**




Base:all respondents affiliated with OT or health agencies, excluding I don't know, not answered and not applicable (n=117)

Providing the best response for children and families requires a clear understanding of agency roles and functions in the care process.

The following statement from one provider suggests that some Māori and Pacific providers want to improve the way agencies work together by better utilising the respective strengths of each agency.

> *Mahi with whānau can be done by different professionals, if the needs of te tamaiti and whānau are identified appropriately, the response can respond better to the need.*
> *– Māori Provider*

# Gateway Innovations Making a Difference

Agency frontline, practitioners and partners expressed that despite some longstanding issues, Gateway has value and should be redesigned to better meet the needs of children in or on the periphery of care.

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*[We] value the Gateway tool as it gives a deep dive on each tamaiti and gives a range of options to support their health and education needs. – Māori Provider*

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Areas of innovative practice across the regions provide opportunities for the redesign of Gateway and these examples, if adopted, could meaningfully improve the process. They reflect that people are overcoming issues within Gateway to meet the needs of children, young people, family and whānau. This chapter presents a snapshot of the innovative practice found through the review, noting that there may be instances of innovative practice that were not captured.

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*Gateway Assessment is a good idea; implementation is the issue. – Pacific Provider*

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## 5. Involving providers in the process

Māori and Pacific providers understand that working and collaborating with Oranga Tamariki and other external providers is an important part of meeting the needs of tamariki, rangatahi, and whānau. The following quote from a care experienced parent who received Gateway, validates this finding.

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*One of the homes I reside[d] in was in Papatoetoe call[ed] Lifelong trust, they had their own social workers as well so when you went into their care not only did you have your Oranga Tamariki social worker, but you had a Lifelong one [too] and they were awesome. – Māori and Samoan Care Experienced Parent, recalled having Gateway, South Auckland*

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Many providers we engaged with were social service providers mandated by iwi or hapū with Māori professionals being represented in various roles. They are

connected to the children by whakapapa and have a vested interest in supporting the whānau through solutions that fit their lives and realities.

> *[We understand] the importance of having Māori clinicians involved paediatricians, psychiatrist etc. They look at the tamariki and whānau as a whole and understand the different cultural perspectives that exist. – Māori Provider*

Some community providers expressed a desire for increased leadership roles in the Gateway process within their respective regions. Some already offer comprehensive and continuous support to families and conduct assessments in a manner that is efficient and culturally responsive.

> *Needs assessments need to be culturally grounded with a holistic view on approaching what wellbeing looks and feels like for children and families. – Community Provider Manager, Lower South*

Some Māori providers have had success in cross-agency collaboration and partnerships, and often work in innovative ways to meet the holistic needs of whānau and families. One provider described the success of their programme for youth in the justice system, Te Pai Ora, while another provider discussed the Hoki ki te Rito project as examples.

> *[We] lead this initiative and facilitate community referrals to improve referral pathways. It includes the 46-marae based panel (sic.). This is where rangatahi that have offended [have] an alternative justice mechanism. [We acknowledge] the success of this and the ability of agencies to work better together. – Māori Provider*
>
> *Initiatives that can support understanding [that] having the right people at the table to address the tailored needs of tamariki and whānau is critical, [like] the equity project Hoki ki te Rito – Māori Provider*

Māori and Pacific providers emphasised that solutions lie within the community, suggesting that community-led responses should be incorporated throughout the Gateway process.

Community-based services delivered through Māori and Pacific providers work in a more collective and holistic way. Many community providers have connections with whānau, supporting a relational service approach. These services are not only more accessible for Māori and Pacific communities, but also build trust with communities.

*We do have those services in our community that are more accessible for whānau and families. Hospitals are foreign places for whānau – trying to navigate and find the place inside the hospitals. Many don't engage and then are struck off the list. – Pacific Provider*

*[We see] success when applying a more whānau ora and kaupapa Māori approach with the whānau that we work with. [We] use Te Whare Tapa Wha model to communicate with tamariki and whānau. Children understand this model. – Māori Provider*

Redesigning the Gateway process with family will benefit children in actioning a more collective approach for better outcomes. Drawing on the phrase, *"it takes a village to raise a child"* the concept of family from a Pacific perspective does not only refer to immediate family, but also acknowledges that all members of the collective play a role in raising the child. In this concept the collective makes up a village.

*There is a village around our children – the child or young person belongs to the village not just the parents [or] carers. – Pacific Provider*

To this point, a Pacific provider suggested redesigning the process to follow the child through their journey, promoting a preventative approach.

*Looking at the things from a family's perspective – the impact. If systems were created to enable families at any level, then we're already winning, we need to look at the whole journey. – Pacific Provider*

# 6. Auckland Region

## *6.1 Enabling nurse and social worker collaboration*

The South Auckland example aligns with Oranga Tamariki's Practice Shift, emphasising cultural responsiveness and strong relationships with families. The practice approach, which centres on Te Puna Oranga, has been positively embraced by staff throughout the focus groups.

Te Huarahi Ngaa Tahi was a collaborative pilot project in South Auckland involving the South Auckland Social Wellbeing Board, Oranga Tamariki Otara, Anglican Trust for Women and Children, and Te Whatu Ora. The pilot operated from September 2021 to June 2023 and was extended due to its success.

The service focussed on families at risk of a child safety intervention following a report of concern. Families could choose Te Huarahi Ngaa Tahi over the conventional Oranga Tamariki pathway. The initiative featured a close collaboration between a registered nurse and social workers. The pilot programme provided an alternative to the standard Gateway and assisted 19 families and 68 children and young people.

The nurse and social worker combination allowed social workers to focus on their duties while the registered nurse addressed the health needs of the families and children involved (similar to the GAC Nurse role described below as an example in the Lower South). This led to a quicker consent process and reduced waiting times for Gateway, and enhanced family engagement.

The success of this prototype was primarily due to its emphasis on relationship-building and trust. By fostering trust, the strategy improved health system accessibility for children and families dealing with various challenges, offering direct, timely support for issues such as mental health and nutrition at home. It also facilitated direct access to paediatric advice, speeding up appointments with paediatricians and providing immediate attention to primary health needs without the usual assessment wait.

The prototype offered the advantage of consistent involvement from the same individuals throughout the process, enhancing the overall experience. Following an assessment, the nurse remained engaged with the family, offered guidance on referrals to secondary services and ensured the follow-up and implementation of recommendations from Gateway.

Additionally, for families needing further assistance to navigate the system, the nurse practitioner helped connect them with Whānau Ora Navigators (see section *Whānau Navigators and GAC Nurses*), further enhancing support and continuity of care.

The Samoan registered nurse utilised her cultural background and knowledge to provide a holistic and culturally responsive approach. Her ability to combine medical expertise with cultural understanding (employing frameworks like Teu le Vā, Talanoa, and Pūrākau) significantly contributed to the prototype's success, leading to its expansion in South Auckland.

Despite the challenge of limited personnel, the initiative has grown, including a new role focused on young people in the Youth Justice system. The overall approach focuses on identifying and addressing health issues early before they reach crisis.

Te Huarahi Ngaa Tahi demonstrates how approaching the issues from a different perspective can be successful. Whilst the approach worked in South Auckland, it may not be as effective in other locations. More work is required to understand its longitudinal benefits.

## 6.2 Applying what was learned from an enhanced Gateway pilot

Puaawaitahi is the Auckland central multiagency partnership consisting of Oranga Tamariki, NZ Police, Starship Child Health and Ngaati Whaatua

Considering the Pae Ora health reform underway[39], the Puawaitahi governance group decided to conduct a review of the Auckland District enhanced Gateway pilot, finalized in June 2022. The review was primarily focused on Te Puaruruhau as a Starship service. It was seen as a good starting point to explore the role of Gateway to:

- Deliver early intervention and prevention
- Challenge Eurocentric practice
- Orientate the service towards family-centredness

This reflected broader cross-sector work to examine how they could develop better ways of working for whānau Māori to better honour our Te Tiriti o Waitangi commitments.

This local level review was valuable in highlighting innovative practice. This included:

- Te Puaruruhau providing Gateway assessments in the community in diverse locations such as schools, homes, primary healthcare facilities, Oranga Tamariki site offices and, on one occasion, Aotea (Great Barrier Island)
- Inclusion of hearing screenings
- Development and testing of communication resources about information on the process to support child and family understanding
- Trialing a speech language therapy pilot, with routine screening (this also covered Northern DHB)
- Achieving additional psychologist resources to support assessments
- Including Auckland Regional Dental Service in assessments.

The local review identified recommendations for the Gateway review to be considered nationally including proposals to:

- Apply Critical Treaty Analysis (CTA) to the Gateway national service specification to ensure Māori values and expectations inform revised policy.

[39] Department of the Prime Minister and Cabinet. (2022, August 3). *Pae Ora – Healthy Futures. Future of Health*. https://www.futureofhealth.govt.nz/pae-ora-health-futures

- Engage Oranga Tamariki, health partners and SLT providers to facilitate a co-design of the Gateway 'consent' documentation and additional resources that goes to whānau and families. This includes a health literacy review of the documents.

- Facilitate a further re-design of the national education profile collected from schools to better identify those with cognitive, behaviour, neuro-developmental, and communication needs, ensure the particular needs of pēpi are captured, and more broadly ensure all questions are specific and relevant to ensure rich information is provided.

- Greater inter-sectorial and cross-agency (MOE, health and other providers) collaboration to develop detailed operational pathways to care that are whānau centered, prioritised for Gateway families, and scalable nationally.

- Fund psychology FTE in order to provide a comprehensive health and developmental assessment. The role of the Gateway psychologist should be funded through the health and education system, agreed nationally, and preferably should include trauma, mental health, and cognitive screening and support. There is also a broader need to address the national lack of access for children (whether eligible for Gateway or not) who need these services and inequity in provision by Health District.

- The need to improve information sharing provisions within inter-sectorial and cross-agency working (such as the Gateway context) to minimise local level variation and prevent information sharing issues that may create barriers to effective working relationships. This process needs to be guided by frontline practitioners who understand the day-to-day issues involved. They also note that Iwi, hapu and whānau should be consulted on the degree of information sharing in a mana-enhancing way.

- To implement a mechanism to monitor implementation of ISAs and family uptake to services.

We will be drawing on these findings to inform proposed future service design.

## 6.3 Gateway Champions play a leading role in Gateway

Focus group engagements in the Auckland region illustrated the importance of the 'Gateway Champion' frontline role. Gateway Champions are responsible for leading the Gateway process in their respective area. This frontline role is influential in supporting, training, and advising social workers in managing children, young people, and families going through the Gateway process.

> *Gateway success relies on a site championing this thing through from start to finish. Someone that keeps everyone involved on their toes, including me. – Site Manager, Auckland*

The Gateway Champions do their best to work within the current Gateway process, but their role highlights the need for system-level changes. These champions, present at most Oranga Tamariki sites in the Auckland Region, serve as primary contacts for inquiries related to Gateway and ensure close collaboration with the GAC. Their responsibilities include:

- Being the initial liaison for coordinators
- Aiding in case follow-ups
- Assisting social workers with referrals
- Organising training or refreshers for staff
- Keeping the site informed on critical Gateway updates or changes.

# 7. Lower South Region

Our engagements in the Lower South identified initiatives adapting the Gateway process to better address the diverse cultural needs of communities in the region. One example is the collaborative effort between Oranga Tamariki and the Ngā Kete Mātauranga Pounamu Charitable Trust, facilitated by Tui Ora's kaupapa Māori family support service.

## *7.1 Whānau Navigators and Gateway Coordinator Clinical Nurses*

Te Kāika and Ngā Kete Mātauranga Pounamu indicated their readiness to spearhead the Gateway process in their areas. Both possess capabilities in primary health care and primary mental health care and are endorsed by their respective hapū and iwi.

> *We can run Gateway. Why are our kids waiting when we have the capacity to do it? We have the services required. We are set up to be a village, a one stop wraparound service.*
> *– Māori Provider, Lower South*

These organisations, among others, are positioned to support service provision in a region with limited services.

Ngā Kete Whānau Navigators assist in the Gateway process by working alongside the Oranga Tamariki Social Worker and the GAC to support access by overcoming cultural and logistic barriers for whānau.

Te Kāika and Ngā Kete Mātauranga Pounamu advised that they can navigate their internal networks in the community to ensure access to services even after Gateway is completed.

We mentioned previously that Pacific families often face challenges due to language barriers, with many finding it difficult to understand the Gateway terminology and paperwork because English is not their first language. To reduce this barrier to Gateway, Pacific Trust Otago wants to assist families and individuals going through the process by utilising their Whānau Ora Navigators.

Pacific Trust Otago Whānau Navigators can provide accessible explanations of specific processes, such as gaining consent or explanation of the Final Gateway Report. This is crucial for enhancing family outcomes and building a strong connection with Pacific communities.

> *No wonder the family didn't sign – because they don't understand this thing. Look at the terms, even I don't understand. Any implementation that relates to Pacific words? So, it needs to be at a level that families can understand. – Pacific Provider, Lower South*

Whānau Navigators often interact with the whānau before Gateway. They assist by offering transportation to the Gateway appointment and accompanying them during the assessment. Additionally, Whānau Navigators participate in the post-assessment MDT.

> *Whānau Navigators are often engaged with our tamariki and whānau before the Gateway assessment happens. The navigators are a wonderful resource as they provide support to the whānau by providing transport to the Gateway appointment, they sit with the whānau (if requested by the whānau) during the assessment, furthermore the navigators attend our MDT meeting. By being present throughout the whole Gateway process, the navigators support whānau to identify issues, create plans for change and consider the whānau long-term aspirations. This is crucial in ensuring an ISA will be successful as it is the whānau voice - what they want to happen.*
> *– Gateway Coordinator Clinical Nurse, Lower South*

These examples from Lower South demonstrate the beneficial impact of partnering with local service providers to have a navigator involved in each step of the Gateway process. The continuous presence of navigators helps whānau identify problems, plan for change, and focus on long-term goals. This involvement was a key element in realising the ISA and its recommendations for health and education while incorporating the family's perspective in the process.

Most notably in the Lower South, GAC's are also clinical nurse specialists (i.e. Gateway Coordinator Clinical Nurse) responsible for performing the initial health assessments to Gateway. With the support of Whānau Navigators, we heard that GAC's in the Lower South can conduct the assessment at the family residence upon request.

> *So that's in terms of the assessment process we really work hard on making sure that the families are able to access us well. So that will be about making sure the appointment times are convenient, working hard with the social workers to make sure that they can support the families. Working hard, even occasionally, we've done home visits to see families because they just aren't going to come into a health facility, it's just too much for them.*
> *– Gateway Coordinator Clinical Nurse, Lower South*

These initiatives help some families overcome obstacles, such as travelling to inner city hospitals from remote areas. It also benefits families with multiple children or other members who may require medical assistance who otherwise cannot or will not go to hospital, making the Gateway process more accessible and providing improved outcomes for children and families.

*We are able to do immunisations and before school checks if needed. They need to be whānau focussed, so in one visit we were also able to get mum in for contraception and looking at her health and getting her up to date with her cervical smear we were able to do that with the public health nurses.*
*– Gateway Coordinator Clinical Nurse, Lower South*

With the support of a Gateway Coordinator Clinical Nurse (here after 'GAC Nurse') in the process, appointments can be expedited, often quicker than through a referral from a GP. Additionally, the GAC Nurse has the training to prescribe medications and conduct Griffiths assessments[40], providing more timely and holistic treatment of needs.

*We have been really good about upskilling both me and my colleague in Southland. We are now doing the health assessments, we're doing Griffiths developmental assessments, [and] I've just done a course on nurse prescribing. So, we're able to do a lot of work around with these families and kind of reduce barriers for them. So, if you've got a whānau coming in who is reluctant to go to the GP, it's actually worth doing the nurse prescribing - we will now be able to get them the medication. – GAC Nurse, Lower South*

The GAC Nurse role is further leveraged when Gateway reveals that a child or young person requires a consultation with a paediatrician. Having connections within the DHBs, GAC Nurses can directly communicate with paediatric departments or Child Development Services (CDS) to arrange appointments.

## 7.2 Practical Information Sharing

As mentioned, our engagements highlighted that there is uncertainty about what information could be shared with who, and when.

We learned about creative solutions being used to share information mindfully and efficiently. In the Lower South, GAC Nurses redesigned specialised templates for distributing critical insights from the Final Gateway Report to MOE Service Managers, RTLBs, and other educational professionals. This has proven effective in mitigating the information gap within the Gateway process.

While this works as a practical solution in the interim, there needs to be a level of consistency in what is being shared nationally. This is especially relevant as many of the children within the cohort move between different regions.

In the Lower South, solid partnerships exist among agencies participating in the Gateway initiative. These partnerships are founded on collaboration, effective communication, and a commitment to the child or young person involved outside the

[40] A developmental assessment.

formal frameworks of the MDT or ISA processes and provide an example of how we can improve the process.

> *[Our] social workers have confidence that the Gateway Assessment is a worthwhile tool for furthering effective implementation of health and education outcomes. The MDT is one of the only opportunities to bring together Te Whatu Ora, and MOE around the table to jointly agree on a service plan. – Senior Advisor Education and Health*

# 8. Bay of Plenty Region

The Bay of Plenty region strategically created the 'Gateway Liaison Social Worker' role and utilised it to ensure the Gateway process was more family centred.

## *8.1 Gateway Liaison Social Worker*

The Gateway Liaison Social Worker (GLSW) was dedicated to supporting the clinical side of the Gateway process. The liaison works alongside social workers, health clinicians and families involved in Gateway.

> *It's a big gap (to fill). But [the GLSW] does a huge amount of work with the families going through the process, explaining it, obtaining their consent, basically walking alongside them. From their initial consent discussion right through the assessment, and we'll talk a little bit more about some of the amazing stuff […]'s doing, with some of the unseen stuff and we call it unseen because it's not widely known. – Practice Leader, Bay of Plenty*

The GLSW emphasised that although the method was not always successful, it was crucial for families to connect with the social worker as an individual first, rather than primarily in their professional capacity.

For this to happen, the GLSW would contact the families or young person involved and introduce themselves as the 'Gateway Social Worker' rather than as an Oranga Tamariki social worker. Families were more receptive, as they would rather not think they were dealing with Oranga Tamariki directly for a health assessment.

> *When I first got into the role when I approached the social worker. How can I help in regards with the consent, acquiring the consent? I'm not introducing myself as (someone from) Oranga Tamariki, but I am introducing myself when I'm ringing the whānau that I'm the Gateway Social Worker and they're all like – ah, what is that? Oh, we just need your consent. These are free benefits for your kids, and it works really well for them. Yeah. Because we knew (during those times we were always in the news) we'd (Oranga Tamariki had) burned the bridges with the communities and the families.*
> *– GLSW, Bay of Plenty*

Similar to the example of the Whānau Navigator, having a role such as the GLSW taking on some of the challenging aspects that are critical to reducing barriers to Gateway, makes the process more accessible for children and families.

## *8.2 Including Young People, Family and Caregivers*

Another innovative approach found in the Bay of Plenty involved young people and their family or caregiver being included in MDT meetings, with the assistance of the

GLSW. This typically involved inviting the young person to the meeting, followed by their family or caregiver, either separately or together based on the young person's preference. This example of practice shows that frontline are listening to the children and young people involved.

> *The young person should be the one to decide who is involved in the process. For example, whether or not they want their caregivers or parents involved. – Māori, Care Experienced Youth, Wellington*

In the current Gateway Specifications, typically the young person and their family or caregiver are excluded from the MDT meetings. The rationale behind their involvement in this example was that the child or young person or family should have a say in the development of the plan, its recommendations, and in selecting their service providers.

> *Since [the GLSW] has been in the position, social workers are attending the MDTs after the health assessment. There's been a lot of work done in the community, improving the relationships, broadening our MDT. So previously we would have the health team, us, and education at the table. [Now] we've really broadened that so that we've got a wider option for referrals for our families moving forward. – Practice Leader, Bay of Plenty*

Moreover, the inclusion of local iwi and service providers was seen as essential, given their practical and potential crucial role in facilitating the child or young person's access to services post-assessment. Community providers seen to have the potential to provide services for the child or young person were also invited to participate in the final discussions in the MDTs.

> *I've done some underground work with our community, especially here in Rotorua and Taupō, introducing my role with the community providers and some iwi that we have connection with within the community. And through that we [are] able to understand their services. So, if we believe that they're going to be helpful for our community, and our tamariki will be benefited by their service, we invite them to MDT, so they understand the Gateways. So, then our intervention referrals will be strengthened more and more and so social workers get a buy-in Gateway is now working [better here], and they attend more. – GLSW, Bay of Plenty*

## 8.3 Strengthening Gateway Governance

The Gateway Governance Group in Rotorua has been key to enabling innovation and close networks that deliver an improved Gateway process. Our engagements in

the Bay of Plenty Region identified an increase in children and young people attending hui-a-whānau meetings but not moving on to a FGC or being placed into care. It was noted that these individuals still had significant health and education needs that required attention to prevent them from entering care. To address this gap, some of the children and young people were referred to the Gateway process despite the limitation on their eligibility status.

> *We are trying to think out-of-the-box in regards with how do we align the Gateway service into the paradigm shift or transitioning of changes within Oranga Tamariki to our community and how much more tamariki and whānau benefit with it. – GLSW, Bay of Plenty*

The success of this initiative to include children and youth attending a hui-a-whānau and improving access to Gateway is primarily the result of the robust Gateway Governance Group leadership (refer to section *Improve the function of cross-agency governance*). The local Governance Group recognised the importance of widening access to Gateways for children at risk of entering care.

Another example of innovative practice enhancing the accessibility of the Gateway process was the translation of the Gateway Education Profile into te reo Māori. The local Governance Group, with support of the GLSW, initiated the translation after several Kura Kaupapa requested to fill out the profiles in te reo Māori.

> *Another significant piece of work that we have worked on is to get the Education Profiles translated to te reo Māori. This came about because we have quite a few kura in our region and they were feeding back to us that they weren't prepared to complete the education profiles in English. Initially, they would respond in Māori and then we could get that translated. But we thought, they are kura, they are full immersion, if we actually want this information, then we need to do something about that. So, we have had the templates translated, we've currently sent them out to the local kura for feedback. – Practice Leader, Bay of Plenty*

## 8.4 Addressing Needs for Early Childhood

Our review uncovers a gap in compiling Gateway Education Profiles for children younger than the age of five who are not attending preschool or Te Kōhanga Reo (refer to section *Support schools to meet the needs of children in care*). Frontline staff have found a way to accomplish this task by collaborating with community providers to do home visits to families.

The Central Kids organisation and its Mātauranga Ake programme have been instrumental for this purpose in the Bay of Plenty Region. The Mātauranga Ake team works directly with families to fill out their child's educational profile. These staff

members are also invited to participate in the MDT meetings to improve service continuity for families.

> *We are trying to think and be creative to how we fill those gaps because we have kids under five who are not enrolled to any ECE or any kōhanga. Mātauranga Ake are doing home visits to each child. Mātauranga Ake only covers Rotorua, and we're trying to cover the other part of Bay of Plenty. – GLSW, Bay of Plenty*

Although this programme is exclusively available in Rotorua, it is an example of how local service providers can step in and do much-needed work to fill gaps in the system.

## 8.5 Offering a Family-Centred Space

Our review highlights the importance of the physical setting for Gateway. Where an overtly clinical or institutional venue can deter families from participating, we heard from frontline staff that providing a safe, family-centred, and culturally respectful space increases participation and receptiveness among children, young people, and their families.

A notable initiative in Rotorua involves a partnership between the Rotorua Library and the Rotorua Children's Health Hub at Te Aka Mauri (Rotorua Museum). The partnership offers a co-located service, making Gateway appointments more accessible to families in the area.

Another advantage of the GLSW is the effective coordination of resources between rural health districts across the Bay of Plenty region, further enabling accessibility to Gateway via location. They can coordinate with other districts to have the appointment at a location closer to the family.

> *And to be fair, because I also cover Waikato now our Waikato DHB team, they also [have been to] Tokoroa, they have a site clinic under one of the services. And they conduct the health assessment within Tokoroa so that our families don't need to travel to Waikato. – GLSW, Bay of Plenty*

The Gateway team engaged with in the Bay of Plenty is also able to travel to the family to conduct the assessment. This is another example of ways the team is 'thinking outside the box' to help the families in need of support.

> *So, our team will travel. They have even travelled to remote areas, Murupara, which is 45 minutes. It was quite a large family, so the team actually went out there and completed the assessment at the local GP office, which was massive for that family. And yeah, just*

*huge benefits for those kids. They've even done home visits when kids or young people haven't due to a whole range of reasons anxiety, or social issues. They haven't actually been able to come into the hospital, so they will go out to the home and see those kids.*
*– GLSW, Bay of Plenty*

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An advantage of this practice is that families can access primary medical support locally without the need to visit a district hospital, in a community setting where activities are provided for all family members to engage in, free from any stigma or trauma associated with the location.

# 9. Te Tai Tokerau Region

The Gateway process in Te Tai Tokerau has undergone several modifications. The team that we engaged with is an example of what is working well in Gateway cross-agency collaboration.

## *9.1 Effective Multidisciplinary Collaboration*

The Gateway approach in Northland offers a comprehensive approach to assessing the speech and communication needs of children undergoing Gateway. The team involves a clinical psychologist, SLTs, and Whānau Navigators (amongst other roles). The model was developed from a pilot project in Te Tai Tokerau in July 2020. The pilot introduced a collaborative model featuring an advanced screening and standardised assessment framework.

The team in Te Tai Tokerau also committed to co-locating these services, making the Gateway more accessible. The following quote exemplifies this practice. Staff names are replaced with fake names for reporting purposes.

---

*… and of course we do have the beautiful villa which is a non-clinical space, so we haven't got our tamariki and rangatahi going onto a sort of a hospital space. That's a very nice space that […] the team have created up there at the villa.*
*– Senior Advisor Education and Health*

---

Results from the pilot indicated significant and previously undetected communication, speech and learning needs among the children and youth assessed. The results from this pilot highlighted the importance of incorporating SLT resources in the Gateway process.

---

*I think we're really lucky around the health and education interface and, you know, education is a really, really important partner when it comes to being an equity leveler for our tamariki. I think overall I am really proud of the way that the service has grown over the last 5-6 years. – Clinician, Te Whatu Ora, Northern*

---

The discussions emphasised the significance of the team's collaborative efforts and leveraging of connections adding to the success of Gateway for the region. They also speak about the inclusion of Whānau Navigators in the process. Having the navigator role helps to overcome barriers between families and the Gateway process and provides tangible support in assisting families to attend their appointments.

---

*I definitely think that the multidisciplinary approach that we've taken on here with nursing and Paediatrics and myself and our new role with the Navigator, I think that in itself is massively important. […] it's*

*much more of that kind of holistic assessment for that young person versus having to then sit on different wait lists and different services and all of those things […]. Those relationships and working together is probably one of the biggest strengths that I can speak to the gateway service up here. […] to make sure that we're doing the best thing for that young person is clearly paramount.*
*– GAC Nurse, Te Whatu Ora, Northern*

---

The collaborative approach of the Te Tai Tokerau team enabled those involved in the Gateway process to deliver a triaged service, including following-up on recommendations.

---

*I think in terms of our multidisciplinary approach, we do really well like we've had clinics with public health nurses that had been in assessments because they're following the child through the school, which I think is really helpful. I mean on days where we have clinics where [the public health nurse can…] think, oh, yeah, actually this child does need some further assessment. Then we're able to bring them back in at another date.*
*– Paediatrician, Te Whatu Ora, Northern*

---

Another practice unique to Te Tai Tokerau is the relationship between the paediatrician and local schools, which brings the health and education aspects of Gateway together. Most notably, the paediatrician follows up with the schools and is aware of how the child is progressing.

Many of the paediatricians we spoke to would have liked to have feedback on how the child is going or what happens to the child after their assessment, but as mentioned in previous sections there is no instrument to close the loop on follow-up.

# 10. Other innovative practice and ideas for a redesigned model

## *10.1 Youth-centred Gateway assessments*

One doctor in the Manawatū-Whanganui region delivers Gateway in a youth-centred setting, and with the approach of building and sustaining a relationship over time.

The clinic is uniquely decorated with anatomic models and pop culture memorabilia. Appointments are at least 30 minutes long and focused on having a detailed discussion with the young person. In between appointments, the doctor offers check-ins over text and drop-in sessions.

These Gateways culminate in an accessible, detailed, and strengths-based written letter to the young person. The GP then takes time to explain the letter contents to the youth in a manner which respects them. The young person is also automatically enrolled in the clinic, to support their ongoing health and wellbeing.

This approach is unique and is not possible for all providers, and may not work for all young people, however it does highlight some of the opportunities in enabling local approaches. It also highlights some of the opportunities to strengthen practice for young people, with flexible support and ways of sharing information that resonate.

## *10.2 Towards an enhanced model for Gateway*

The Gateway Assessment review identified mechanisms that were performing well and those that were not serving the process. The gaps and solutions identified offer a unique opportunity to redesign Gateway to better meet the needs of children and young people in or on the periphery of care.

Although some solutions are currently being utilised in practice, any enhancements to Gateway require further testing and development, including with frontline staff involved in the process. The insights documented in this review serve as a foundation for the future redesign and enhancement of Gateway but are subject to ministerial direction.

# Research Design

## Data Collection

Data was collected from engagements, survey instruments, administrative, needs codes and contract data as detailed below.

### *Engagements*

Engagement was prioritised as a key driver to better understand the needs of those who access Gateway. It was carried out through specifically targeted regional activities complemented by national efforts, focussed on the following groups:

- Children, young people, and families in the Oranga Tamariki Action Plan priority group
- Oranga Tamariki frontline staff
- Health and Education staff that work with these children and their families
- Partners and providers that support children and their families.

The engagements were conducted by Oranga Tamariki Action Plan Engagement Managers supported by the Oranga Tamariki Evidence Centre as requested and ensuring alignment with the Evidence Centre Ethics Protocol.[41]

Regional engagements consisted of individual and group sessions ranging from three to ten participants, facilitated both in-person and online throughout the country, bringing together key local stakeholders. Sessions primarily focussed on frontline staff and sector groups, along with iwi and Māori providers and groups.

Ongoing discussions were had with cross-agency stakeholders to understand their experiences and input to design a future system. This included meetings with GAC's, education professionals, health clinicians and other partners.

Periodic engagement was conducted to ensure external perspectives were integrated, involving children's community groups such as the Youth Advisory Group, VOYCE Whakarongo Mai, other children's agencies and oversight bodies.

### *Survey Instruments*

Two anonymous, opt-in surveys were available online. One survey for Gateway relevant cross-agency frontline staff and another survey for care experienced parents and young people, family members and caregivers. The surveys complemented the regional engagements. Surveys were accessible concurrently with regional engagement activities from August to October 2023. Stakeholders were informed through Oranga Tamariki communication channels, newsletters, and community groups.

[41] Department of the Prime Minister and Cabinet. (2022, August 3). *Pae Ora – Healthy Futures.* Future of Health. https://www.futureofhealth.govt.nz/pae-ora-health-futures/

## Administrative Data

Gateway data was gathered from the IAP and analysed for the period from 1 July 2017 to 30 June 2023.

This information includes Gateway details logged by social workers in the child's Health and Education Assessments (HERA) record within CYRAS. A HERA record acts as the 'parent' record, holding all data on the child or youth in the Gateway process. Despite changes in 2014 to improve data handling, issues with HERA record quality and consistency still need to be addressed. Modifications have simplified accessing referral, appointment, and profile information, yet accurately extracting needs assessment data still poses challenges (refer to *Ensure consistent recording of needs data*).

Noted in the What We've Learned section of this report**,** the current system does not systematically record whether the child receives the recommended referral or service. Information about whether a service is received, and any updates noted are typically written within the case notes, which social workers upload as separate documents into CYRAS.

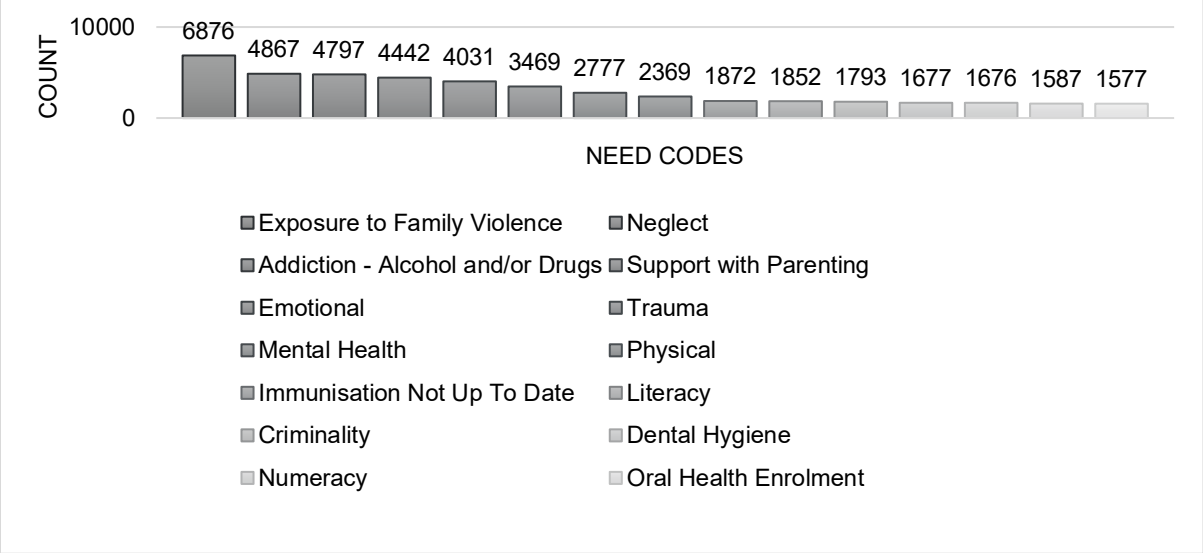
Where Gateway may not be required, the Social Worker will mark the 'Reason for Gateway not required' box, avoiding a new Gateway record.

## Needs Codes Data

After receiving the Final Gateway Report the GAC manually selects from a list of 192 needs codes to input into the Gateway IT Tool based on their interpretation of the health and education needs identified for the child or young person (refer to Appendix IV – *Gateway Assessment Data Input Process*).

Needs codes data analysed for all Gateways created between 2018 to 2023 (Figure 24) shows the most frequent needs codes reported. These can be categorised broadly into abuse, parental, emotional, behavioural, trauma, dental, vision, immunisation and learning concerns (in order of frequency from left to right).

**Figure 24. Most frequent needs codes from Gateways 2018 to 2023 financial years**

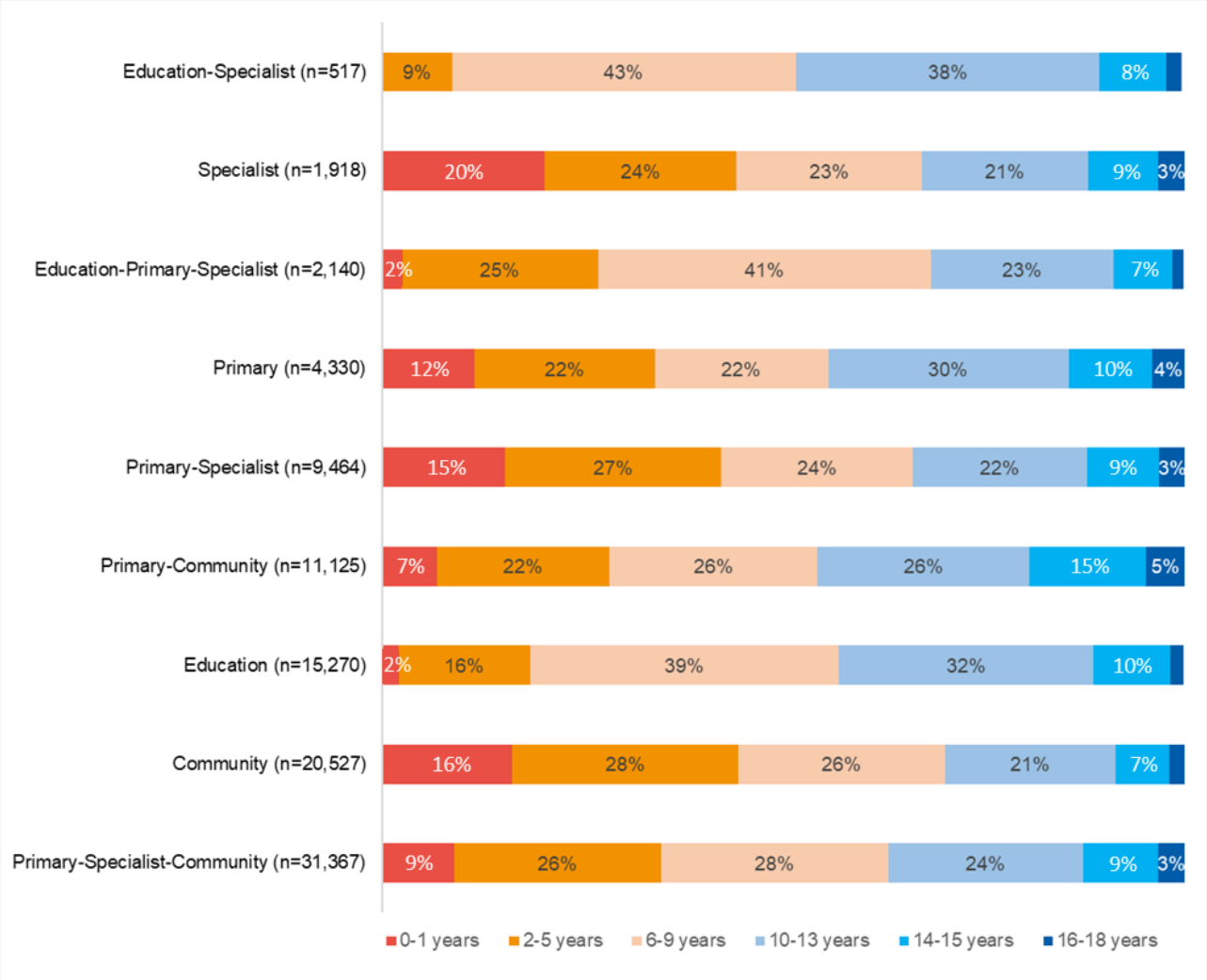


We further analysed Gateway needs codes by grouping them into service provision pathways. We collaborated with GPs in this process of grouping the needs, which can be addressed by Primary health, Specialist health, Education support or a Community partner.

For many needs, these groups were joined together representing needs potentially that span across service provision pathways (e.g. Primary-Specialist, Primary-Specialist-Community, Education).

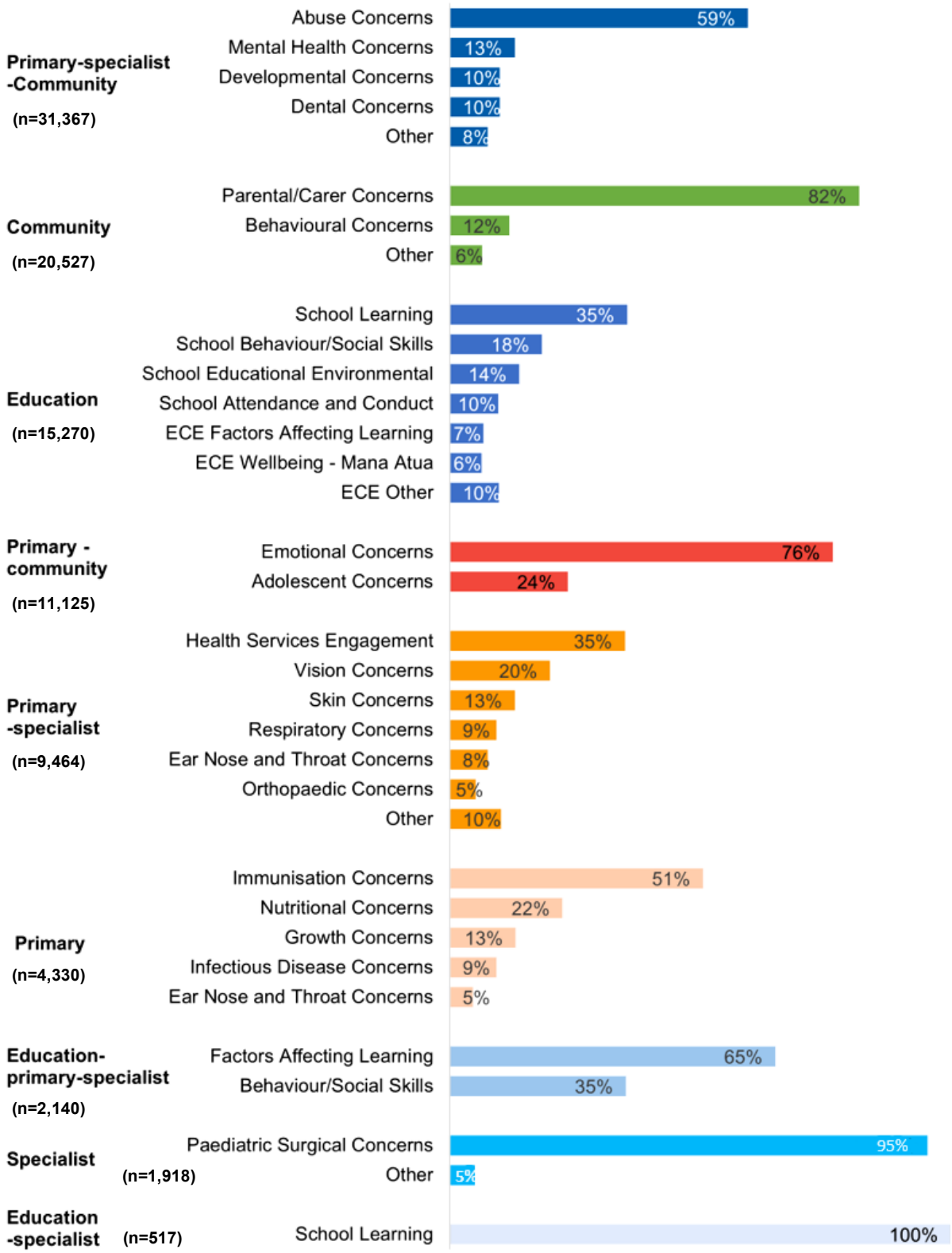
For children aged six to nine, large portions of needs pertain to Education-Specialist (43 percent), Education-Primary-Specialist (41 percent), and Education (39 percent) service groups (Figure 25), underscoring the importance of a triaged service with emphasis on education support to meet needs identified for this age group.

**Figure 25. Service Group Pathways by age breakdown 2018 to 2023 financial years**




Primary was tightly coupled with other service group pathways, excluding education (Figure 26) where data limitations are well known. This underscores the importance of having access to a Primary service pathway for Gateway that is triaged with Education and Community pathways.

**Figure 26. Service Group Pathways count and proportion by needs concern 2018 to 2023 financial years**




Gateway needs codes matched potential service pathways with the caveat that a continuum of care exists for most needs. Needs identified for the Specialist pathway were mostly paediatric (Table 4).

**Table 4. Specialist Pathway needs concern categories**

| Concern | Identified Need |
|---|---|
| Paediatric Surgical Concerns | 1,615 |
| Cardiology Concerns | 48 |
| Endocrinology Concerns | 29 |
| Blood and Cancer | 4 |

## *Contract Data*

Gateway contract data about health assessment services outsourced by Oranga Tamariki to external organisations was extracted from July 2018 to July 2023. Evident in this data is the cost for GACs who are contracted to manage Gateway via Te Whatu Ora Health Districts (refer to Appendix V – Gateway Regional Utilisation; and section *Address funding and utilisation issues*).

Contract data gathered for this review gives a basic view of the cost implications and regional utilisation rates.

# Limitations

While the evidence highlights the main issues and positive aspects of Gateway, there are some limitations regarding the interpretation of findings in this report.

Engagement was limited to Auckland, Lower South, Bay of Plenty and Te Tai Tokerau, due to timing and resourcing constraints. A travel ban was put in place during the engagement period requiring engagements to be held online.

The two national surveys provided a representative sample of perspectives from cross-agency staff, and care experienced young people, whānau and caregivers. Specifically, the Youth, Family and Caregiver Survey had a sample size ($n < 100$) of participants meaning that quantitative data interpretation of survey results cannot be generalised to the entire population of care experienced youth, whānau or caregivers.

Data input quality issues exist within CYRAS and the Gateway IT Tool because there is variation across Health Regions as to interpretation of Gateway needs codes and consistency of input into the system.

These data input discrepancies are explained within the report findings and the above caveats were considered when interpreting the results within this report.

# Appendix I

## Gateway Research Questions

The following list of sub-questions were utilised alongside main questions during focus group engagements with frontline staff and care providers (Table 5).

**Table 5. Other questions and sub-questions**

| | |
|---|---|
| 1 | Are we currently fulfilling the intent of Gateway? |
| 2 | Is the intent of Gateway appropriate? |
| 3 | What needs to be flexible to fit with local aspirations and resources, and what should be consistent across the country? |
| 4 | Is the eligibility criteria appropriate? |
| 5 | Should other groups of children and young people in the Oranga Tamariki system have access to Gateway? |
| 6 | How can Gateway help ensure proportionate responses to identified levels of need? |
| 7 | Is Gateway appropriately resourced to fulfil the intent, and where are specific resource shortages? |
| 8 | How does Gateway align with and add value to the wider system of engagements? |
| 9 | How can Gateway be better integrated with the wider developmental, health, education, and oranga journey of a child or young person, and their whānau? |
| 10 | What are the implications and opportunities presented by wider reforms? |
| 11 | Should Gateway be better aligned or integrated with the health and education assessment process for young people in the youth justice system? |
| 12 | How can the Gateway process be implemented in line with Te Tiriti o Waitangi, embody kaupapa Māori approaches and principles, and be mana-enhancing for whānau? |
| 13 | How can agencies support a greater role for iwi and Māori partners (if desired in a community), for example, in delivering Gateway Assessments? |
| 14 | How can Māori/ Iwi/ whānau play a stronger role in decision making around Gateway, including in the assessment process itself? |
| 15 | How can it better embody Pacific and other cultural values? |
| 16 | How can Gateway be framed around strengths and oranga for the children and young people going through the process, rather than deficit focused? |
| 17 | What are roles and responsibilities across agencies in delivering and overseeing the assessment process, including evaluation, continuous improvement, funding, policy and oversight? |
| 18 | Are the roles and responsibilities between key professionals in the assessment process clear? |
| 19 | How can children, young people, and whānau voices be better supported and valued alongside others (e.g. clinicians)? |
| 20 | Should there be a review process which whānau can activate if unsatisfied with the initial outcome? |

# Regional Engagement

Engagements were guided by the following Kaupapa Māori principles (Table 6).

**Table 6. Kaupapa Māori Principles of Engagement**

| Whanaungatanga (belonging, cohesion) | Rangatiratanga (chieftainship) |
|---|---|
| To enhance and empower good relationships and connections for the wellbeing and advancement of the tamariki and their whānau with the greatest need. | Give time and space to tamariki, whānau, iwi, community to lead and make decisions that determine best outcomes that ensure whānau are transforming systems that beet meet their needs. |
| **Manaakitanga (care, uphold, support)** | **Wairuatanga (spiritual synergy)** |
| To support and encourage in its highest regard reciprocal hospitality, respect and protection of mana and whakapapa to maintain balance of priority populations response needs first and foremost that advances the aspirations of tamariki, whānau, iwi, and community. | Whakamana the holistic components of te ao Māori that nurture, support, grow and heal tamariki, whānau, iwi, and community. |
| **Kotahitanga (unity)** | **Kaitiakitanga (guardianship)** |
| That there is unity and synergy amongst individuals and groupings to better meet the needs for tamariki, whānau, iwi, and community in self-determination. | To be the guardian of the people involved, looking after them, placing their best interests first. |

Table 7 presents the list of care providers inclusive of Māori and Pacific, and community providers involved in the engagement process.

**Table 7. Community and Service Providers**

| Region | Examples of support provided to children, young people, and whānau |
|---|---|
| **Auckland** | Early intervention, Education support work, ACC Accreditation, Development Assessment, Parenting Programmes, Functional Family Therapy, Lighthouse Short Stay Homes, Therapeutic Group Home, Specialist Caregiver Programme, Disability support, Intensive wraparound, Shared Care, Supported Living Services, Transition Services, Very High Needs Services, Primary Health Care, Whānau Ora, Well Child, Social Work, Care Services, Teen Parent Social Services, Teenage Mothers Accommodation, Early Childhood Centre, Whānau support. |
| **Auckland/Northland** | Whānau Advocacy (Community Social Worker), Whānau and Foster Care Services, Early Intervention – Tatai Hono Mokopuna. |
| **Dunedin, Lower South** | Primary Health Care, Dental Care, Tamariki Ora, Manaaki Ora Nursing, Supported Accommodation, Whānau Ora Navigation, Whānau Support, Whānau Care – Shared Care, Family Start, Home-based Family Support, Therapeutic services, Social Workers in Schools (SWIS), Caregiving and Respite Care, Counselling, Youth Addiction, Foetal Alcohol Spectrum Disorder (FASD), Counselling in school. |
| **Invercargill, Lower South** | Primary Health Care, Community Nursing, Mental Health, Whānau Ora, Whānau Support, Transition Support, Supported Accommodation, SWIS, Disability Services, Social Work, Counselling, Family Start, Group Parenting Programmes, Foster Care, Strengthening Families. |

Table 8 presents the list of region-specific cross-agency partners and advisory groups that were consulted and engaged with through the review.

**Table 8. Engagement with cross-agency partners**

| Cross-agency partner | Region | Involvement in the Gateway Assessment process |
|---|---|---|
| **South Auckland Social Wellbeing Board** | South Auckland | Involved in leading Te Huarahi Ngaa Tahi prototype in South Auckland. The prototype looked at an alternative approach to the Gateway Assessment. This prototype was a partnership between Oranga Tamariki (Otara site), Counties Manukau District Health board, and the Anglican Trist for women and children. |
| **Te Tai Tokerau cross-agency group** | Te Tai Tokerau | Health and Education staff involved in the Gateway Assessment in Te Tai Tokerau |
| **Gateway Co-ordinators across New Zealand** | National | Contracted by health to co-ordinate/conduct the Gateway Assessment. |
| **General Practitioner** | Palmerston North | Mid-central DHB (District Health Boards). Involved in conducting the Gateway Assessment |
| **Bay of Plenty DHB** | Bay of Plenty | Health and Education staff involved in the Gateway Assessment in the Bay of Plenty region |
| **South Auckland Education staff** | South Auckland | Education staff that are involved in the Gateway Assessment in South Auckland |
| **North & West Auckland DHB** | North and West Auckland | Health staff involved in the Gateway Assessment |
| **Invercargill cross-agency group** | Lower South-Invercargill | Health and Education staff involved in the Gateway Assessment in Invercargill and Lower South |
| **Dunedin cross-agency group** | Lower South - Dunedin | Health and Education staff involved in the Gateway Assessment in Invercargill and Lower South |
| **Lower Hutt DHB** | Lower Hutt, Wellington | Health staff involved in the Gateway Assessment |
| **Central Auckland DHB** | Auckland | Health staff involved in the Gateway Assessment |
| **General Practitioner** | Horowhenua | Youth One Stop Shop – previously involved in conducting the Gateway Assessment |
| **The Oranga Tamariki Youth Advisory Group** | National | An advocacy group made up of care and youth justice-experienced young people who provide insights and feedback on Oranga Tamariki policy and services. |
| **Voice Whakarongo Mai** | National | Non-for-profit agency dedicated to upholding the voices of the care experienced. |

Table 9 gives a breakdown for each region and focus group count, the cross-agency frontline focus group engagements conducted across multiple regions.

**Table 9. Engagement with Oranga Tamariki frontline staff groups**

| Focus Group | Region | Staff Involved in the Gateway Assessment |
|---|---|---|
| **South Auckland** | South Auckland | Care and protection social workers, practice leader, supervisors, Gateway administrator, site manager, senior advisor education and health. All staff are directly involved in the Gateway process |
| **Central Auckland** | Central Auckland | Care and protection social workers, practice leader, supervisors, Gateway administrator, site manager, disability advisor Senior Advisor Education and Health. All staff are directly involved in the Gateway process |
| **North and West Auckland** | North and West Auckland | Care and protection social workers, practice leader, supervisors, Gateway administrator, site manager, Senior Advisor Education and Health. All staff are directly involved in the Gateway process |
| **Otago Urban** | Dunedin | Care and protection social workers, practice leader, supervisors, Gateway administrator, site manager, Senior Advisor Education and Health. All staff are directly involved in the Gateway process |
| **Invercargill** | Invercargill | Care and protection and Youth Justice social workers, practice leader, supervisors, Gateway administrator, site manager, Senior Advisor Education and Health. All staff are directly involved in the Gateway process |
| **Rural Lower South** | Balclutha, Gore and Alexandra | Care and protection social workers, practice leader, supervisors, Gateway administrator, site manager, Senior Advisor Education and Health. All staff are directly involved in the Gateway process |
| **Bay of Plenty** | Whakatane | Care and protection social workers, practice leader, supervisors, Gateway administrator, site manager, Senior Advisor Education and Health. All staff are directly involved in the Gateway process |
| **Te Tai Tokerau** | Northland | Care and protection social workers, practice leader, supervisors, Gateway administrator, site manager, Senior Advisor Education and Health, Māori partnership and community representation. All staff are directly involved in the Gateway process |
| **Clinical Services** | National | Clinical specialists nationwide. All staff are directly involved in the Gateway process |
| **Disability Support Services** | National | Disability advisors nationwide. All staff are directly involved in the Gateway process |
| **Puketai Care and Protection Residence** | Dunedin | Health residence staff. All staff are directly involved in the Gateway process |

# Appendix II

## Cross Agency Staff Survey

The national cross-agency staff survey consisted of three sections.

- Section one asked a set of control questions.
- Section two asked a set of demographic questions.
- Depending on participant answers to sections one and two, they were directed to a tailored set of questions pertaining to their sector and role in Section three. This section consisted of six-point Likert style questions followed by open-text questions for selected topics.
- The question combination represented a mixed-methods approach to the data gathering process.

Survey participants comprised of Oranga Tamariki, MOH, MOE, Health New Zealand, Service Partner Providers and Māori Community Providers (Table 10).

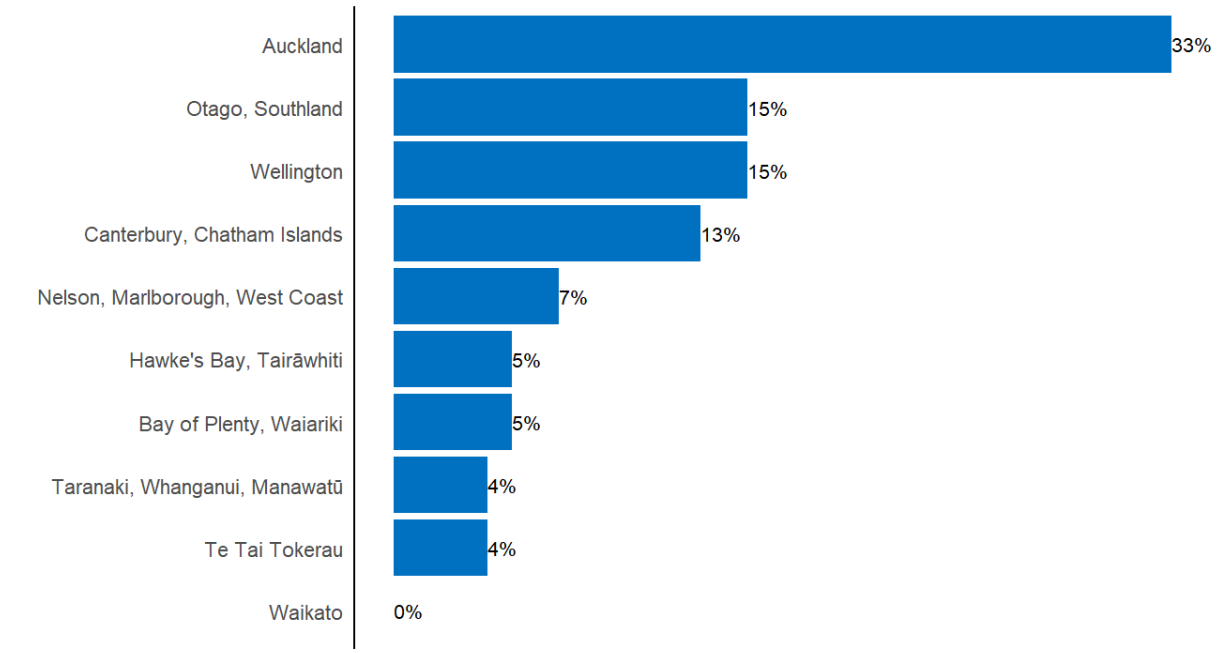
**Table 10. Kaimahi Survey – Characteristics of respondents and sector (n = 252)**

| Sector | % |
|---|---|
| ***Agency Affiliation*** | |
| Te Tāhuhu o te Mātauranga – Ministry of Education | 35 |
| Oranga Tamariki – Ministry for Children | 29 |
| Te Whātu Ora – Health New Zealand | 29 |
| Service Partner Provider | 4 |
| Māori Community Provider | 2 |
| Manatū Hauora – Ministry of Health | 1 |

**Based on all respondents, excluding not answered and 'prefer not to say'.*

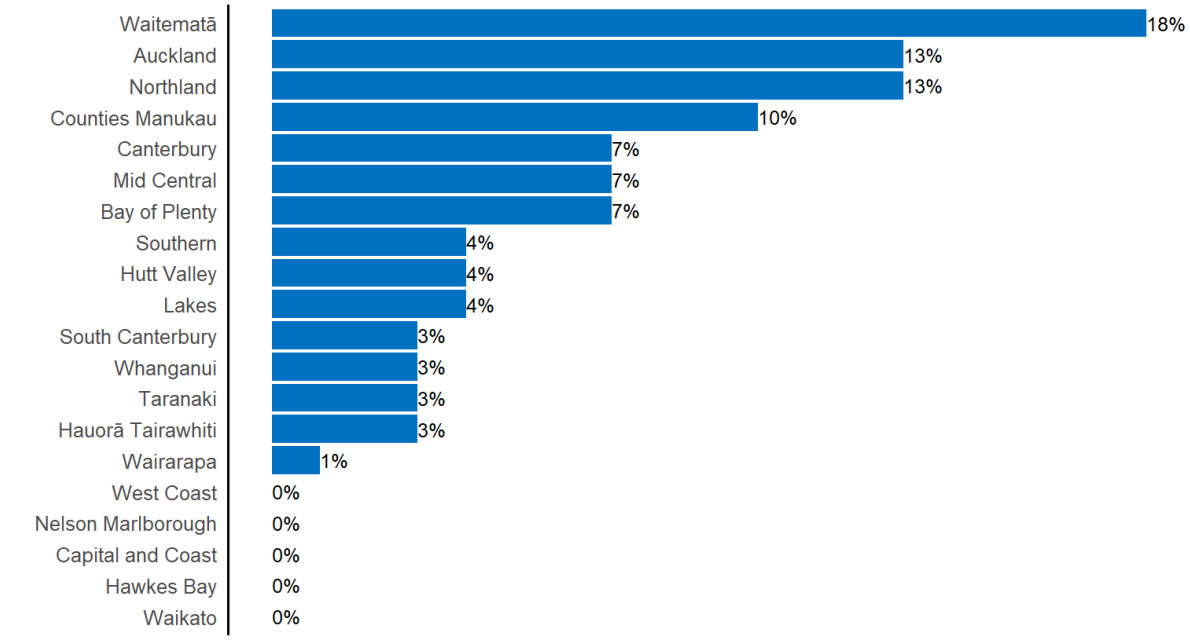
The following figures describe the breakdown of respondents by region for each sector.

**Figure 27. Oranga Tamariki affiliated survey respondents by region**



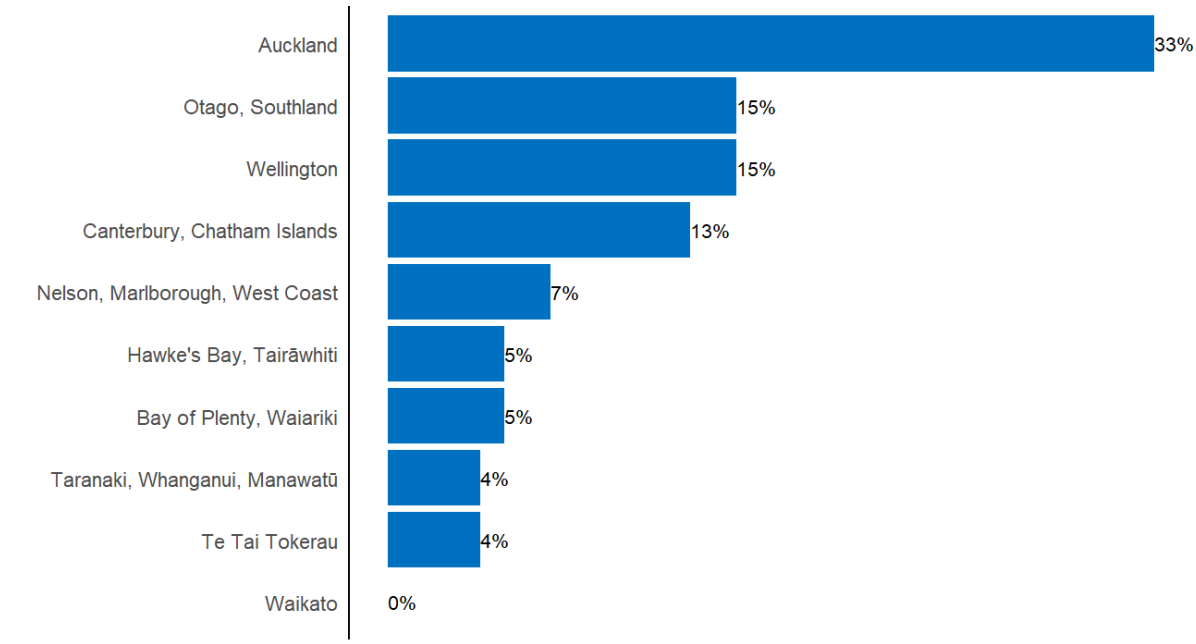

Base:all respondents affiliated with MoE,
excluding not answered, prefer not to say and not applicable (n=55)

**Figure 28. Health affiliated survey respondents by region**




Base:all respondents affiliated with health agencies,
excluding not answered, prefer not to say and not applicable (n=71)

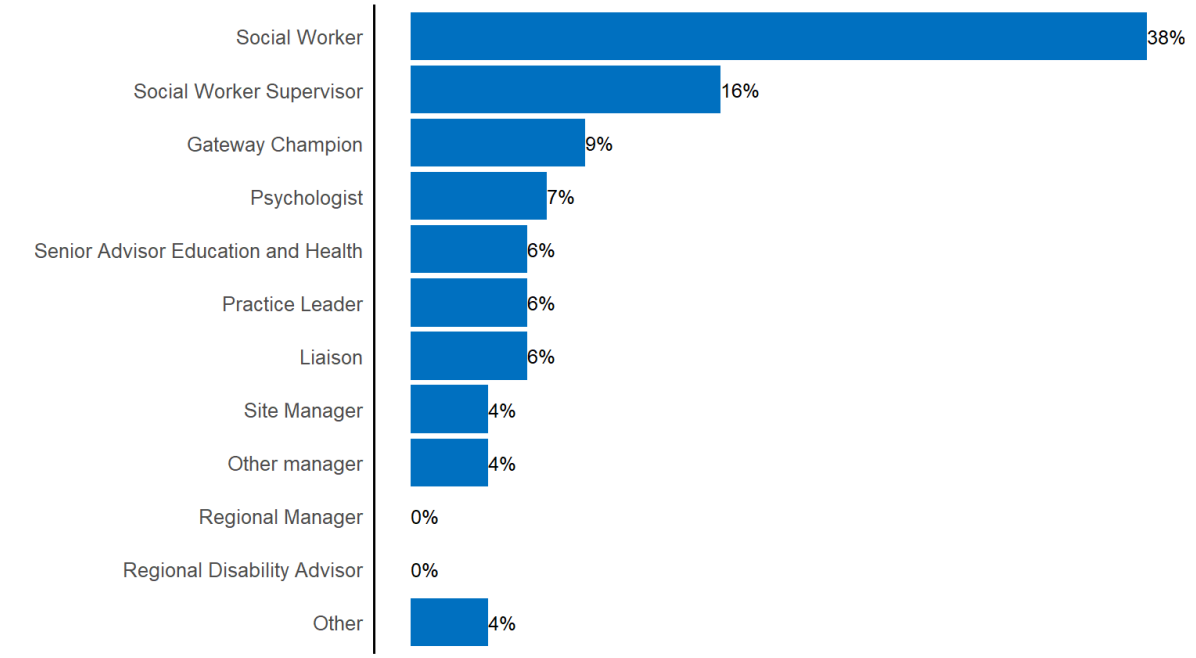
**Figure 29. Education affiliated survey respondents by region**




Base:all respondents affiliated with MoE,
excluding not answered, prefer not to say and not applicable (n=55)

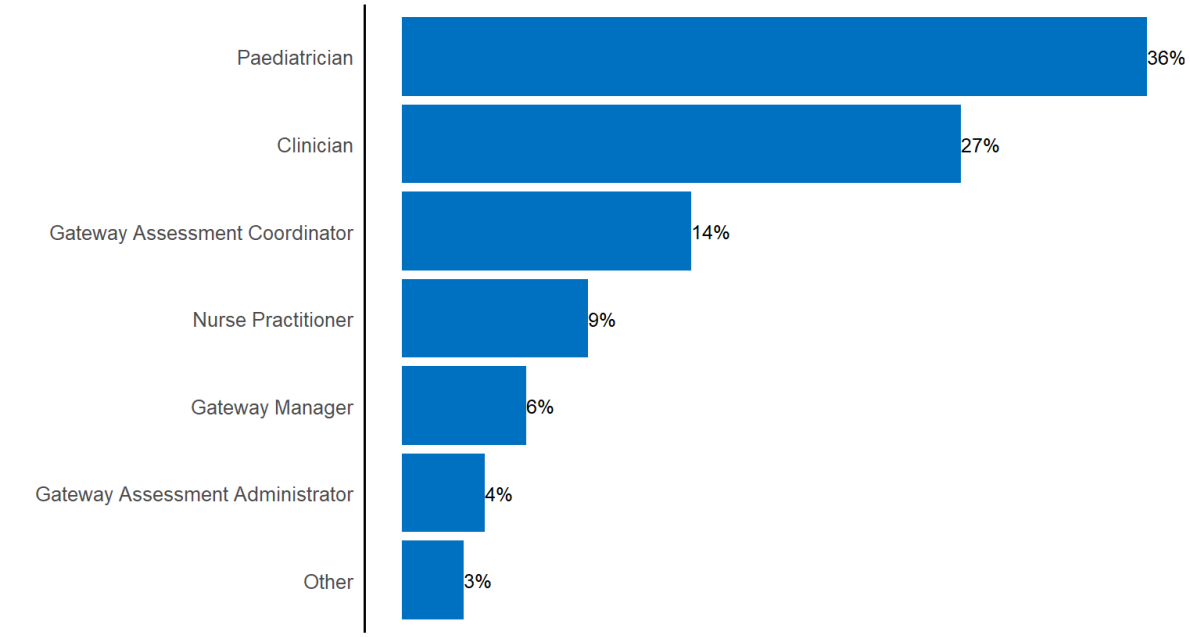
Participants were asked about their role pertaining to Gateway. The following figures give a breakdown of agency affiliation by respondent role.

**Figure 30. Oranga Tamariki affiliated survey respondents by frontline role**



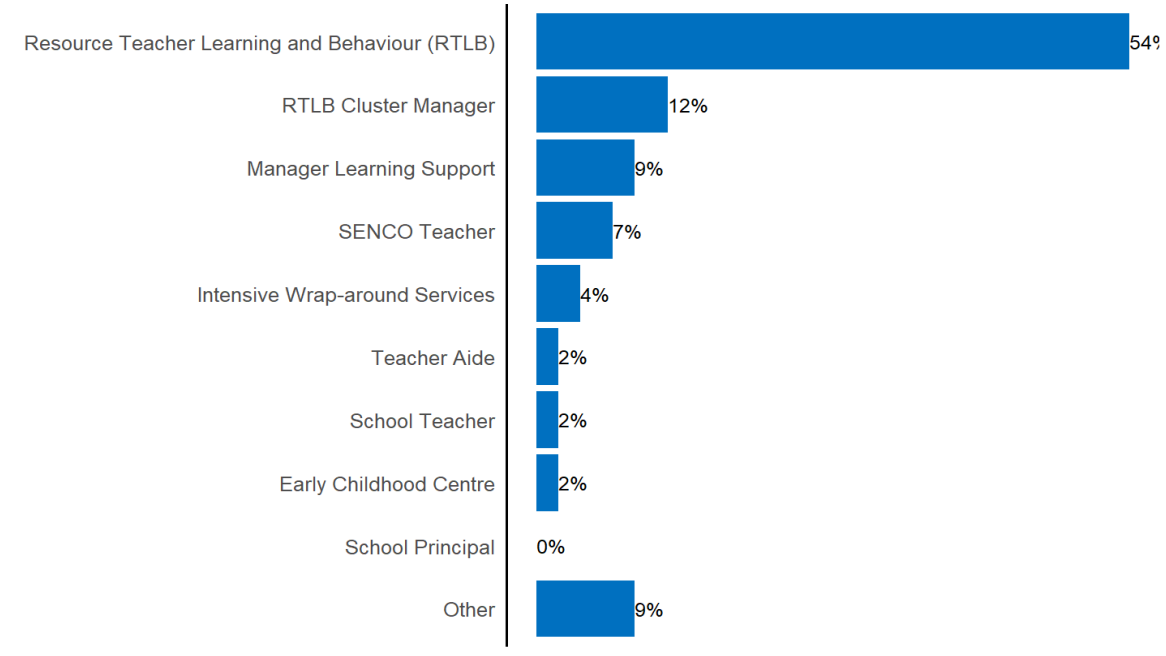

Base:all respondents, excluding not answered, prefer not to say and not applicable (n=69)

**Figure 31. Health affiliated survey respondents by role**




Base:all respondents affiliated with health agencies,
excluding not answered, prefer not to say and not applicable (n=77)

**Figure 32. Education affiliated survey respondents by role**




Base:all respondents affiliated with MoE,
excluding not answered, prefer not to say and not applicable (n=57)

# Cross Agency Survey Themes and Responses

The following tables present a summary of themed responses to the question *"What's not working well"* in the Gateway process by frontline role.

**Table 11. Oranga Tamariki – What's not working for the Gateway process (n=66)**

| Role | Summary of participant responses |
|---|---|
| **Gateway Champion (n=6)** | Concerns about timeframes and caseloads, indicating challenges in managing workloads and meeting deadlines. |
| **Liaison*** | The length of time taken to assess children, especially for psychological needs, was a key issue, suggesting inefficiencies or resource constraints in the assessment process for mental health needs. |
| **Other Manager*** | Notable problems with engagement of Oranga Tamariki Social Workers in encouraging family or whānau participation, implying potential communication or motivational challenges to attend the service. |
| **Other Professional*** | Issues with timeliness of assessments and ability to create actionable plans, pointing to systemic inefficiencies due to a lack of services available. |
| **Practice Leader*** | Significant delays in paediatric assessments (over six weeks), highlighting timeliness as a constraint in the assessment process. |
| **Psychologist*** | Concerns about a rushed MDT process with limited time for thorough assessments, suggesting a need for more comprehensive and relaxed assessment procedures. |
| **Senior Advisor Education & Health*** | The main issue is the time taken to complete health assessments, indicating a need for more efficient health assessment processes in coordination with the DHB. |
| **Site Manager*** | The breadth and depth of assessment reports must be improved, implying a need for more detailed and comprehensive assessments. |
| **Social Worker Supervisor (n=9)** | The poor quality of education assessments (e.g. the completion of the education profile), indicating specific deficiencies in this aspect of the assessment process. |
| **Social Worker (n=23)** | The lack of follow-up after assessments are conducted and recommendations given is a major concern, pointing to a gap in ongoing care or services post-assessment. |

**Actual count is suppressed for reporting purposes*[42].

**Table 12. Health – What's not working for the Gateway process (n=71)**

| Role | Summary of participant responses |
|---|---|
| **Clinician (n=14)** | Challenges with incomplete or outdated referrals and the need for Oranga Tamariki social workers to be more engaged, with some being new and unfamiliar with the process, affecting the efficiency of the Gateway Assessment. |
| **GAA*** | Concerns about the quality of referral information, which affects the assessment's effectiveness, slow response times from Oranga Tamariki staff, and difficulties in scheduling family meetings. |
| **GAC (n=10)** | An increase in assessments without a corresponding increase in resources, leading to pressures on the system—difficulty in managing the increased workload, impacting the quality and timeliness of assessments. |
| **Gateway Manager*** | The current model is not child-centric, with families not at the centre of the process. Highlighted the need for a more holistic approach that considers the child and their family's overall well-being. |
| **Nurse Practitioner (n=6)** | Difficulties in contacting Oranga Tamariki staff and challenges with the availability of Oranga Tamariki social workers for critical meetings. |

[42] Stats NZ Microdata output guide - Microdata-Output-Guide-2020-v5-Sept22update.pdf

| Role | Summary of participant responses |
|---|---|
| **Child Health Commissioner*** | Inconsistent application of referrals, leading to gaps in addressing critical health issues, with a need for follow-up on important health issues. |
| **Navigator*** | Lack of cultural support in the process and the need for more culturally sensitive assessments and interventions. Emphasised the importance of cultural sensitivity in interventions for better outcomes. |
| **Paediatrician (n=21)** | Issues post-assessment, particularly if additional support or specialist referrals are needed, with a lack of follow-up or action. Emphasised problems persisted with follow-up or action after the assessment, affecting the child's continuity of care and support. |

**Table 13. Education – What's not working for the Gateway process (n =78)**

| Key theme | Description |
|---|---|
| **Timeliness and coordination** | Emphasised communication, timing, and coordination issues within the process. |
| **Meeting needs** | Challenges with understanding and meeting the needs of children and families. |
| **Resource access** | Problems exist with consistency, resources, and access in the process. |
| **Collaboration** | Difficulties remain in collaboration and support from different stakeholders. |
| **Effectiveness of assessment** | Concerns about the effectiveness and implementation of the assessment. |
| **Follow-up with schools** | Issues with school involvement, follow-up on assessments, and process variability. |
| **Educational purpose** | Challenges with collaboration between RTLB and social workers' roles, and the assessment's educational purpose. |
| **Information sharing** | Concerns about lack of information from the child or youth's assessment back to education professionals and understanding specific needs. |
| **Accountability** | Lack of guidelines and involvement between Oranga Tamariki social workers and school staff in education service follow-up. |

Table 14 and Table 15, present a summary of themes extracted from Health and Education frontline staff on the inclusion of voice in the Gateway process. Responses answered the following survey question:

*Q: Could you explain more about what can be done to better include the voices of whānau, caregivers, children and young people in the Gateway process?*

**Table 14. Health themes on inclusion of voice in Gateway process (n=64)**

| Key Theme | Summary |
|---|---|
| **Direct inclusion and participation** | Respondents advocate for asking families, caregivers, and children to directly participate in various stages of the Gateway process. This could include involving them in completing certain sections of assessments or reports. |
| **Welcoming and inclusive environment** | Emphasis is placed on creating an environment where families, caregivers, children and youth feel welcome to express their views. This involves ensuring that they are comfortable, and their input is valued during interactions. |
| **Partnership with families and caregivers** | The need to partner with families and caregivers in identifying and addressing the needs of children is highlighted. This partnership approach can foster trust and ensure that the voices of families and caregivers are heard and considered. |

| Key Theme | Summary |
|---|---|
| **Feedback mechanisms** | Implementing feedback mechanisms for families and children involved in the Gateway process is seen as essential. This could include regular check-ins or surveys to gather their insights and opinions. |
| **Respect for cultural values and practices** | Respecting and integrating cultural values and practices into the Gateway process is crucial, especially when working with diverse communities. Cultural responsiveness can enhance engagement and participation. |
| **Communication and understanding** | Improving communication with families and children is vital. This involves not only speaking to them but also listening actively and empathetically to their concerns and perspectives. |
| **Child-friendly approaches** | Adapting the process to be more child-friendly, possibly through age-appropriate communication or activities that engage children in a meaningful way. |
| **Training for professionals** | Training for professionals involved in the Gateway process on how to effectively engage with children and families is suggested. This training could focus on communication skills, cultural capability, and child or youth development. |

**Table 15. Education themes on inclusion of voice in Gateway process (n=72)**

| Key Theme | Summary |
|---|---|
| Whānau and child's voice in Education Profile | Address the challenges in including whānau and student voices in the education profile. |
| Meaningful involvement of the child | There needs to be better inclusion of children's feelings and needs in the process to allow for more meaningful involvement. |
| Empower youth voice in the process | Emphasise the voice of young people and children in addressing their needs in the Gateway process. |
| Clarity of information, consent, and communication | Resolve issues with information sharing, the role of parental consent in the process, complexities of needs, and need for clearer communication. |
| Whānau and child's voice heard by agencies involved | Ensuring whānau and children's voices are heard in schools and by various agencies, supporting their involvement in meetings. |

Table 16 presents key themes across Oranga Tamariki frontline roles. Themes underscored the importance of family and youth involvement with suggestions on how the process can be enhanced to facilitate.

**Table 16. Oranga Tamariki themes on inclusion of voice in Gateway process by role (n=32)**

| Role | Key Themes | Summary |
|---|---|---|
| **Gateway Champions*** | Seeking Direct Feedback | Suggest a system that actively seeks the thoughts of families and children, indicating a need for more direct and intentional feedback mechanisms. |
| **Liaisons*** | Family Inclusion in Planning | Emphasises that families are not part of the planning nor supported to be part of the process, suggesting a lack of direct involvement and support for family participation. |
| **Other Managers*** | Experienced Staff Engagement | Highlight the benefits of having experienced, competent staff who engage with families, caregivers, and children, implying that staff experience plays a key role in effective engagement. |
| **Practice Leaders*** | Need for Better Collaboration | Suggest the need for more joined-up efforts between Oranga Tamariki and Health, to address the potential lack of coordination in including family voice. |

| Role | Key Themes | Summary |
|---|---|---|
| **Psychologists*** | Feedback from Families | Recommend seeking feedback directly from families and children, emphasising the importance of hearing their perspectives in the process. |
| **Senior Advisors Education and Health*** | Option to Attend Meetings | Suggests that families and caregivers should have the option to attend panel meetings, advocating for more direct family and caregiver involvement in decision-making processes. |
| **Site Managers*** | Promoting Active Participation | Emphasises the promotion of active participation in the process, indicating a need for strategies that actively involve families. |
| **Social Workers (n=15)** | Parents and Youth Voice | Notes that the voice of parents and youth is often missing in the process, highlighting a significant gap in including these critical perspectives. |
| **Social Worker Supervisors (n=7)** | Involvement in MDM/ISA Process | Suggest that families could be more actively involved in the MDM/ISA process. indicating a desire for their more active participation in planning and decision-making. |

Table 17 presents a snapshot of quotes extracted from Health, Education, Oranga Tamariki and Care Partner frontline staff on ease of interpretability of the Final Gateway Report for families and suggestions for improvement. Responses answered the following survey question:

*Q: Do you think the Final Gateway Report is easy to interpret, use and communicate to Whānau, caregivers, children and young people? And what could be done better with regards to this part of the process?*

**Table 17. Education staff direct quotes on accessibility of information for families and youth**

| Agency | Role, Area | Survey Quote |
|---|---|---|
| **Education** | RTLB, Wellington | Involve the school in the ISA process - they need a voice. Students need a voice - they should be included in the planning. When reports are released there should be a conversation not just a letter of recommendations. |
| **Health** | Paediatrician, Counties Manukau | Brochure is not easy to understand especially for those with low literacy |
| **Health** | Clinician, Counties Manukau | Many families are attending not fully understanding what the Gateway is. They often feel that they have to consent as it is part of the OT process. I feel uncomfortable that we cannot share recommendations directly with whanau. |
| **Health** | Paediatrician, Canterbury | Could evolve process for families who are not attracted to Gateway – joint working between Oranga Tamariki and Health to visit [and] discuss with whanau together. |
| **Health** | Paediatrician, Location Unknown | Brochure for families and consent process: understanding of consent does not seem well understood by some OT Social Workers. The brochure content is accurate but too wordy for many (most) families to read and understand. |
| **Care Partner** | Service Provider, Taranaki-Mānawatu | Lack of understanding of the report by Oranga Tamariki social workers - but they are not fluent in health jargon and also often not interested or aware of Positive Youth Development and its importance in influencing health outcomes. |
| **Oranga Tamariki** | Liaison | There should be a separate report for the whānau and for the professionals. |

| Agency | Role, Area | Survey Quote |
|---|---|---|
| **Oranga Tamariki** | Social Worker, Bay of Plenty | Information is usually easy to read, but some whānau find it difficult to understand. Sometimes kids fall through the cracks as whānau do not respond to further appointments and social workers are not kept in the loop to give the oomph for work to be completed. |
| **Oranga Tamariki** | Social Worker, Canterbury | We don't tend to share the Final Gateway Report with whānau as it isn't very mana enhancing and focuses more on their deficits rather than their strengths. |

**Table 18. Oranga Tamariki themes on perception of follow-up after ISA by role (n=49)**

| Role | Key Theme | Summary |
|---|---|---|
| Gateway Champions* | Follow-up Lacking | Mentioned the issue of social workers and supervisors not following up on recommendations, suggesting a gap in adherence to procedures and a need for better compliance or oversight. |
| Liaisons* | Practicality of Plans | Pointed out that plans are often unrealistic 'wish lists', indicating a need for more practical, achievable goals in the ISA and reports. |
| Practice Leaders* | Role of Supervisors | Mentioned that supervisors could be more involved in ensuring that recommendations are followed up, highlighting a potential area for leadership improvement. |
| Psychologists* | Accountability and Review | Suggested the need for more accountability and review in the process, implying a desire for more thorough oversight and follow-up. |
| Senior Advisors Education & Health* | Review and Support to Services | Highlighted the need for more review of recommendations and support in accessing services, indicating a gap in the follow-up and implementation of report recommendations. |
| Site Managers* | Balanced Approach Needed | Concerned that the ISA is often too vague and that there is an over-focus on health, suggesting a need for a more balanced approach in the reports. |
| Other Managers* | Importance of Reports | Emphasised the need for Social Workers to understand the importance of the ISA and Gateway Report. |
| Social Worker Supervisors (n=7) | Training for Social Workers | Noted the need for more training and consistency for social workers in handling the ISA and final report, indicating a skill gap in the handling and delivery these documents. |
| Social Workers (n=19) | Timeliness of Report Provision | Suggested that it would be beneficial if the ISA and final report could be provided quicker, indicating a need for more timely access to crucial information. |

**Table 19. Health themes on perception of follow-up after ISA by role (n=65)**

| Role | Key Theme | Summary of insights |
|---|---|---|
| Clinicians (n=15) | Consistency and Communication | Advocated for a standardised template for the ISA and Gateway report to ensure consistency. Emphasised need for timeliness and better communication between involved parties. |
| GAAs* | Follow-up Efficiency | Observed that cases are often closed by the 3-month review, indicating more attention to follow-up. Concerned the ISA not always being completed or followed up effectively. |
| GACs (n=10) | Process Adequacy | Belief that there may not be significant issues needing improvement in the current process. Suggestion that the process is functioning adequately as it stands. |

| Role | Key Theme | Summary of insights |
|---|---|---|
| Nurses (n=6) | Effective Documentation | Positive view of both the Gateway report and ISA, highlighting their thoroughness and usefulness. |
| Child Health Commissioner* | Implementation Effectiveness | Observed that recommended actions identified are not always effective or well-implemented. Suggested better execution of identified actions to improve outcomes. |
| Navigators* | Family Inclusion | Emphasised the importance of including the family's voice in the process. Believes that the process works well as long as family perspectives are considered and included. |
| Paediatricians (n=21) | Recommendation Follow-up | Concerned about the recommendations made by health professionals in the ISA and final report not being followed up or actioned effectively. Suggested better implementation and follow-through of recommendations. |

**Table 20. Education themes on perception of follow-up after ISA (n=39)**

| Key Theme | Summary |
|---|---|
| Follow-up and engagement | Education staff highlighted the need for more focus on the follow-up of recommendations, checks on progress, and staff involvement. |
| Inclusive collaboration | Emphasised a need for the inclusion of social workers and schools in the ISA process in the completion of final Gateway steps. |
| Role clarification | Clarity needed on actions to be taken by Oranga Tamariki support staff and school involvement for children and youth in the Gateway process. |
| Child-focused discussion | More discussion needed about the Gateway report and ISA, follow-up on recommendations, to ensure child-focused outcomes. |

*Q: In the event that a child or young person does not receive support through the Gateway Assessment, what might be the reasons?* Other - Open text explanation.

**Table 21. Cross-agency direct quotes of reasons why no needs were identified**

| Agency | Role, Location | Survey Quote |
|---|---|---|
| **Education** | RTLB, Canterbury | We have answered this only from the education perspective – Needs are those identified that can be supported within school. |
| **Oranga Tamariki** | Social Worker, Lower South | Needs already identified and supports already in place. |
| **Oranga Tamariki** | Practice Leader, Central Auckland | No access to resources e.g. long waiting lists for mental health, and limited assessment e.g. considering non-funded vaccinations for things like meningitis. |
| **Oranga Tamariki** | Social Worker, Bay of Plenty | Too long waitlist for supports. |
| **Health** | Clinician, Northland | No follow through of partner agencies. |
| **Health** | Child Health Commissioner | There is no suitable service available. |
| **Health** | Paediatrician, Northland | Lack of information / insufficient information received at the time. |
| **Health** | Paediatrician, Lakes | Service not available. |
| **Health** | Paediatrician, no location | No appropriate service in the community to meet the needs of the child or young person. |

| Agency | Role, Location | Survey Quote |
|---|---|---|
| **Health** | Paediatrician, Canterbury | Oranga Tamariki closes the case and therefore recommendations difficult to [follow-up]. |

*Q: Please tell us more about whether services are available to support the needs identified for a child or young person?*

**Table 22. Oranga Tamariki staff direct quotes on service availability**

| Agency | Role, Area | Survey Quote |
|---|---|---|
| Oranga Tamariki | Gateway Champion, Central Auckland | Further work needed around children's eligibility for teacher aide and if the children are not in care that this should be covered by MOE and not expect funding from Oranga Tamariki for this as it is an education need. Sometimes this is put in the ISA as a recommendation for children that do not have a legal status with Oranga Tamariki and this is more an operational issue than something a social worker and supervisor can agree to. |
| Oranga Tamariki | Gateway Champion, Central Auckland | It's really difficult to say, as different services will have different referral pathway and criteria, waitlist etc., for accepting or not accepting a child into service. For example, a referral to MOE Learning Support, the criteria for a child to meet behaviour service from a psychologist can look very different to what is presented of the needs of the child, and what stakeholders have identified as the needs of the child, the same can be applied to SLT, [and] occupational therapist support from MOE etc. Such referral criteria can also vary from different learning support team[s] in the same office or across different offices. |
| Oranga Tamariki | Liaison, Bay of Plenty | […] We do not have counselling for sexually abuse children especially under 5. No service for Fetal Alcohol Spectrum Disorder (FASD) intervention. Not enough counselling for trauma available - for sexualised behaviour.<br>Teacher aide time is limited. […] We need more of ICAMHS.<br>We do not have intervention service available for behaviour in between 'high risk' to just behavioural issues. |
| Oranga Tamariki | Liaison, South Auckland | Services are available but they are limited […]. It is also dependent on whether the social worker refers them. |
| Oranga Tamariki | Practice Leader, Bay of Plenty | The identified needs change over time - from physical, to trauma and mental health. However, the services and supports do not support these – i.e. [There is] no resourcing for these. There are community agencies with health, Oranga Tamariki and education contracts that would be more appropriate. Gateway assessments need to go into the community, not [just] physical health paediatricians. |
| Oranga Tamariki | Practice Leader, Central Auckland | As mentioned, a lack of resources is the most significant barrier. [There is] limited additional education support, lack of capacity to meet identified mental health needs, limited access to neurodevelopmental and disability services, and FASD assessments. |
| Oranga Tamariki | Practice Leader, Taranaki | Any services that are put in place are usually put in place by the swkr through other planning mechanisms - eg FGC or Court planning, and via OT referral/funding. Gateway does not [have] a fast-tracked pathway through publicly available health services. The ISA plan often falls short of what is required for the children Oranga Tamariki work with |
| Oranga Tamariki | Senior Advisor Education and Health | The most significant challenge is obtaining and receiving adequate mental health assessments and interventions in a timely way. Te Whatu Ora's children and family mental health service CAFMS is quite constrained in what referral they accept particularly if the presenting issue appears to be behavioural linked rather than mental health. |
| Oranga Tamariki | Social Worker Supervisor, Lower South | There are counselling and family functional therapy services available. Also, basics such as eye checks are usually followed up on - we fund this quite often. However, there is nothing more than this and accessing mental health services is extremely difficult. |

**Table 23. Health staff direct quotes on service availability**

| Agency | Role, Area | Survey Quote |
|---|---|---|
| Health | Clinician, Southern | There are services available to meet the needs of the child/adolescent. The biggest barrier is the child/adolescent not attending the follow-up appointments with the required services, due to parent/caregiver not taking them, whānau shifting or transient. |
| Health | Clinician, Waitemata | This is the big question there are often significant gaps in the services that are available to whānau who present to Gateway. Furthermore, may whānau who encounter Gateway have significant barriers to access any sort of help. Systems are not designed to help. Many things make it hard including financial transport and communication deficits. In Tāmaki Makaurau there are distinct areas for services [which] is a significant barrier to help as many who encounter Gateway are very mobile. If they move, they have to start again. |
| Health | Clinician, Taranaki | I can refer to medical follow up needs but have no control over e.g. trauma and counselling or educational needs or mental health supports. |
| Health | Clinician, Canterbury | Our Gateway team has a great relationship with other services and can often get children past the waitlists for things like mental health support and therapy. The biggest barrier is parent/caregiver consent. |
| Health | Clinician, Waitemata | Services to fully support a child who has experienced trauma, especially therapeutic services, and support for the caregivers need to be long term. At times when children are diagnosed with a mental health or developmental difficulty – that takes priority – even though the trauma may well be the reason for the difficulties, it is often not addressed at all. |
| Health | Clinician, Waitemata | Services are hypothetically available but then referrals not made or not accepted, or no follow-up provided following referral/triage or [being] waitlisted. |
| Health | Clinician, Counties Manukau | […] As far as possible, we are working out at MDT what is realistically going to be possible for this whānau. I suggest there would be a lot of regional variation in this. |
| Health | GAC, Southern | Usually, they are available in the bigger towns. The problem can be [is] where there is no service in some of the small rural locations |
| Health | GAC, MidCentral | There is a very long waitlist in this region for Cognitive assessments (assessments for Autism, ADHD, Intellectual Disability). The service responsible for contracting these now prioritises Gateway clients, which has been helpful but still quite a wait.<br>There is a lengthy waitlist for therapeutic input relating to trauma grief and loss in one of the regions that we service, but great communication from that provider.<br>Health referrals within our Te Whatu Ora region go through quickly and depending on the service, can provide a timely response. It is challenging accessing assessment or support for mild mental health needs. |

**Table 24. Oranga Tamariki staff direct quotes on service availability**

| Agency | Role, Area | Survey Quote |
|---|---|---|
| Education | RTLB, Auckland | There is a gap between services especially around counselling or finding respite. |
| Education | RTLB, Nelson | Often there is a huge waitlist, or those on the Gateway panel do not represent the services needed, so support services are difficult to obtain. Often the student circumstances are so complex they inhibit support e.g. education support requires attendance and consistency, but home or living situation inhibits this. |
| Education | School, NA | Unfortunately, there [are] waiting lists for a number of services and specialists that prevent faster progress for a child. I believe that the Gateway Assessment is an extremely valuable tool, but it does [need] to be reviewed in how we make it work more efficiently for all involved. What can be adjusted to make the process more powerful, for example a document that states what the next steps are following the initial assessment as some children do need further assessments like cognitive assessment before the Final [Gateway] Report is made. This would give clear direction for the whole team supporting the child. |
| Education | RTLB, Auckland | I often do not hear anything further once a Gateway assessment has been completed. The school or our Gateway coordinator attends follow up meetings unless the student is an active RTLB case. |
| Education | RTLB Cluster Manager, Hawke's Bay | As cluster manager we are just the activator in between the school and Oranga Tamariki and Health to ensure the Education Profile is completed unless the child is new into care - in which case we pick the child up as a case. This rarely happens, so we are rarely involved in any of the on-the-ground support. We are certainly available if the Education Profile indicates low levels of learning and behaviour of note, but this relies on […] identifying what is needed after or during the assessment. |
| Education | RTLB, Auckland | RTLBs are available to offer support to both the students and their teachers. This is dependent on the child staying in the school long enough for the SENCO to refer them and, importantly, whether we are the right service to manage the student's needs. We can definitely offer support with identifying and working around barriers to learning, but an educational and/or clinical psychologist may be required. |
| Education | Anonymous | At present health, education and social services are facing staffing problems. Although we identify referral pathways and supports for children it is often the case there are long wait lists or just not the availability of staff. |

**Table 25. Health themes on the MDT process by role (n=51)**

| Role | Summary of Perspectives |
|---|---|
| Clinician (n=13) | Challenges remain due to Oranga Tamariki social workers not attending and issues with them not being engaged or knowledgeable about the children's cases. Further concerns expressed about not having information about the child's history, affecting their ability to contribute effectively. Positive feedback given on usage of Zoom for online meetings. |
| GAA* | Highlighted social workers often do not attend meetings, which is a significant concern. Issues with social workers not being adequately prepared, affecting the efficiency and effectiveness of the meetings. |
| GAC (n=10) | Recognised this part of the process as crucial for actual progress and outcomes. Some expressed satisfaction with the collaborative efforts and achievements in this stage. |
| Gateway Manager* | Concerned that families are not present in the process. Recommendations should ideally be developed with family involvement. Emphasised the need for more family-centric approaches. The meetings are not always effective from an education perspective. Involvement of educational professionals might be lacking or not fully utilised. |
| Child Health Commissioner* | Mention of local variance, suggesting that the involvement of appropriate people in meetings may differ by region. |

| Role | Summary of Perspectives |
|---|---|
| Nurse (n=6) | Emphasised that MDTs work well when all the necessary participants are present, suggesting room for improvement in attendance and engagement within the meetings. |
| Navigator* | Highlighted the need and benefit of including the family's voice in the process. |
| Paediatrician (n=18) | Process needs to be more family inclusive, culturally responsive and sensitive to the needs of different families. Involvement of appropriate people depends on the perspective of key support persons. Suggested that there is variability in the involvement of the right individuals in the MDT. |

Table 26 presents a summary of themes from Oranga Tamariki frontline staff perceptions on the MDT process.

**Table 26. Oranga Tamariki themes on MDT process by role (n=43)**

| Key theme / Role | Description and count |
|---|---|
| **Social Worker (n=17)** | |
| **Family-Centred Focus** | Social workers pushed for a more child, young person, or family-centred strategy in these gatherings, ensuring that the decisions and conversations directly assist the children, young people, and families they assist. |
| **Additional Resources and Support Needed** | Social workers also raised the issue of needing more resources or assistance to manage cases effectively and follow up with children, young people, and their families following MDT meetings. |
| **Gateway Champion or Liaison (n=7)** | |
| **Gateway Process Optimisation** | More attention should be paid to shortening the appointment process and enhancing scheduling procedures to optimise the MDT process for improved outcomes. |
| **Role Clarity and Participation** | To improve efficiency and lessen reliance on certain people, they recommended that each meeting participant have a clearer understanding of their role and expectations. |
| **Improvements to Policy and Protocols** | They also suggested more information about modifying intra-agency policies and procedures to assist the MDT process better. |
| **Social Worker Supervisor (n=7)** | |
| **Leadership and Guidance** | Supervisors emphasised the necessity of stronger leadership and guidance within the meetings to ensure these sessions are fruitful by concentrating on important problems. |
| **Feedback and Evaluation Mechanisms** | Enhance the MDT process's efficacy, by obtaining regular feedback and evaluation, which could fill the gaps in professional development or training and improve team members' effectiveness in these multidisciplinary situations. |
| **Psychologist*** | |
| **Focus on Mental Health** | Psychologists emphasise the value of taking into account mental health issues in case talks and push for a more comprehensive understanding of the child's needs. |
| **Clinical Perspectives and Insights** | Psychologists suggested they offer crucial clinical perspectives on case discussions, drawing attention to details that other professionals might miss. |
| **Interdisciplinary Communication** | Psychologists observed difficulties or strengths in the ways that various fields interact and cooperate at these gatherings. |
| **Assessment and Intervention Techniques** | They emphasised the importance on drawing tangible and effective conclusions from these sessions, that make effective interventions for the children and families concerned. |

# Appendix III

## Youth, Family, Whānau and Caregiver Survey

The Youth, Family, Whānau and Caregiver survey took a similar design to the staff survey which consisted of three sections.

- Section one asked a set of control questions.
- Section two asked a set of demographic questions.
- Depending on participant answers to sections one and two, they were directed to a tailored set of questions pertaining to their experience of Gateway in Section three. This section consisted of individual and matrix-style questions followed by open-text questions for selected topics of experience.

The combination of questions represented a mixed-methods approach to the data gathering process.

Participants included care experienced youth and young parents between sixteen and twenty-four years of age (connected with the youth advocacy agency, Voyce Whakarongo Mai), family and whānau members and caregivers, and non-kin caregivers. Table 27 gives a full description of participants to the survey.

**Table 27. Characteristics of Participants: Youth, Family and Caregiver Survey (n = 56)**

| Demographic Variables | Count | % |
|---|---|---|
| ***Relationship*** | | |
| I am over 16 and a care experienced young person | 24 | 43 |
| I am not care experienced but have had contact* | 3 | 5 |
| *I am the parent of a child or youth** | *5** | *9** |
| I am a family or whānau member of a child or youth* | 2 | 4 |
| I am a family or whānau caregiver of a child or youth* | 7 | 12 |
| I am a caregiver of a child or youth | 18 | 32 |
| Other (relationship) | 2 | 4 |
| ***Ethnicity of CE Youth and Parents**** | | |
| New Zealand European** | *16** | *29** |
| Māori ** | *18** | *32** |
| Samoan** | *3** | *5** |
| Cook Island Māori** | *1** | *2** |
| Other** | *2** | *4** |
| ***Ethnicity of Family and Caregivers**** | | |
| New Zealand European** | *22** | *39** |
| Māori ** | *8** | *14** |
| Other** | *2** | *4** |
| ***Recalled Participation in Gateway*** | | |
| Yes | 26 | 46 |
| No | 18 | 32 |
| Not sure | 12 | 21 |
| ***Representative Region*** | | |
| Te Tai Tokerau | 5 | 9 |
| North and West Auckland | 5 | 9 |
| South Auckland | 4 | 7 |
| Bay of Plenty | 3 | 5 |

| Demographic Variables | Count | % |
|---|---|---|
| Waikato | 6 | 11 |
| Taranaki-Manawatū | 4 | 7 |
| Wellington | 8 | 14 |
| Canterbury | 14 | 25 |
| Lower South | 4 | 7 |
| Upper South | 1 | 2 |
| Prefer not to say | 2 | 4 |

**Includes parents who also identified as care experienced.*
***Calculated taking 'total response' approach to ethnicity which may add up to more than 100 percent due to respondents identifying with more than one ethnicity.*

Figure 33 shows the perceptions of experience across four individual questions asked to care experienced young people and young parents.

**Figure 33. Care Experienced Young People – Perceptions of experience with Oranga Tamariki**

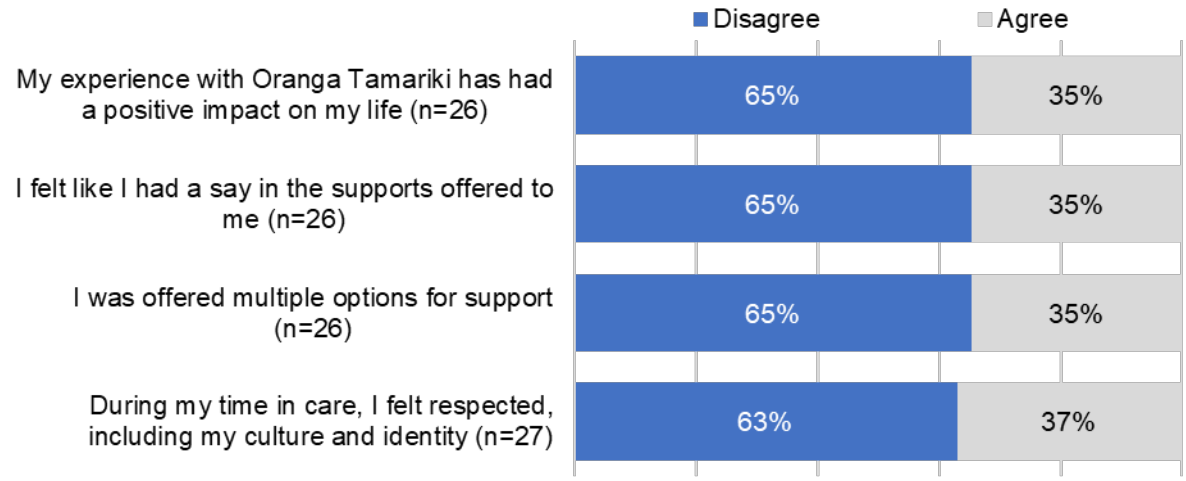
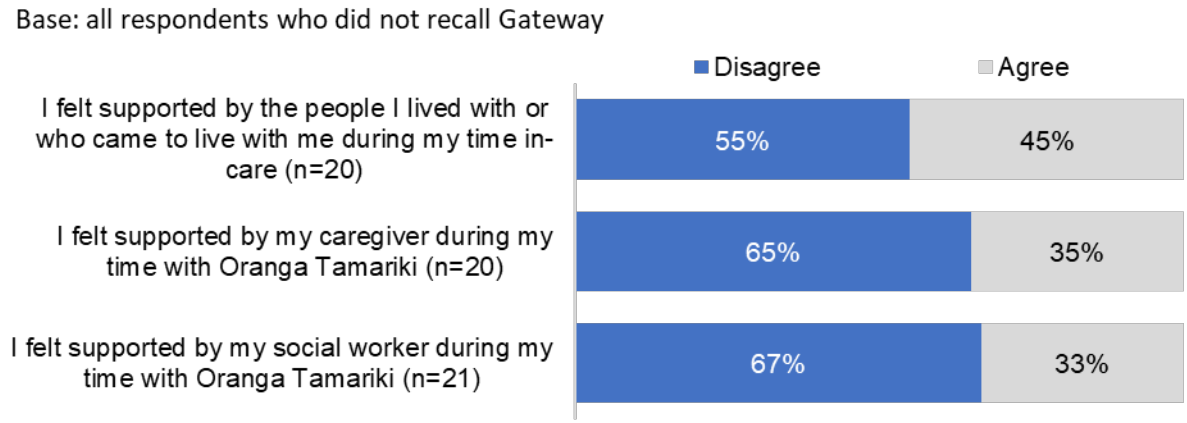



Figure 34 shows care experienced young people and young parents' perceptions of the quality of close relationships supporting them throughout their time in-care.

**Figure 34. Care Experienced Young People – Perceptions of close relationships while in care**

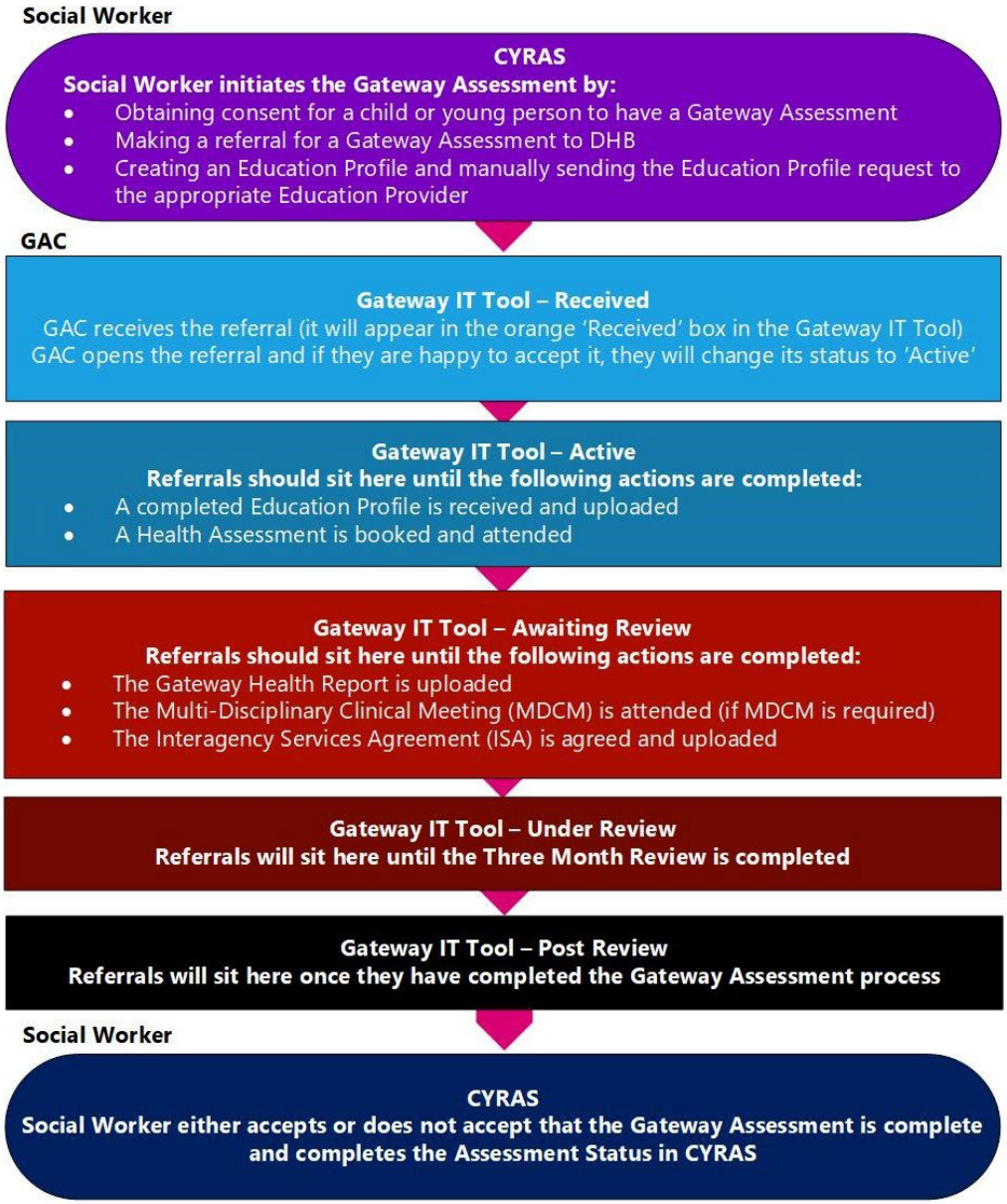


# Appendix IV

## Gateway Assessment Data Input Process

Figure 35 visualises the flow of Gateway data input and describes the tasks for each role involved in the process.

**Figure 35. Flow diagram of Gateway assessment process**

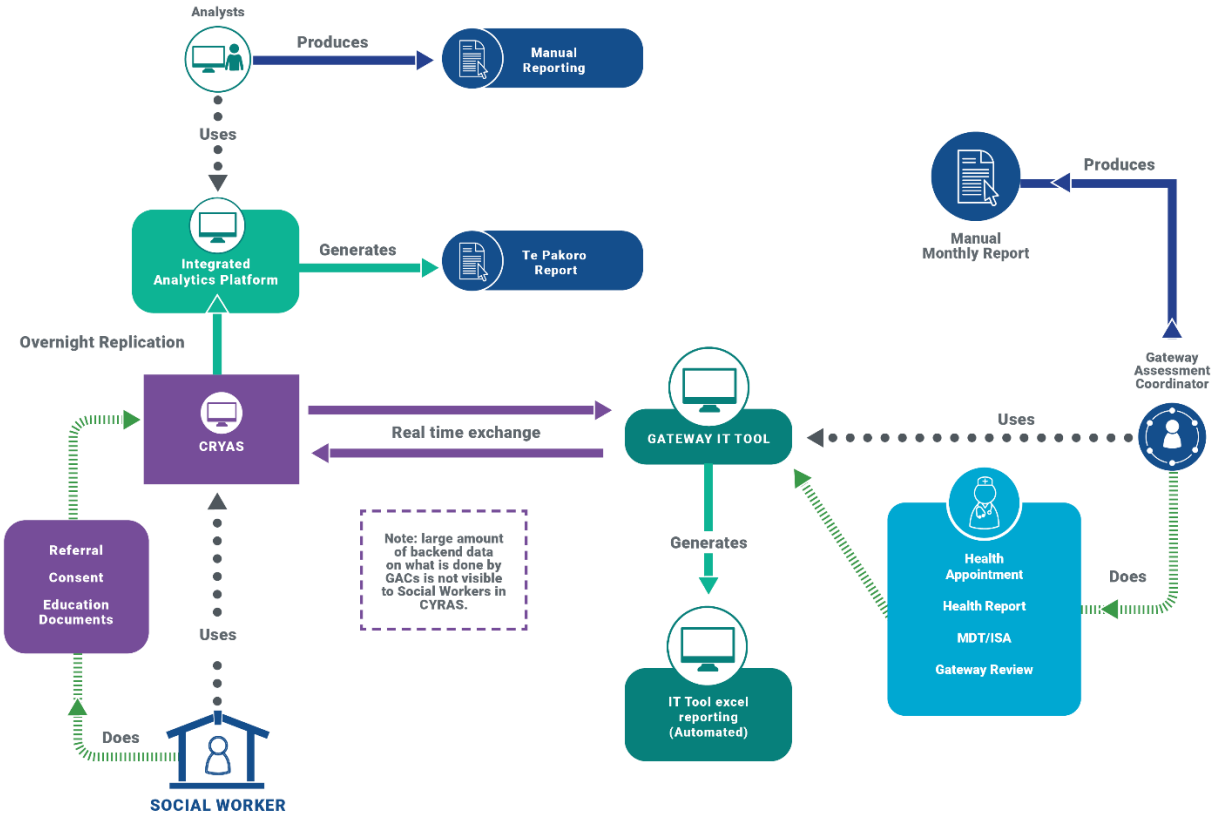



*Note: Diagram is taken from the Gateway IT Tool Guide[43]

[43] Oranga Tamariki. (n.d.). *Gateway Assessments. Gateway IT Tool - User Guide*. Internal document: unpublished.

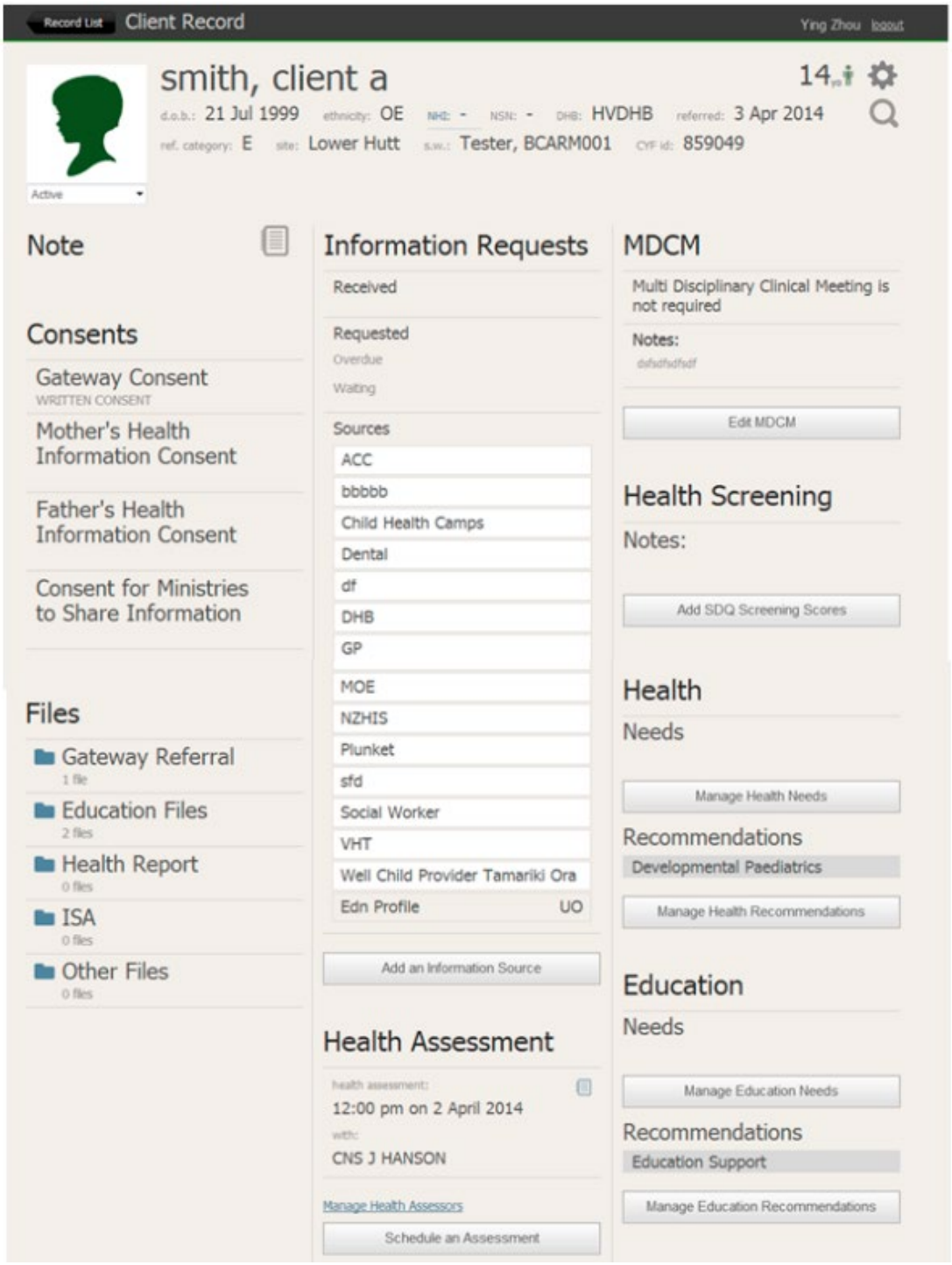
The Gateway IT Tool is an external facing platform where sections of the child's HERA record linked to the CYRAS database can be accessed by Health staff. Figure 36 visualises the data system and flow of data in relation to Gateway and the Gateway IT Tool.

**Figure 36. Gateway IT Tool Data system flow diagram**



After the Education Profile and Health Report are completed, the GAC uploads them to the Client Record (Figure 37) within the Gateway IT Tool.

**Figure 37. Client record screen in Gateway IT Tool**




The GAC inputs the child's diagnosed health and education needs by selecting Needs Codes from dropdown menus on the Client Record screen within the Gateway IT Tool (Figure 38 and Figure 39). Heath and Education Needs Codes are organised into 28 categories. Each need is identified by an abbreviation indicating its category, for example, 'BHEV' for Behavioural Concerns. Additional information for a

Need is added by selecting from 'Yes', 'No', 'Declined to be assessed', or 'Could not assess'. By default, all Needs Codes are marked as 'No' indicating non-applicable.

Education Needs Codes are categorised into 11 groups, five for school, and six for Early Childhood Education (ECE). Like Health Needs, these are prefixed with abbreviations, like 'LRNG' for Learning, or prefixes 'SCH' for school-level and 'ECE' to indicate their category.

**Figure 38. Inputting education needs codes in the Gateway IT Tool**

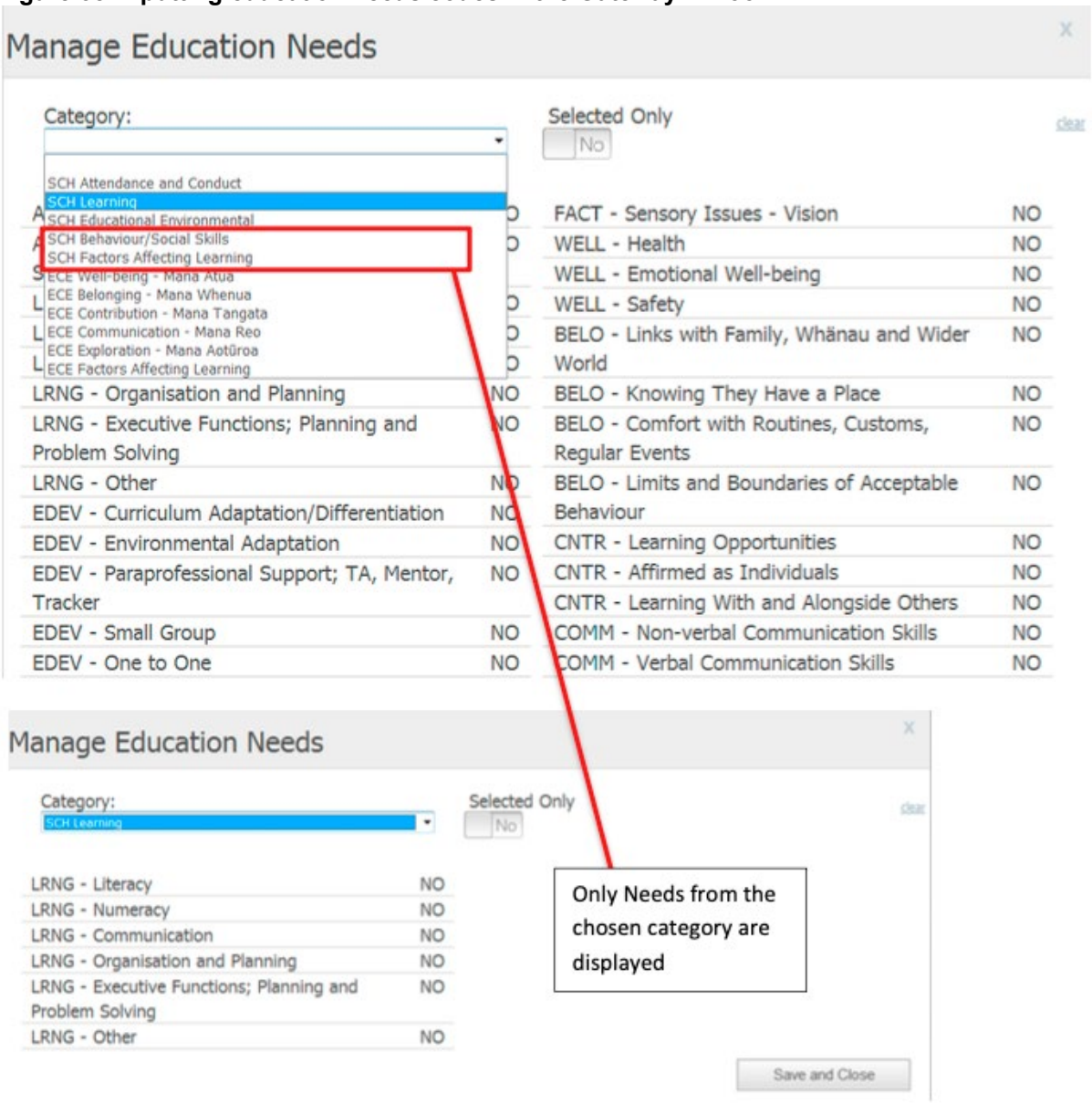
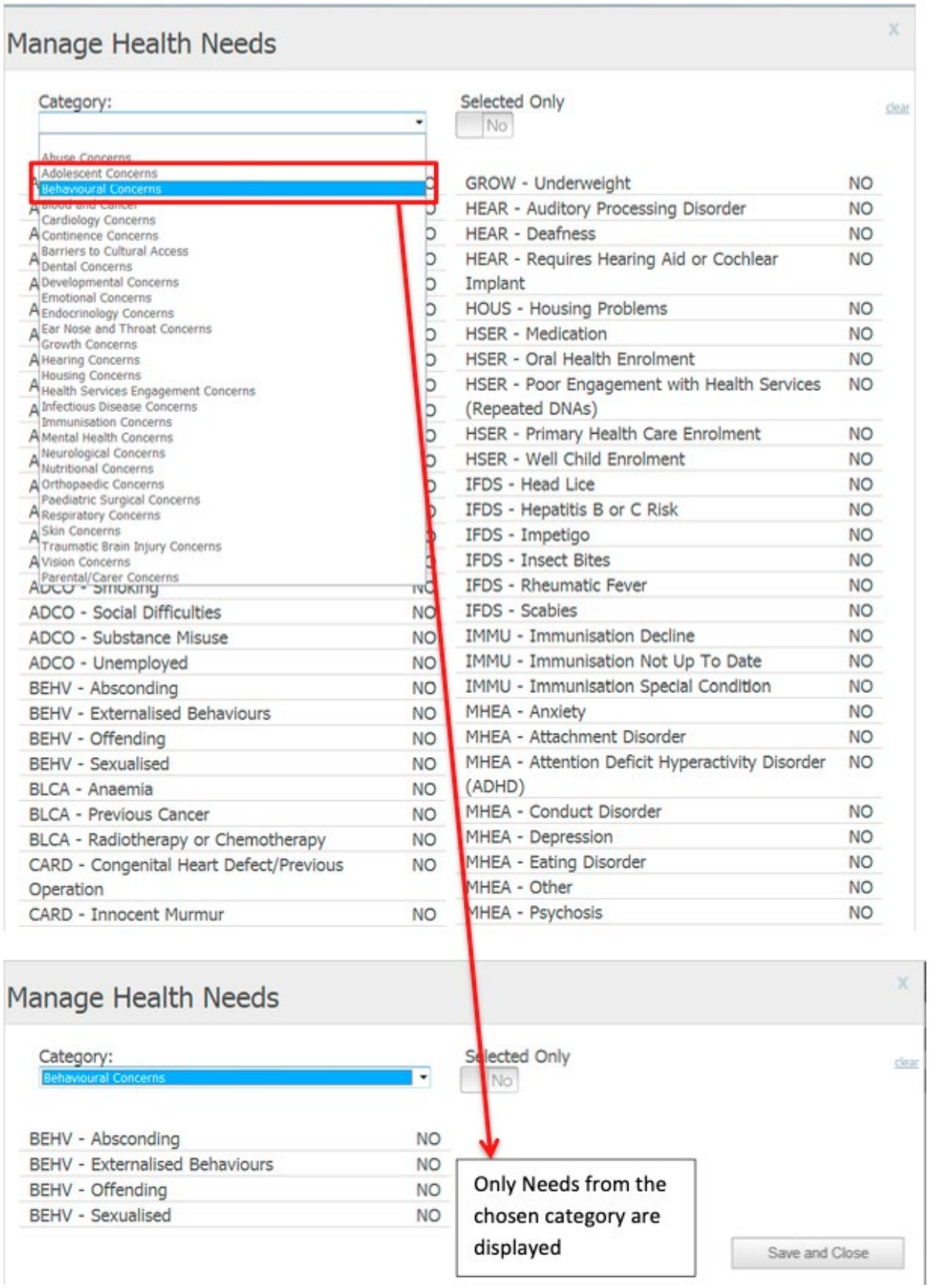


**Figure 39. Inputting health needs codes in the Gateway IT Tool**

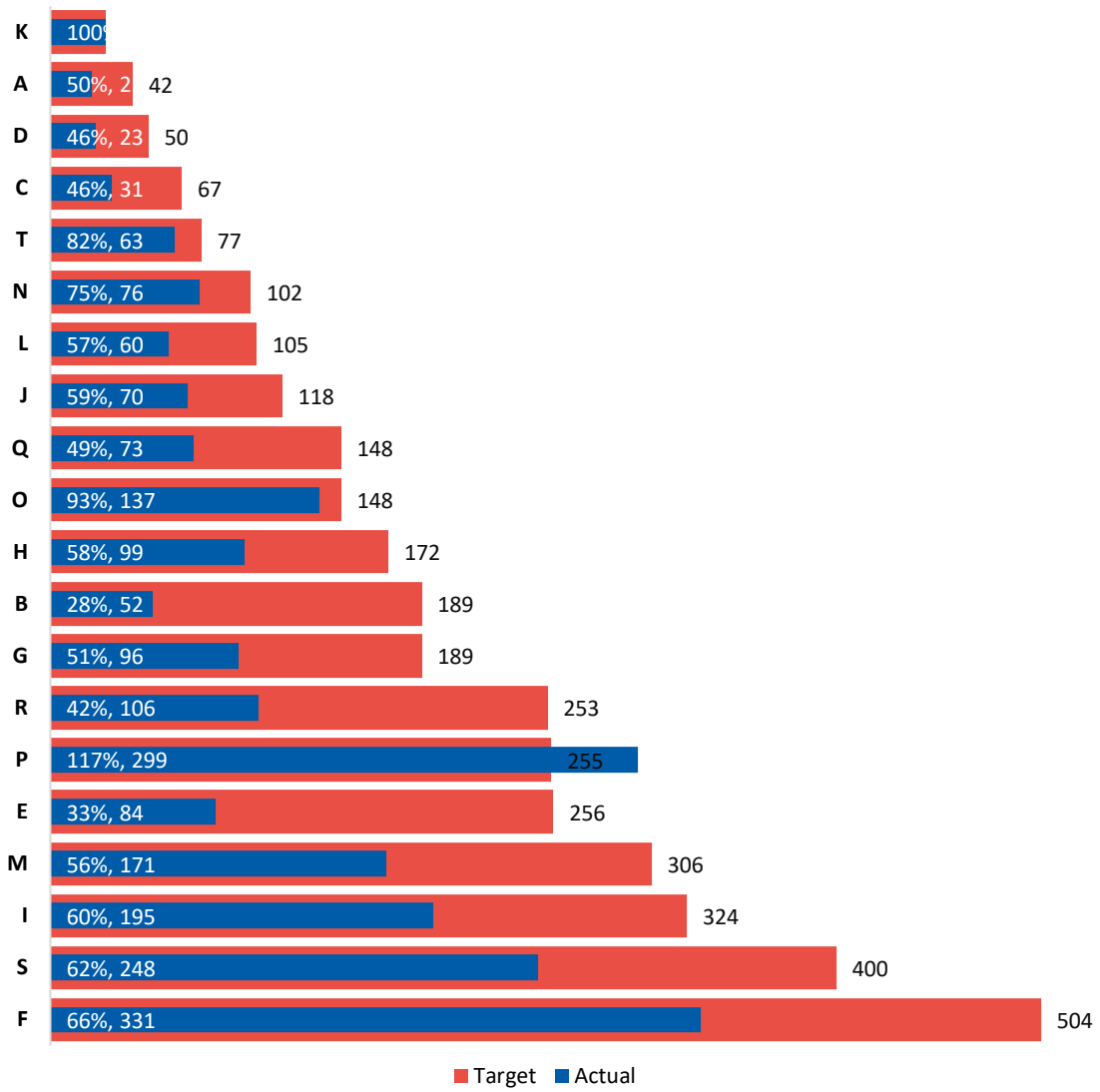


# Appendix V

## Gateway Regional Utilisation

Figure 40 shows the health regional breakdown of Gateway utilisation rates for the 2023 financial year. Utilisation rates ranged from 28 to 117 percent. Health regions are deidentified for reporting purposes. Target count (Red) refers to number of Gateways expected, while 'Actual' (Blue) refers to Gateways actually delivered.

**Figure 40. Health regional breakdown of utilisation rates for 2023 financial year**




From this data, we see a consistent underutilisation of Gateway across the board. Many reasons have been disclosed from the frontline engagements that may explain why Gateway is underutilised (refer to section *Address funding and utilisation issues*).

# Appendix VI

## Other Tables and Figures

Figure 41 shows administrative data which gives a regional breakdown of the reasons for Gateways reported by Oranga Tamariki.

**Figure 41. Backend Data on Locality Breakdown – Reasons for Gateways**

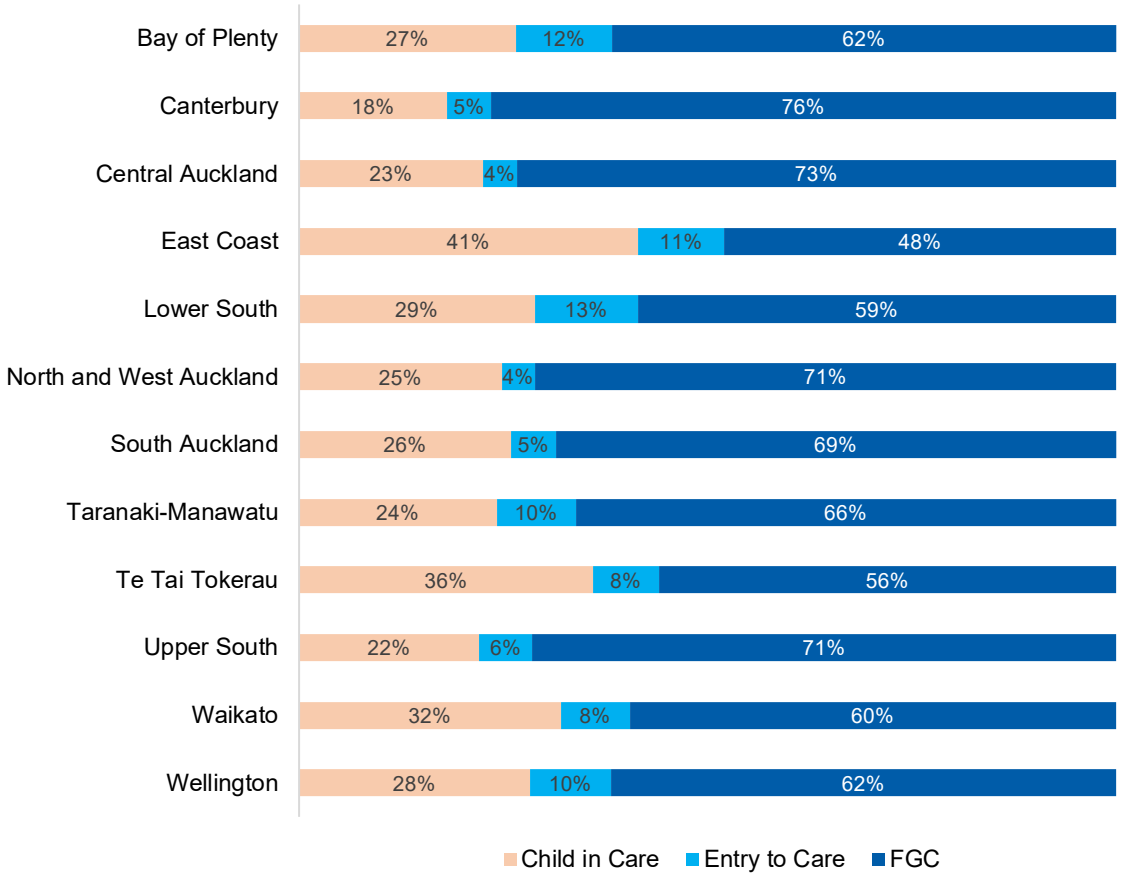
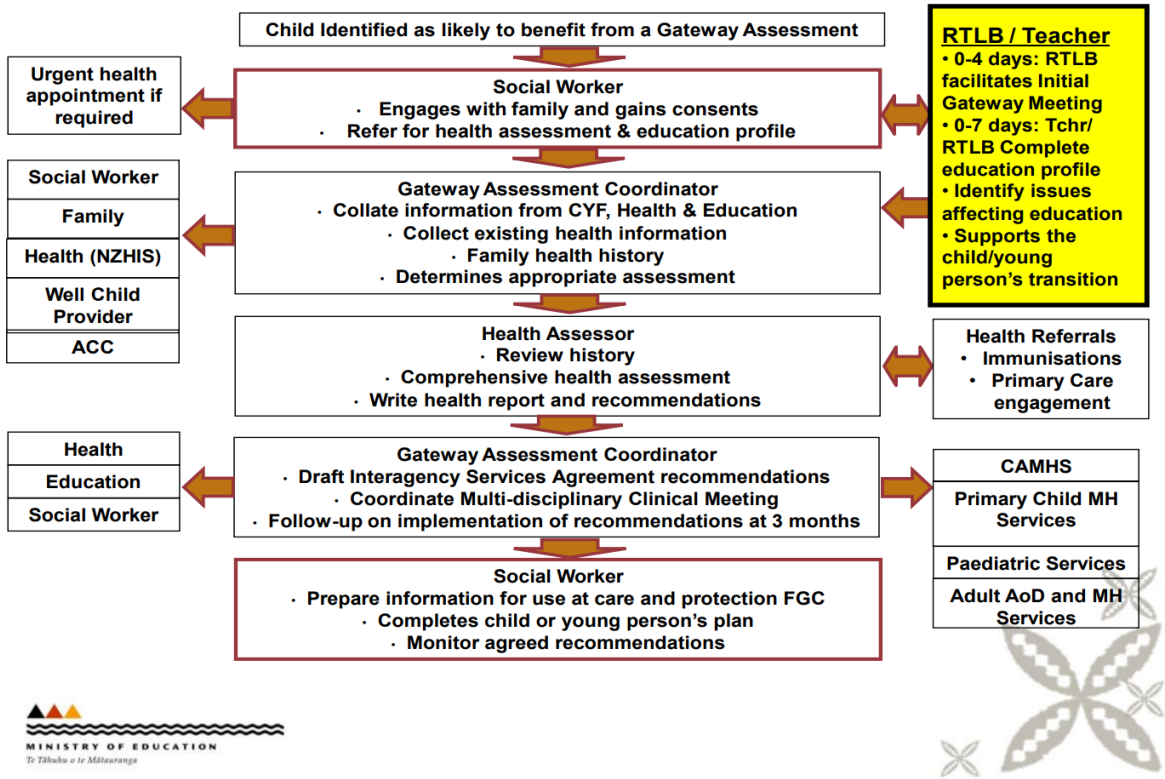


Figure 42 is an MOE flow diagram of the Gateway process and the different roles and responsibilities appointed. This diagram also gives a brief description of the parts of the process relevant to education components and frontline staff.

**Figure 42. Ministry of Education flow diagram of Gateway process for RTLBs**




*RTLB Gateway Guide[44]

[44] Ministry of Education. (2013). *RTLB Gateway Guide*.

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