

Annual Caregiver Satisfaction Survey

Deep Dive – Strengthening the caregiver experience

Findings from the 2024 survey wave

The Oranga Tamariki Social Impact and Research team works to build the evidence base that helps us better understand wellbeing and what works to improve outcomes for New Zealand's children, young people and their whānau.

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Context

Our annual Caregiver Satisfaction Survey was run from **October 7th to 28th, 2024**, to better understand caregivers' experiences and needs. Both **whānau** (family/kin) and **non-whānau** (non-kin) caregivers participated, sharing insights on their satisfaction with the support they receive from Oranga Tamariki.

This is a deep dive report for the 2024 survey wave, which focuses on caregivers' experiences of support across critical areas including education, health, financial assistance, respite, training, social worker practice and child transitions.

Findings show that while many caregivers are committed and resourceful, they continue to face systemic challenges such as delays in support, inconsistent communication, high social worker turnover, and limited access to respite and training.

The survey was distributed via email to 1,868 active caregivers, with 665 participating. For full details on the survey design, methodology and demographic characteristics, please refer to Topline Report One¹.

¹ Valdivia, L. A., & Subedi, K. (2025). Annual Caregiver Satisfaction Survey: Topline Report One. Wellington, New Zealand: Oranga Tamariki—Ministry for Children.

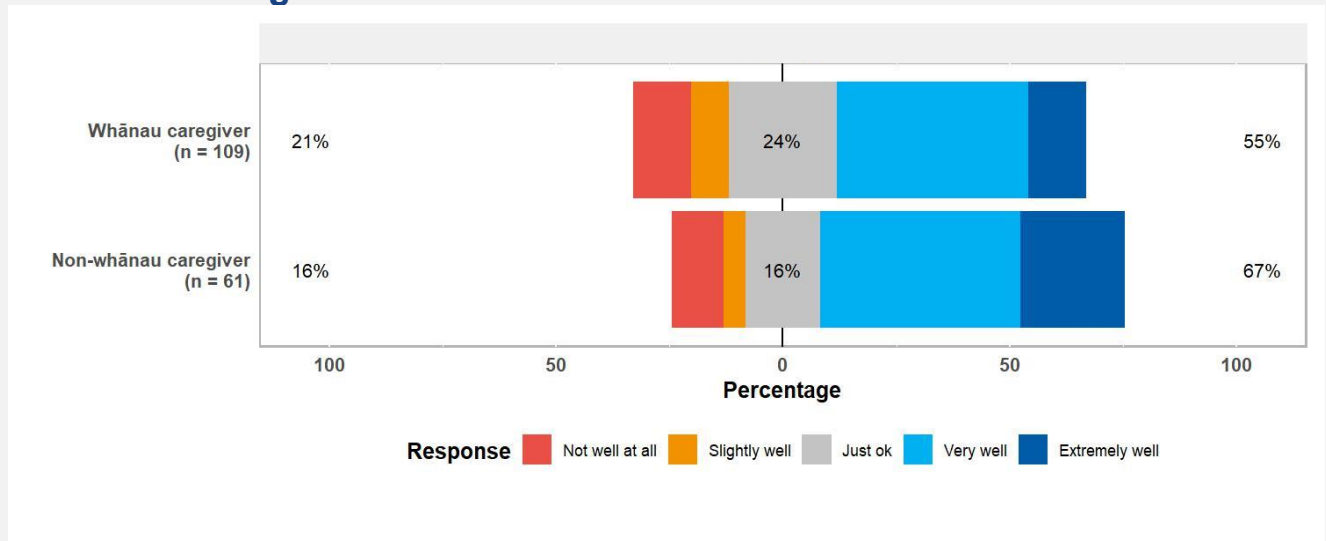
Deep Dive Findings

1. Preparedness among first-time caregivers

For 170 respondents who reported to be first-time caregivers, we asked about their perception of preparedness in caring for the child or young person.

Figure 1 shows that first-time **non-whānau** caregivers report a modestly stronger sense of readiness: **67%** felt very or extremely well prepared, versus **55%** of first-time **whānau** caregivers. The proportion who felt under-prepared is similar – roughly one in five for both groups – while whānau caregivers were more likely than non-whānau caregivers to sit in the “just OK” middle ground (**24%** versus **16%**).

Figure 1. Overall, how well did Oranga Tamariki prepare you to become a caregiver?

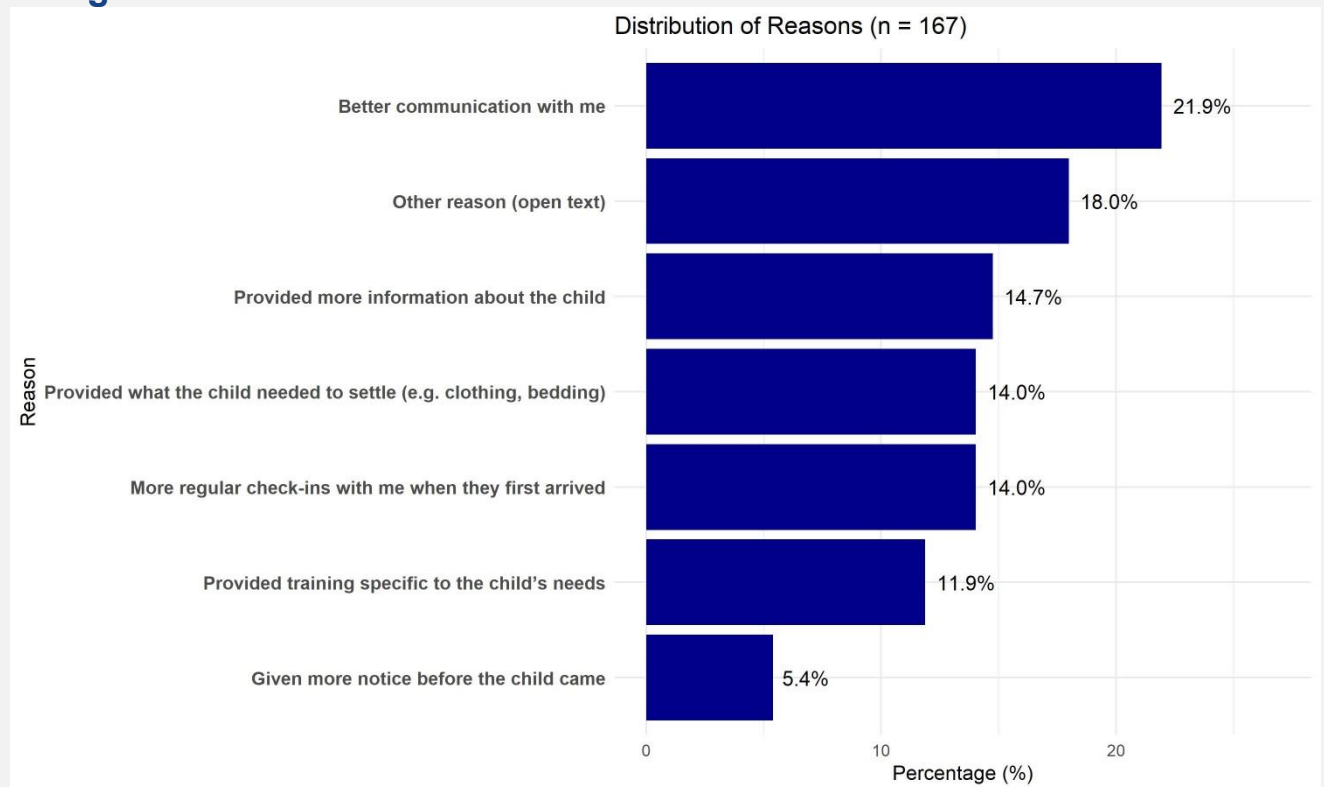


Summative interpretation: Placements are often emergency-driven, so many caregivers felt no advance preparation could truly suffice. They praised their social workers’ support, but wished for timelier support, clearer information and tailored guidance to feel fully prepared to care for the child or youth.

1.1 What would have helped?

The most frequently selected improvements about what would have helped better prepare them are presented in **Figure 2**.

Figure 2. How could they have prepared you better to become a caregiver?



Note. A check-all-that-apply (CATA) multiple-response question² – results use a total response approach accounting for all respondent selections presenting each category's share of the overall total (100%).

Figure 2 shows the two top reasons “**Better communication with me**”, and “**Provided more information about the child**” amounted to **36.6%** combined. Eighteen percent selected ‘**Other reason**’ which further explain the quantitative results and why those needs matter.

Caregivers often mentioned receiving children in urgent or emergency contexts. They praised social workers’ dedication yet still felt in the dark about the child’s background and reasons for removal.

“Given the urgent situation the social worker did an amazing job with navigating our case in the short time span he was given. Things could have been better but were fine for what it was. More notice and training of course would be appreciated if the circumstances were not so rushed.”

² CATA or multiple response multiple choice questions record every category a respondent chooses. Analysis of these questions focuses on reporting frequencies or proportions of total count represented for the question.

“I was unaware of the circumstances fully of why my nephew had to leave his carers.”

“It was urgent care so given the circumstances I was provided [for] extremely well. It just all happened so quickly. But outstanding support was given.”

Material support and child-specific training amounted to **25.9%** combined: **“Provided what the child needed to settle”** and **“Provided training specific to the child’s needs”**, especially for children with diverse or disability needs (**Figure 2**).

Other caregivers wanted equipment (e.g. car seats, push chair and toys), training on trauma-informed care and how to navigate relationships with the child’s birth-family.

“I had to buy car seats, push chair, cot and toys.”

“Ensure we have the equipment needed for the child we are caring for.”

“More training on how to manage family members and stress.”

“More information on the process [and] steps from emergency to short term guidance [and] preparation for interacting with the child’s bio[logical] whānau.”

Some caregivers felt the emergency nature of placement made advance preparation impossible, especially when having to cover the child’s expenses upfront with no advance notice.

For them, the quality of on-the-spot financial support – rapid responses and knowing what their entitlements are – mattered more than pre-placement training.

“It was 6-8 weeks before any support [was provided] even when I constantly tried to contact social workers.”

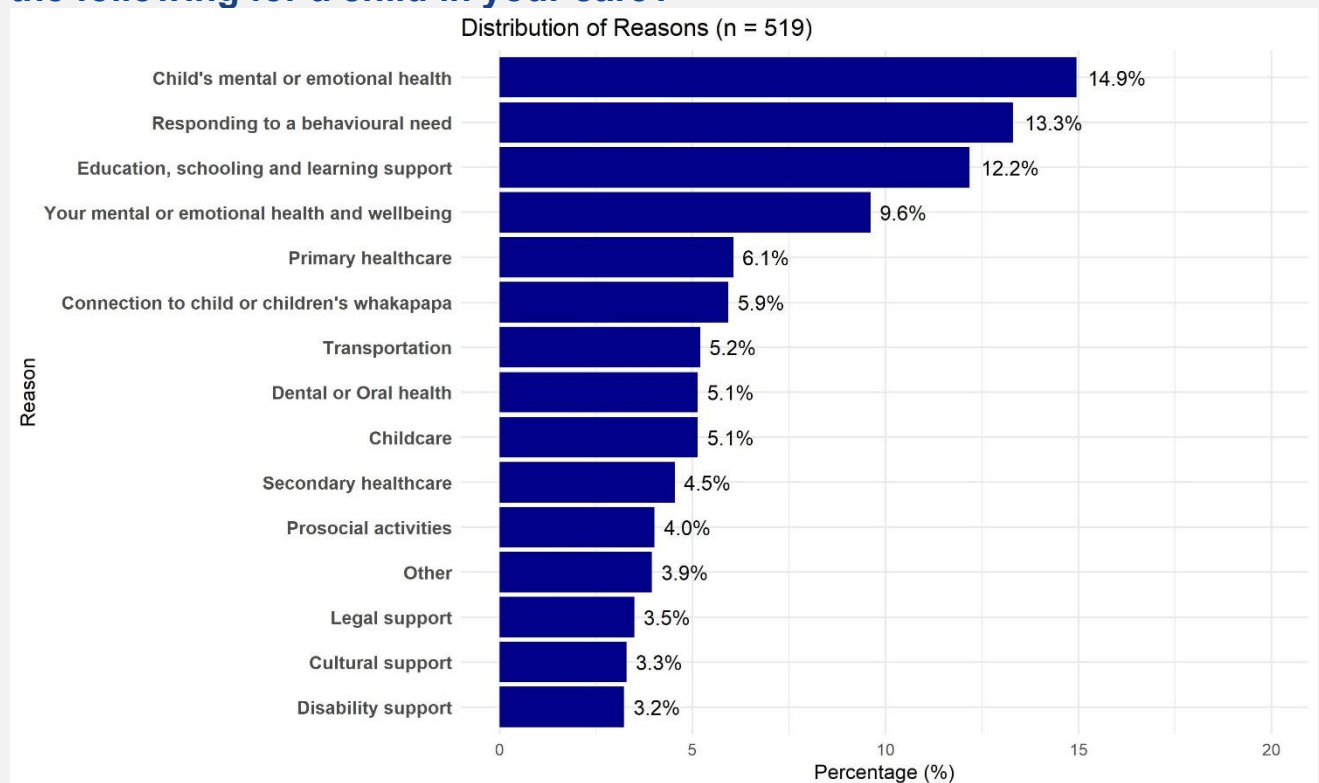
“My first board payment was received over a week after the child came into my care, it made my financial situation tight covering food and doing travel [...] I also needed to purchase bedding, towels, furniture for her which I did largely using my credit card and took several weeks to pay that back. Travel allowance didn’t start being paid to me for over two months after she came into my care.”

2. Needs of concern for children: What worries caregivers most and why?

Caregivers were asked which needs concerned them the most from a selection of choices.

Figure 3 suggests the key concerns are child-centred and developmental. The three top concerns are: “**Child’s mental or emotional health**”, “**Responding to a behavioural need**” and “**Education, schooling and learning support**” amounting to **40.4%** combined.

Figure 3. In the last 12 months, have you felt concerned with any of the following for a child in your care?



Note. CATA multiple-response question – results use a total response approach accounting for all respondent selections presenting each category's share of the overall total (100%).

Mental and emotional health concerns for both child and caregiver amounted to **24.5%** combined (**Figure 3**).

Caregivers often describe dealing with complex trauma, anxiety, and behaviour challenges that existing support services can't meet in-time. Timely counselling, specialist assessments, or respite care, are paramount.

“While I have not been concerned with my own wellbeing I do see [how] it could become a concern.”

2.1 What's behind the numbers of needs concerns?

Regarding 'Other' concerns (Figure 3), caregivers' open response feedback reveals four interrelated pain points:

Gaps between expected and delivered support: Many describe a wide spectrum of unmet needs – petrol vouchers, tutorship fees, support for holiday or after-school activities, specialist medical assessments, education, even small items like a guitar – highlighting both the wide range of children's requirements and the perceived available support.

"Only give[s] \$20 petrol vouchers to drive over 100 kms."

"Needing overnight toilet training and it not being on the [child's] plan."

"Great concern about education. As he is in [Youth Justice] with school exemption he has received no education for [the past] two years."

Contact with birth whānau needs to be child-centred and consistent:

Caregivers worry about unsupervised family visits, unclear plans for reunification, and lack of a single, unified approach across relations with whānau, multiple caregivers or professionals.

"A decision to send a child unsupervised to the abusive household without discussion, and us as caregivers having to deal with the fallout."

"Letting [our] child see potential whānau without supervision, before DNA test proves connection. Can be [a] safety risk."

"[Felt concerned about] contact arrangements with family"

"[Needing] a unified approach between carers"

Frustration with Oranga Tamariki practice: Comments point to lack of awareness of entitlements, variable or inconsistent social-worker judgments, limited information-sharing, and a sense of not being heard, which in some cases erodes trust to the point that caregivers stop asking for assistance.

"No support asked for [from Oranga Tamariki] as I'm not familiar with what is [or] is not available for the child."

"Majority of the time most things that I'm needing done with the children will 90% of the time be completed however it takes me multiple attempts,

calls, emails and basically harassment just to get what I'm needing and even then it's mostly the bare minimum. Communication is an issue; tells us one thing and supervisor [says] something different."

"When [I] request support for [the] child [I am] blatantly declined. Different rules and allowances for the two children in our care."

Complex behavioural and social-relational needs: Caregivers emphasise the strain of managing complex behavioural challenges, negative parental interference, the shortage of tailored strategies for managing stress, anxiety issues and limitations of respite options.

"Not listening to the caregiver around [parental] contact and putting [the] child in a very stressful situation causing trauma and anxiety."

"The child requires support with most of the above [needs concerns], I've done all of the above myself. Again, probably because I have experience in the disability sector and can negotiate the minefield of information."

"All my mokos have bowel issues that are needed to be supported by a specialist or doctor. The bowel issues interfere with schooling, sports events, socializing, attending camps plus embarrassing for the oldest one who is 13. They are all in pull-ups."

"[The] respite carer didn't feel full[y] equipped to take care of his needs for respite care. [He is] a very complex child who needs the very best of care."

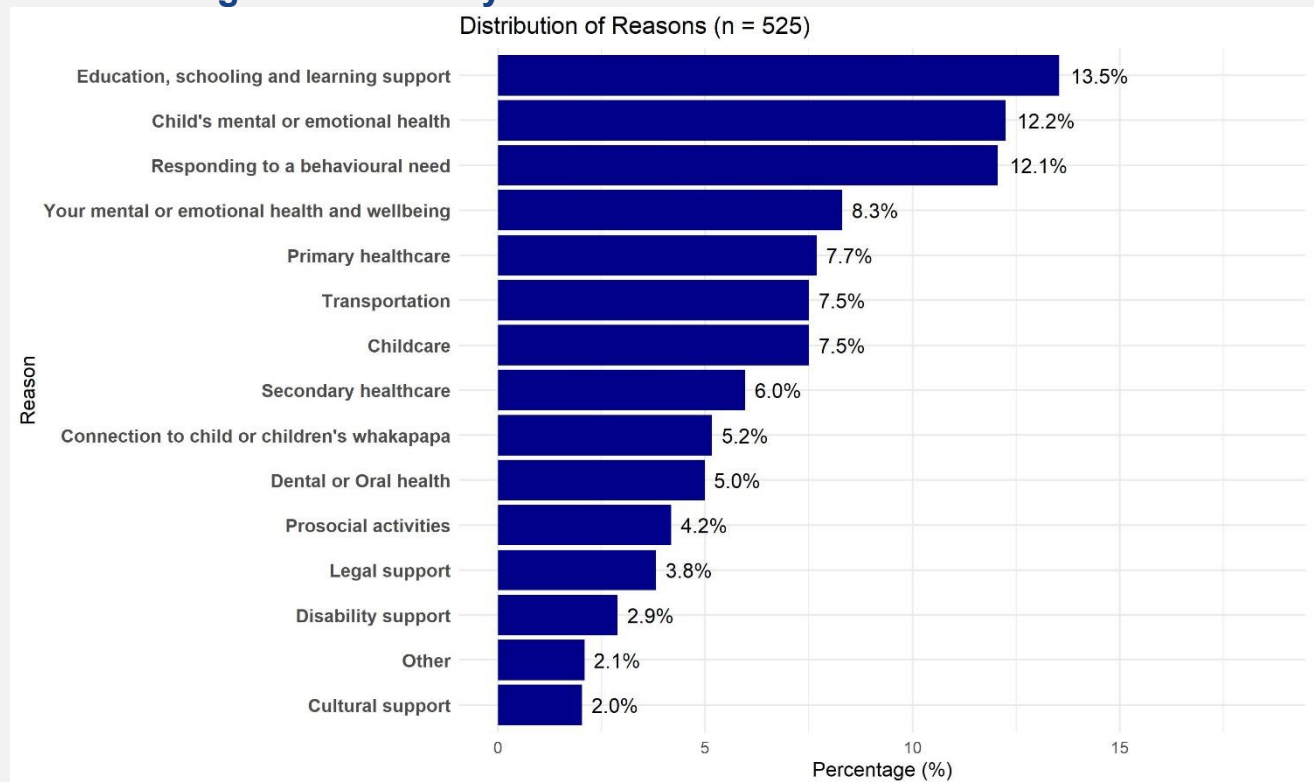
Summative Interpretation: Overall, regarding the response to needs concerns, while examples of strong support were reported, the dominant narrative is of inconsistent practice and unmet expectations, leaving caregivers to navigate significant emotional, logistical, and behavioural challenges with limited and sometimes mistrusted, support from Oranga Tamariki.

2.2 What support was most frequently needed?

Figure 4 shows that among 525 caregivers, leading requests for support centred around child's education, development and wellbeing, amounting to **38.2%** combined: **"Education, schooling and learning support"**, **"Child's mental or emotional health"**, and **"Responding to a behavioural need"**. Together with previous findings, the top three items underscore how tightly education, emotional health and behavioural needs are intertwined.

Secondary but still common needs include the caregiver's own mental health (**8.3%**), primary healthcare (**7.7%**), and practical logistics such as transportation (**7.5%**) or childcare (**7.5%**). All other categories rank below six percent.

Figure 4. In the last 12 months, did you need support with any of the following for a child in your care?



Note. CATA multiple-response question – results use a total response approach accounting for all respondent selections presenting each category's share of the overall total (100%).

Open-text answers highlighted '**Other**' gaps missing from the list (2.1%):

- **Respite breaks for caregivers**, especially for those handling complex behaviours
- **Medical consent hurdles** – navigating approvals for specialist procedures
- **Hands-on help at home or with moving**, pointing to the physical load of caregiving.

2.3 Support needs across the neurodevelopmental spectrum

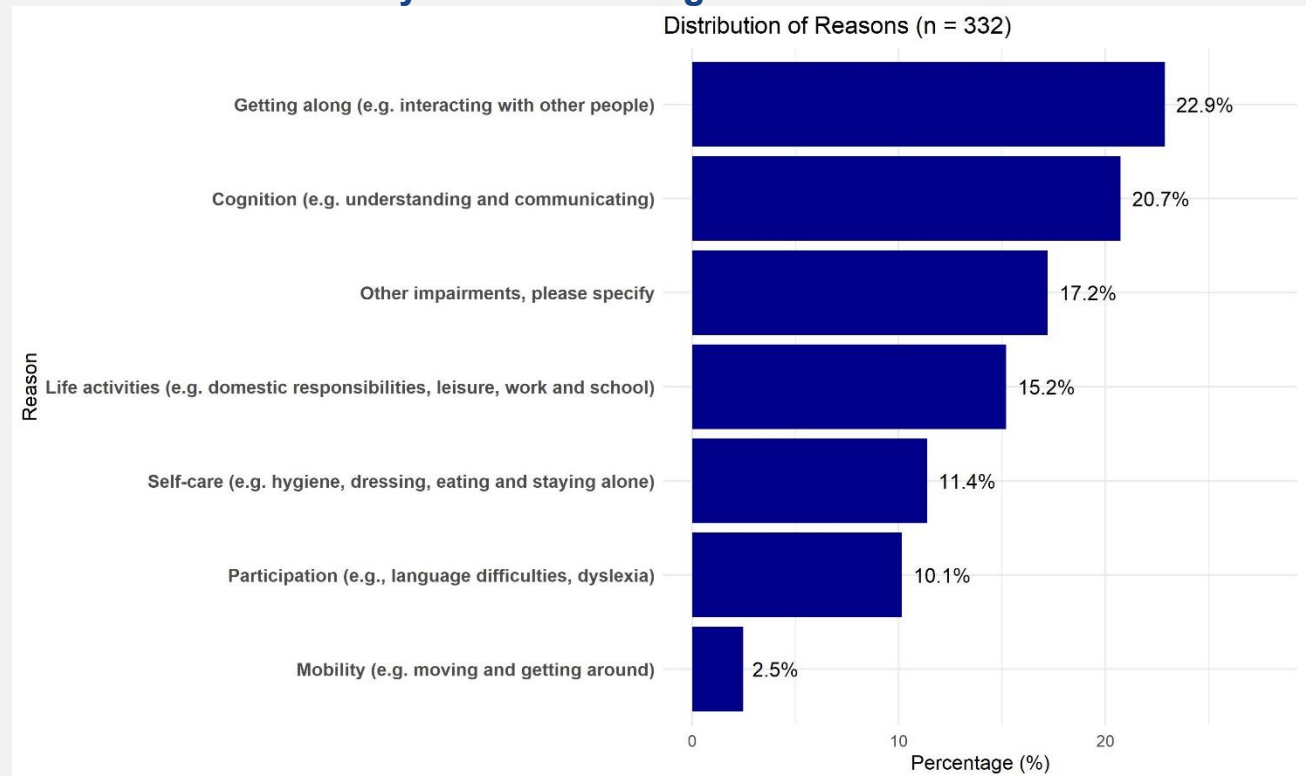
We asked caregivers whether a child needed support with any of the six functional domains across the neurodevelopmental spectrum³: social interaction ("getting along"), cognition and communication, broader adaptive life activities, self-care, participation (e.g. language or dyslexia), and physical mobility (**Figure 5**).

Figure 5 shows the most frequently flagged items among 332 caregivers. One-quarter pointed to social-relational difficulties, '**Getting along**' (22.9%), and one-fifth

³ Michelini, G., Carlisi, C. O., Eaton, N. R., Elison, J. T., Haltigan, J. D., Kotov, R., Krueger, R. F., Latzman, R. D., Li, J. J., Levin-Aspensson, H. F., Salum, G. A., South, S. C., Stanton, K., Waldman, I. D., & Wilson, S. (2024). Where do neurodevelopmental conditions fit in transdiagnostic psychiatric frameworks? Incorporating a new neurodevelopmental spectrum. *World Psychiatry*, 23(3), 333–357. <https://doi.org/10.1002/wps.21225>

cited '**Cognition**' challenges such as understanding and communicating (**20.7%**), while mobility-related issues were less common (**>2.5%**). This finding suggests many children struggle most with interaction (e.g. Getting along) and information-processing (e.g. Cognition, and Participation).

Figure 5. Previously, you said a child in your care needed support: Was that related to any of the following?



Note. CATA multiple-response question – results use a total response approach accounting for all respondent selections presenting each category's share of the overall total (100%).

Figure 5 'Other impairments' open text response reveal a layered and overlapping web of needs (**17.2%**).

Children were mentioned to commonly present with multiple neurodevelopmental or behavioural conditions – diagnosed or suspected such as Attention-Deficit Hyperactivity Disorder (ADHD)⁴, Sensory Processing Disorder (SPD)⁵, Fetal Alcohol Spectrum Disorder (FASD)⁶, Oppositional Defiant Disorder

⁴ Salari, N., Ghasemi, H., Abdoli, N. *et al.* The global prevalence of ADHD in children and adolescents: a systematic review and meta-analysis. *Ital J Pediatr* 49, 48 (2023). <https://doi.org/10.1186/s13052-023-01456-1>

⁵ van den Boogert, F., Klein, K., Spaan, P., Sizoo, B., Bouman, Y. H. A., Hoogendijk, W. J. G., & Roza, S. J. (2022). Sensory processing difficulties in psychiatric disorders: A meta-analysis. *Journal of Psychiatric Research*, 151, 173–180. <https://doi.org/10.1016/j.jpsychires.2022.04.020>

⁶ Zeng, X., Cai, Y., Wu, M. *et al.* An overview of current advances in perinatal alcohol exposure and pathogenesis of fetal alcohol spectrum disorders. *J Neurodevelop Disord* 16, 20 (2024). <https://doi.org/10.1186/s11689-024-09537-w>

(ODD)⁷, Autism Spectrum Disorder (ASD)⁸ – alongside intellectual-functioning or learning challenges that require speech therapy and teacher-aide time.

“My child has been diagnosed with a few things and we have been working very closely with PCSS, CAF and a psychologist for his needs. PCSS have been at the centre of everything providing financial assistance for my child's needs.”

“Developmental Trauma, PTSD, Anxiety, Sensory difficulties, ADHD, suspected ASD, OCD, ODD, Attachment Disorder.”

“Autism Spectrum disorder; Complex post trauma disorder.”

“He was diagnosed with FASD in 2016. Then he was diagnosed with Mild Intellectual Disability in 2023, I don't get why his records wasn't carried on after his first diagnosis.”

Equally pressing are psychological issues: trauma-related anxiety, depression, attachment difficulties, self-harm, sleep problems, and grief, all of which call for specialised mental-health interventions.

“[The child has] Complex Developmental Delay, Chronic depression resulting in a fortunately unsuccessful suicide attempt.”

Physical and medical needs add a further load: such as frequent hospital trips, chronic conditions (e.g. cerebral palsy, global developmental delay), vision or hearing problems, and dental care needs – often complicated by transport barriers, were reported.

“Cerebral palsy and global developmental delay.”

“[The child had a] Head injury aged four and a half months has left slight cerebral palsy on left side of body.”

⁷ Hawes, D.J., Gardner, F., Dadds, M.R. *et al.* Oppositional defiant disorder. *Nat Rev Dis Primers* **9**, 31 (2023). <https://doi.org/10.1038/s41572-023-00441-6>

⁸ Bougeard, C., Picarel-Blanchot, F., Schmid, R., Campbell, R., & Buitelaar, J. (2021). Prevalence of autism spectrum disorder and co-morbidities in children and adolescents: A systematic literature review. *Frontiers in Psychiatry*, *12*, 744709. <https://doi.org/10.3389/fpsy.2021.744709>

“We were a fair distance from hospital for weekly appointments and felt it would be beneficial for babies to be closer.”

Caregivers also highlight day-to-day behavioural regulation challenges⁹ (anger, aggression, concerning sexualised behaviour¹⁰) and significant developmental delays affecting bowel control or motor skills.

“Dysregulation, ability to manage big emotions, anger at being in care, not enough factual reasons given of why he was in care in a way he could understand.”

“ADHD, ODD, Intellectual disability, trauma with internalising and externalising features, sexualised behaviours etc.”

“Chronic constipation with overflow faecal incontinence secondary to faecal impaction. Failure to adequately empty bowel with oral laxatives. She has been like this since three years old.”

Summative interpretation: The findings thus far highlight a need for integrated, reliable support that spans medical, psychological, educational, and behavioural services – and for consistent follow-through on requests for support.

2.4 High demand for education-related support

No matter which domain a child’s reported need falls into, **33% of 519** caregivers reported education related support as a common shortfall (**Figure 6**).

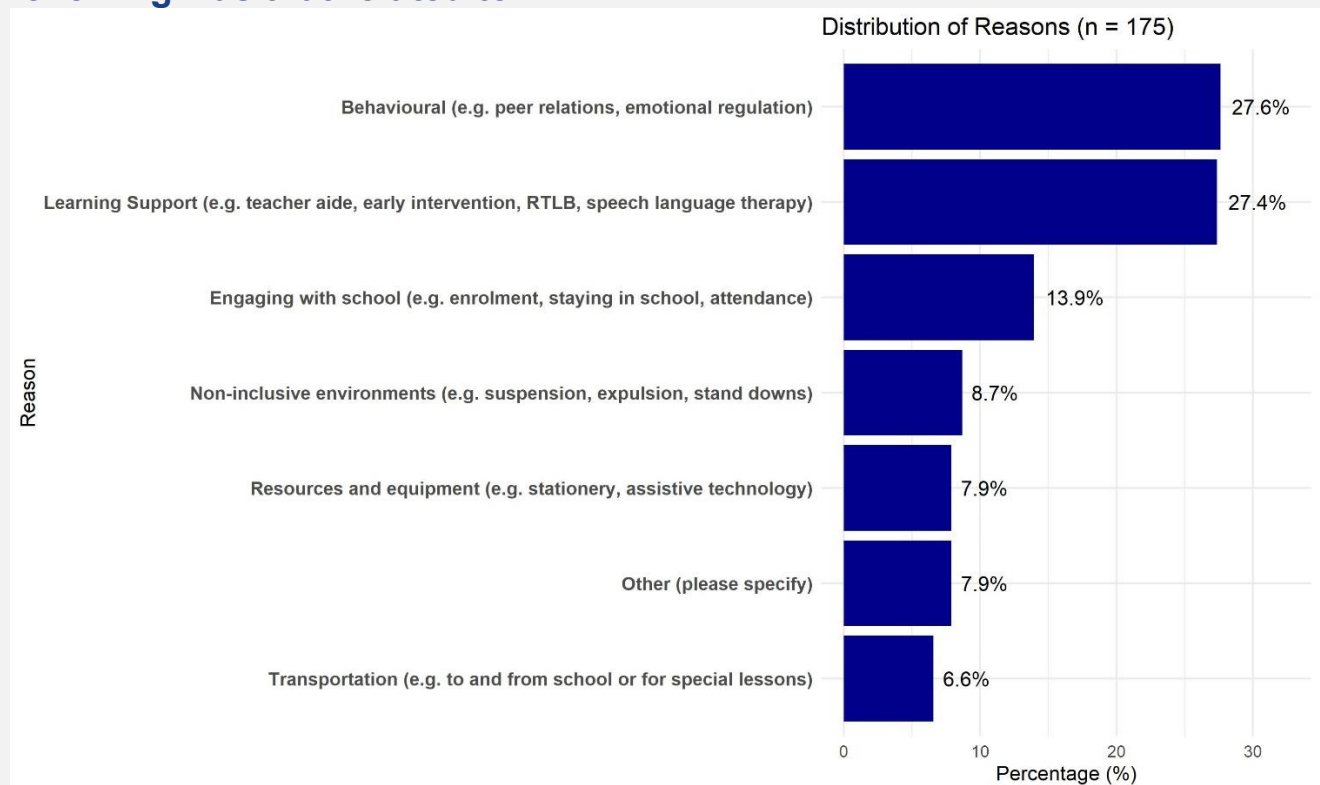
Across the responses, educational support is a recurring gap – spanning from early-childhood services, individual education plans, bullying mitigation, and specialist therapies for sensory processing disorders.

Regarding education concerns, **Figure 6** identifies two needs that tower above the rest – each flagged by more than a quarter of caregivers (**55% combined**): **‘Behavioural’** issues that affect schooling such as peer relations and emotional regulation (**27.6%**), and direct **‘Learning Support’** such as teacher-aide time, early intervention, RTLB, and speech-language therapy (**27.4%**).

⁹ Balart, I., Sadurní Brugué, M., & Pérez-Burriel, M. (2021). Behavioural regulation difficulties at primary and secondary school: risk and protection factors. *Emotional and Behavioural Difficulties*, 26(3), 264–279. <https://doi.org/10.1080/13632752.2021.1943176>

¹⁰ [Concerning or harmful sexual behaviour | Practice Centre | Oranga Tamariki](#)

Figure 6. You said a child in your care needed support with their education and schooling in the last 12 months. Which of the following was that related to?



Note. CATA multiple-response question – results use a total response approach accounting for all respondent selections presenting each category's share of the overall total (100%).

The next tier of education concerns involved **'Engaging with school'** – enrollment, attendance, and staying in class (**13.9%**).

Less-frequent but still notable concerns related to **'Non-inclusive environments'** – suspension, expulsion and stand downs (**8.7%**), learning **'Resources and equipment'** or assistive tech (**7.9%**), and **'Transportation'** to or from school and special lessons (**6.6%**).

"Because of the distance to nephews school and travelling there and back four times a day five days a week, it was a financial burden to our weekly income. Oranga Tamaki has been absolutely great recognising this and have been supporting us with travel allowance."

Open-text **'Other'** category revealed other nuanced needs related to support with education and learning (**7.9%**):

Learning and developmental support: Caregivers want tailored reading, writing, math help and Individualised Education Plans (IEP)¹¹ from preschool onward.

“Make it more about meeting children’s needs and less about budgets and bureaucracy. Especially in Education.”

“Additional support for math and reading after school as they are well below the average norm.”

Bullying prevention and behavioural support: intense peer bullying and complex behaviours (including sexualised behaviour and trauma) require coordinated school and specialist resources.

“Violent bullying (child was the victim).”

“Strategies to deal with learned behaviour (sexual) that stemmed from her unaddressed trauma.”

“Responding to sexual trauma.”

Specialist services and extra-curricular activities: requests range from speech-language therapy and sensory supports to grief counselling, music classes, and even second-round school-uniform funding.

“Speech language therapist [for] auditory processing disorder; [and] dental specialist.”

“Assistance with learning and ADHD extra support at school.”

“[...] I have been trying to get new uniform for my child as he has grown out of his one since four years now and we are not allowed to from Oranga Tamariki.”

System delays: Many caregivers describe stalled or withdrawn funding (e.g. for music lessons) and unfulfilled reimbursement promises, fueling frustration with

¹¹ Ministry of Education. (n.d.). *IEP Online: Individual Education Plans*. Te Kete Ipurangi. [IEP Online / Inclusive practices / Kia ora - NZ Curriculum Online](#)

perceived inaction from Oranga Tamariki. Some caregivers feel Oranga Tamariki is unresponsive to follow-up requests.

“I am having to contact my moko's lawyer to try and get financial help for education and medical fees. The child is already five years behind [in school] and I had hoped that Oranga Tamariki would pay for one [tutor] lesson per week which they [had] agreed to and then ren[e]ged.”

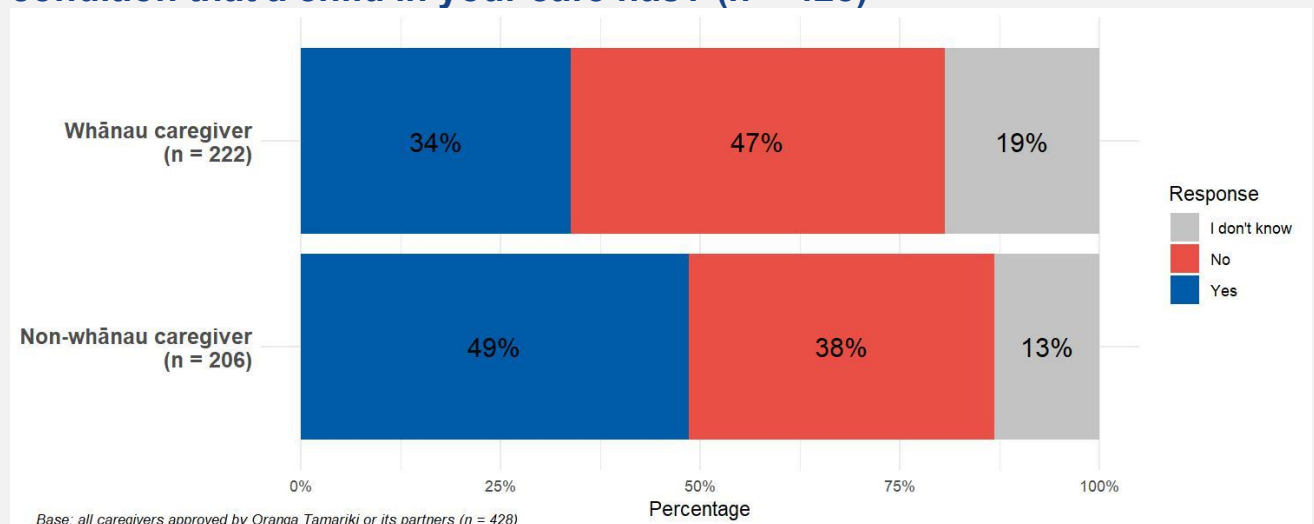
“We were categorically told that our child's music therapy was being stopped because she (social worker) needed to save money because of government cuts.”

“They [social worker] need to follow up on issues a lot faster and reply to people's email not just the ones they wish to deal with.”

2.5 When there is a known disability diagnosis

Figure 7 shows **34%** of **whānau** caregivers versus **49%** of **non-whānau** caregivers reported a known formal diagnosis of a disability-related impairment for the child in their care. The lower ‘yes’ rate and higher ‘I don’t know’ rate among **whānau** caregivers suggest barriers to formal assessment or differing views of disability.

Figure 7. Are any of the previously mentioned supports needed because of a known diagnosis of a disability or long-term health condition that a child in your care has? (n = 428)



Key finding: When a diagnoses or suspected condition, was known, it often spanned across multiple, overlapping domains.

Caregivers most often reported:

- **Neurodevelopmental and behavioural conditions**— (e.g. ADHD, FASD, ODD, ASD, SPD) and intellectual-function challenges.

- **Psychological needs**—trauma, anxiety, depression, attachment issues, self-harm, grief.
- **Chronic medical or physical issues**—cerebral palsy, asthma, vision and hearing problems, dental and surgical needs, frequent hospital visits.
- **Behaviour-regulation concerns**—anger, aggression, sexualised behaviour, food issues, self-care routines.
- **General developmental delays**—motor, bowel, or overall growth milestones.

3. Information provided by Oranga Tamariki

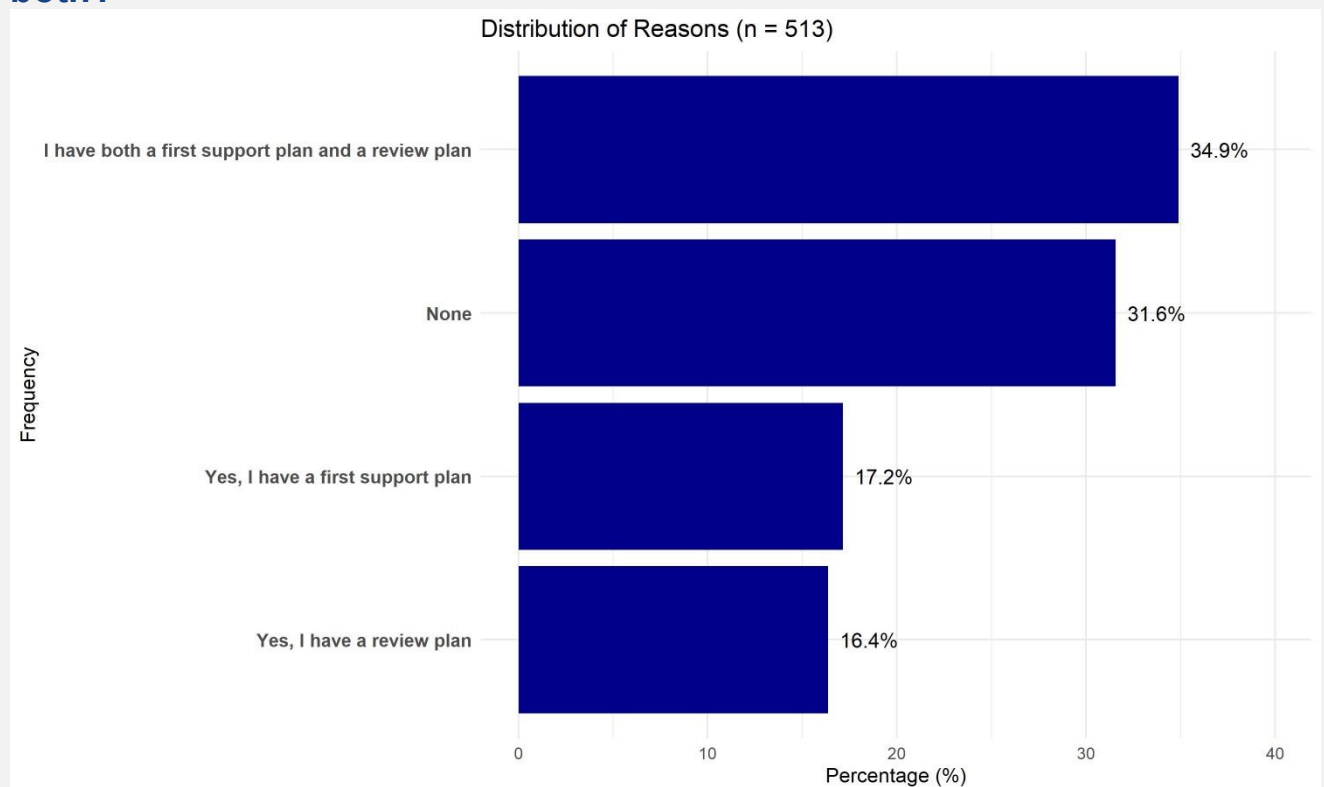
The following section discusses caregiver satisfaction with support plans and the quality of information shared by Oranga Tamariki about the child or young person.

3.1 Caregiver Support Plans and All About Me Plans – who has them?

Individual awareness of Caregiver Support Plans appears far from the standard.

Figure 8 shows out of 513 caregivers, **34.9%** reported receiving both an initial Support Plan and subsequent Review Plan (having both is the gold standard), while **31.6%** reported receiving ‘None’ at all – meaning neither plan was received. The remainder are split between **17.2%** reported having an initial Support Plan, and **16.4%** having only a Review Plan.

Figure 8. Do you have a Caregiver Support Plan or Review Plan or both?

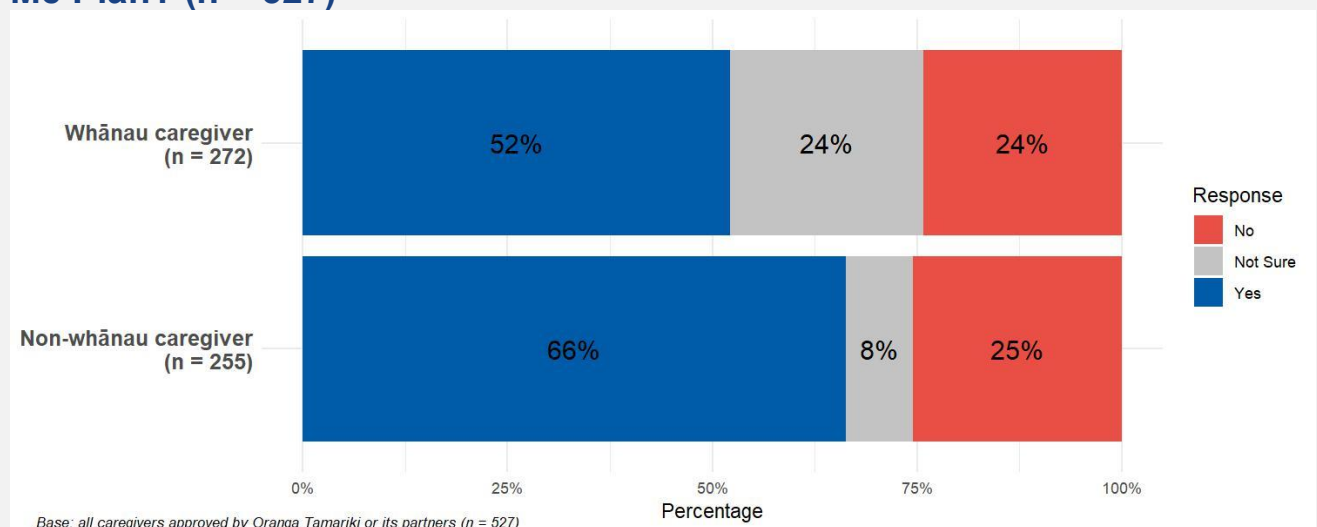


Key finding: Roughly one in three caregivers are navigating without any formal, written plan (or awareness of one), and another third has only partial planning coverage— suggesting implications on tightening social worker planning practice with caregivers.

3.2 All About Me Plans – a notable gap for whānau

Figure 9 shows two-thirds of **non-whānau** caregivers (**66%**) have seen the child's Plan, compared with **52%** of **whānau** caregivers. The '**Not Sure**' response is three times higher among **whānau** caregivers (**24%** versus **8%**), suggesting both lower exposure and lower clarity about what the **All About Me Plan** looks like among whānau caregivers.

Figure 9. Have you seen or received a copy of the child's All About Me Plan? (n = 527)



3.3 Caregivers' satisfaction with the quality of information they receive

Table 1 summarises caregiver satisfaction with seven areas of information received for the child in their care.

Key findings:

- Whānau caregivers consistently report feeling better informed compared to non-whānau – often by 7 to 17 percentage points, except on behavioural needs, where both groups report less than 50% satisfaction.
- Information on behavioural needs, disability needs and past neglect are the weakest spots. Caregivers report the lowest satisfaction for these areas and highest outright dissatisfaction, signaling clear information gaps.
- Proportion of “Mixed feelings” is sizeable across the board (18-36%). Even where satisfaction is high, many caregivers feel the information received is inconsistent or not enough.

Table 1. How satisfied are you with the information provided from Oranga Tamariki about the following?

Information Area	Whānau % “Satisfied or Very satisfied”	Non-whānau % “Satisfied or Very satisfied”	Key observation
Your child’s learning and developmental needs	52%	45%	Majority of whānau caregivers feel well-informed; non-whānau are not as satisfied
Your child’s disability needs	57%	47%	Moderate satisfaction for whānau, while non-whānau caregivers may want better information
Your child’s cultural identity	71%	60%	Strongest result for whānau caregivers; Gap suggests non-whānau need extra support with cultural guidance
Your child’s behavioural needs	43%	45%	Both groups are least satisfied here; highest proportion of mixed feelings
Your child’s health and wellbeing	61%	56%	Majority satisfied, but a quarter of whānau and a fifth of non-whānau have “mixed feelings”
Child’s past neglect, abuse or trauma	52%	35%	Largest disparity, non-whānau are likely to be dissatisfied (35%) as satisfied
Info on accessing caregiver support	59%	52%	Slight whānau lead; one in four caregivers report “mixed feelings”

Note. Refer to Appendices to view full figures and results for each measure.

4. Caregiver satisfaction with financial supports

Table 2 summarises caregiver satisfaction with selected aspects of financial support.

Table 2. Thinking about the allowances, reimbursements and extra payments from Oranga Tamariki, how satisfied are you with:

Aspect of financial support	Whānau % “Satisfied or Very satisfied”	Non-whānau % “Satisfied or Very satisfied”	Key observation
Time it takes to receive reimbursements and extra payments	57%	58%	Processing speed once a reimbursement is claimed is the strongest point; roughly 3 in 5 caregivers are satisfied with this
Ease of accessing reimbursements and extra payments	48%	47%	Satisfaction drops to just under half; suggests systemic hurdles leave a quarter of caregivers frustrated
Availability of information on what they’re entitled to	40%	35%	The weakest point of financial support, one-third are outright dissatisfied, and another third feel mixed – or partially informed

Note. Refer to Appendices to view full figures and results for each measure.

Key findings:

- Getting reimbursed is quicker than making the claim. Biggest barrier is getting the claim attended and filed. Many struggle to navigate the front-end process and paperwork involved and depend on their caregiver social worker for entitlement support.
- Information is the biggest gap. Inconsistency over what is claimable, how to claim it, or whether previous funding can be reinstated fuels frustration among caregivers.
- Across measures for financial supports, whānau versus non-whānau differences are small. Both groups report similar experiences with each aspect, though whānau rate clarity on entitlements slightly higher.

“I think when you are told to use email as a communication, that the social worker does need to read the emails and acknowledge any request for information. E.g. I wanted permission for the child to see an optometrist when he failed the exam at the school. And I had to email the social worker 2-4 times, and in the end when he (the child) returned to whanau, I still hadn't been given approval for him to see the optometrist. Also, I would ask if the child could attend after school activities, and I would just end up paying for them, because I never got a reply from the social worker. She let me down a lot, but was awesome when she started with the

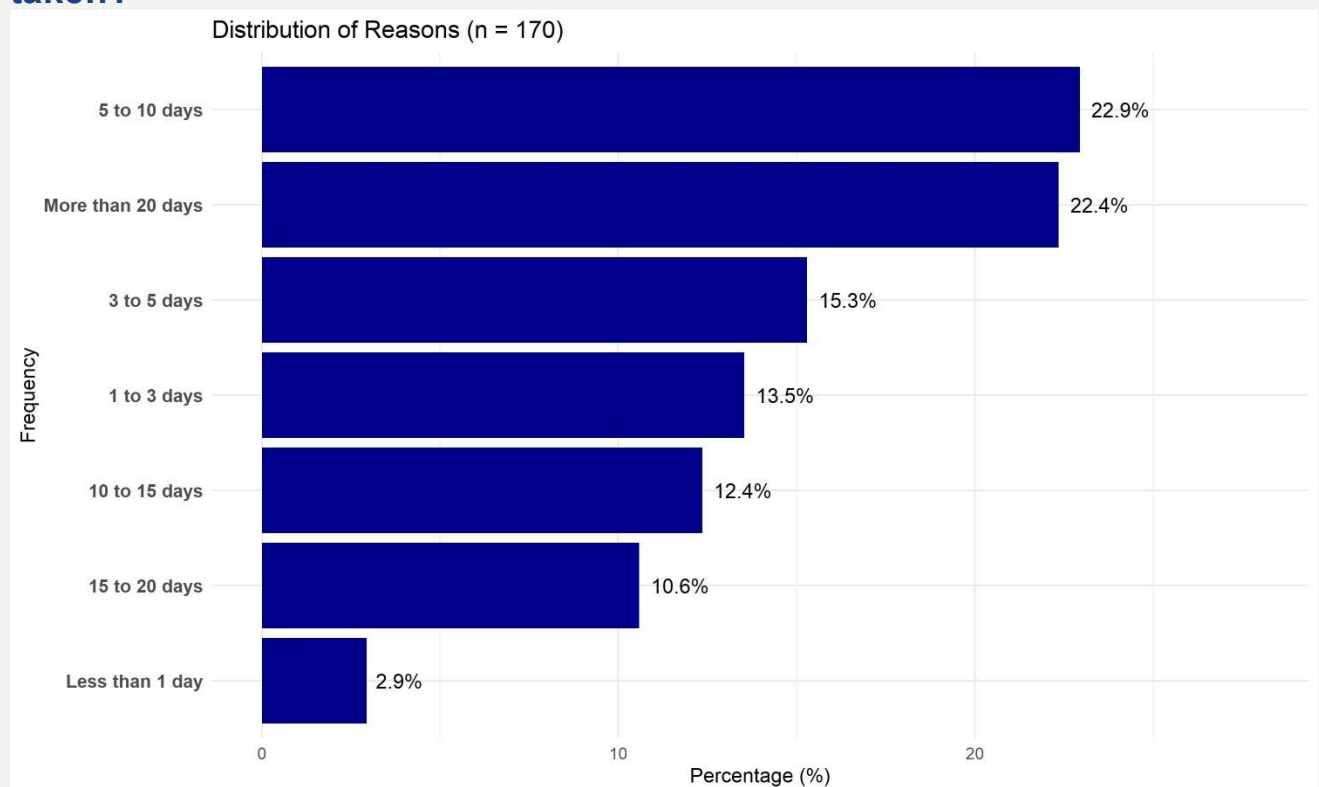
children for a few months, and slowly the excuses came. When I rang her, she was in court, or some other excuse.”

“The child has been in my care for many years. I registered their non accidental injury which enabled them to receive funding from ACC to cover his rehabilitation which includes Speech, Occupational, physio, and almost full time teacher Aides at primary and secondary school. I have had to advocate for him on a number of occasions. He is unable to access his community alone, I have to provide transport to and from activities. Currently I'm paying for horse riding lessons out of my own pocket, long story. I'm a pensioner.”

5. Respite care – availability, and why caregivers under utilise it?

Of caregivers who reported taking respite, in the last 12 months, **Figure 10** shows roughly **46%** took between five to twenty days – **‘5 to 10 days’ (22.9%)**, **‘10 to 15 days’ (12.4%)**, and **‘15 to 20 days’ (10.6%)**. While **22.4%** took over 20 days, suggesting a high demand for respite breaks.

Figure 10. In the last 12 months, how much respite care have you taken?

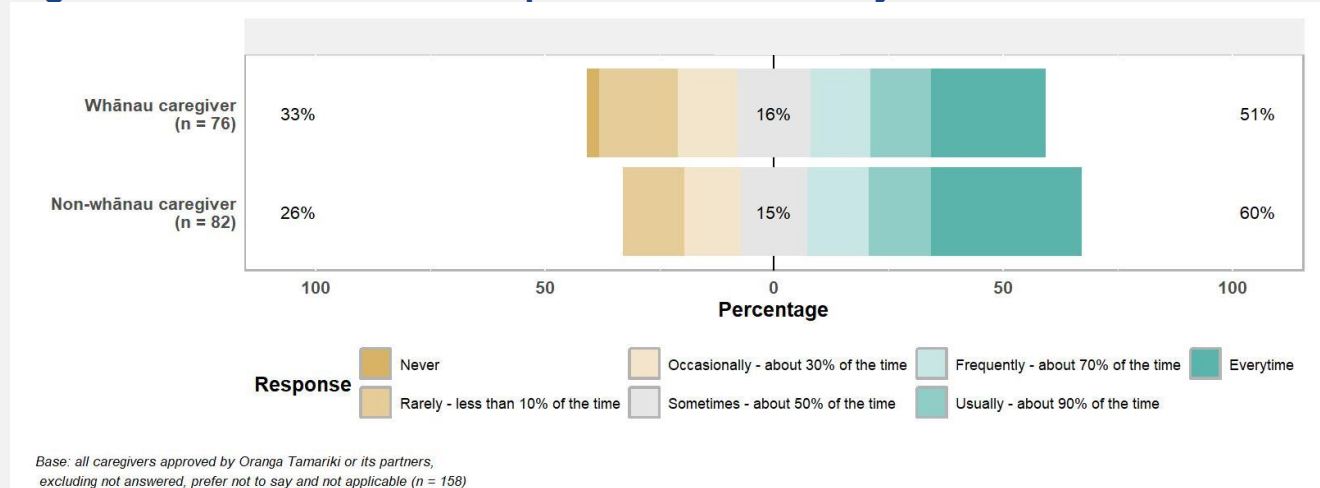


5.1 Was respite available when caregivers needed it?

Among **158 caregivers** who responded to the question, **Figure 11** shows **whānau** caregivers may struggle more to secure respite than **non-whānau caregivers**. A further one-in-six across both groups could get respite only half the time when needed.

Just over half of **whānau** versus three out of five of **non-whānau**, can count on respite when they ask for it.

Figure 11. How often was respite available when you needed it?

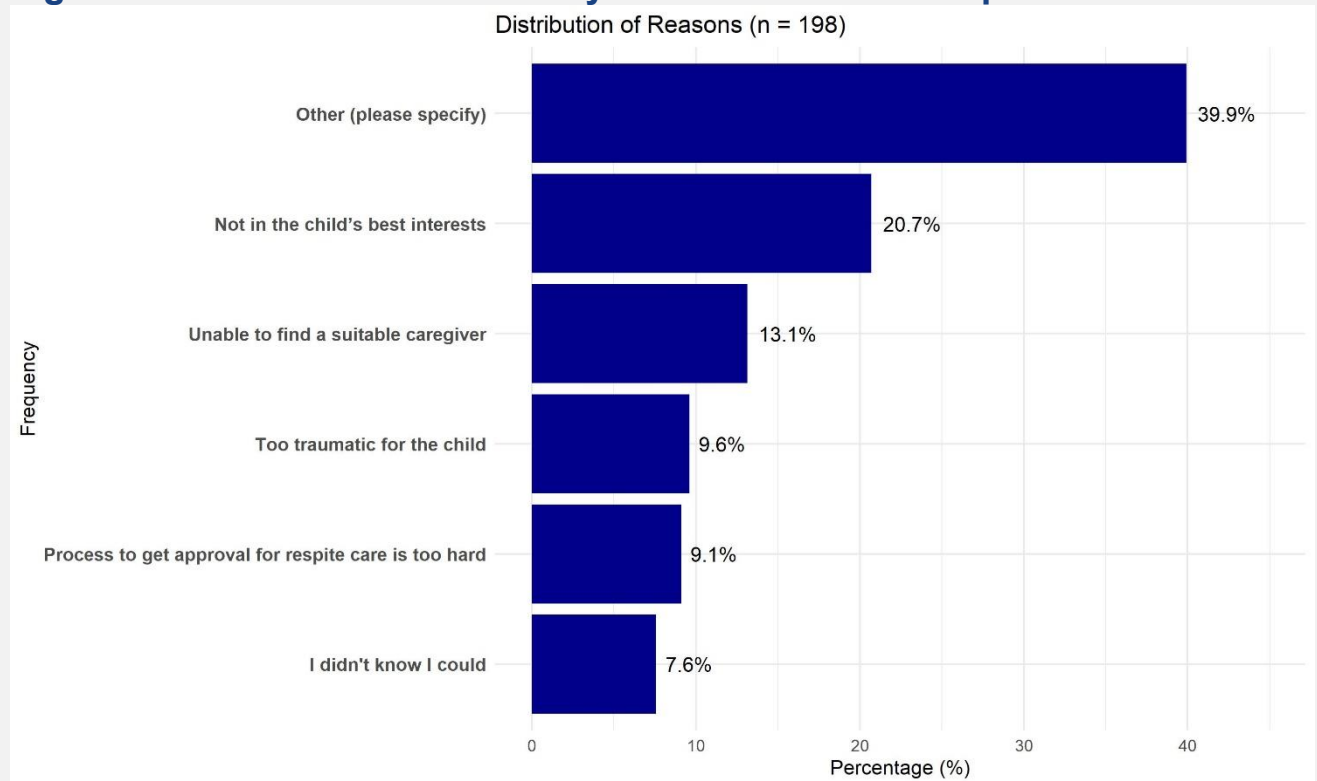


5.2 Why caregivers didn't take respite

Figure 12 presents the most reported reasons for caregivers not taking respite. The single largest bar accounts for **'Other' (39.9%)** open-text responses, which capture the wide mix of personal or situational reasons (e.g., didn't feel the need, getting support from other whānau members, or child resistance to the caregiver being absent).

Among the predefined options, the top three barriers to respite are **'Not in the child's best interests' (20.7%)**, **'Unable to find a suitable caregiver' (13.1%)**, and **'Too traumatic for the child' (9.6%)**.

Suffice to say, taking respite is complicated for caregivers.

Figure 12. What are the reasons you could not take respite care?

Open text themes extracted from **'Other'** category (39.9%) as follows:

Not needed or not preferred: Some caregivers reported not needing respite – either because they themselves were respite caregivers or they did not feel the need. Others prioritised the child's wish to stay home.

"They are my children, loved, settled and secure. We do not require 'breaks' from each other."

"We manage ourselves within the whanau. I used to send them to a week long camp in the holidays, something they enjoyed, that was our respite care."

"We won't send him to someone he doesn't know and when asked for a babysitting allowance it isn't available."

Others **relied on informal help from relatives or friends** or already had scheduled stays with the child's birth whānau.

"Children have court ordered visits with maternal grandparent (6 weeks a year) so I don't need to use respite often."

Some **felt respite would unsettle or traumatise the child**, especially very young children.

“The time it takes him to readjust back from respite is not worth it. Plus, when we had it two years ago he was sent to a caregiver that had not done the training at all.”

System barriers: Oranga Tamariki could not supply an approved respite carer or failed to approve one the caregiver sourced.

“Finding someone who will be happy to care for child's health needs is not easy. I did find a Caregiver who is with [Community Provider], would be great but Oranga Tamariki won't allow due to cost.”

“They don't have respite where I live that [is] what I get told all the time.”

Approval processes were described as “too hard”, or social workers did not action requests.

“We had chosen our own respite carers who knew the children and loved them. But when they saw the application forms they all thought the forms were too noseey and withdrew.”

Some caregivers reported **not being aware respite existed** or turned to other agencies instead.

“I didn't know about it, too traumatic for child and not sure what's involved to do this.”

“I was referred to respite through (Iwi Partner Name) none was avail[able] with Oranga Tamariki.”

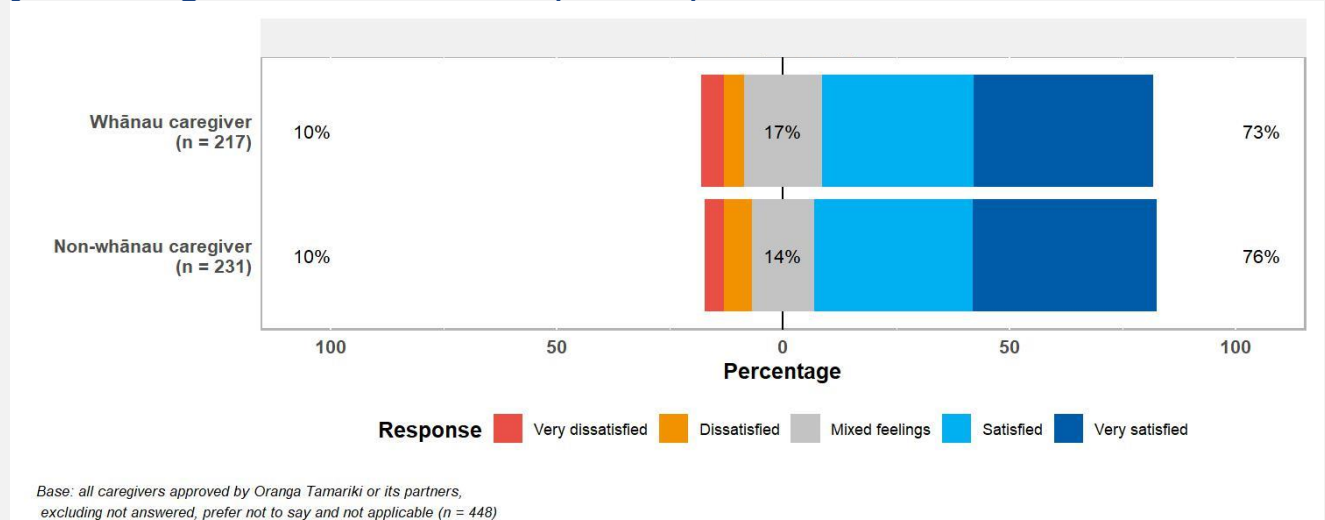
6. Social worker practice

The following section reports caregiver satisfaction with various critical aspects of social worker support.

6.1 Caregiver's social worker support

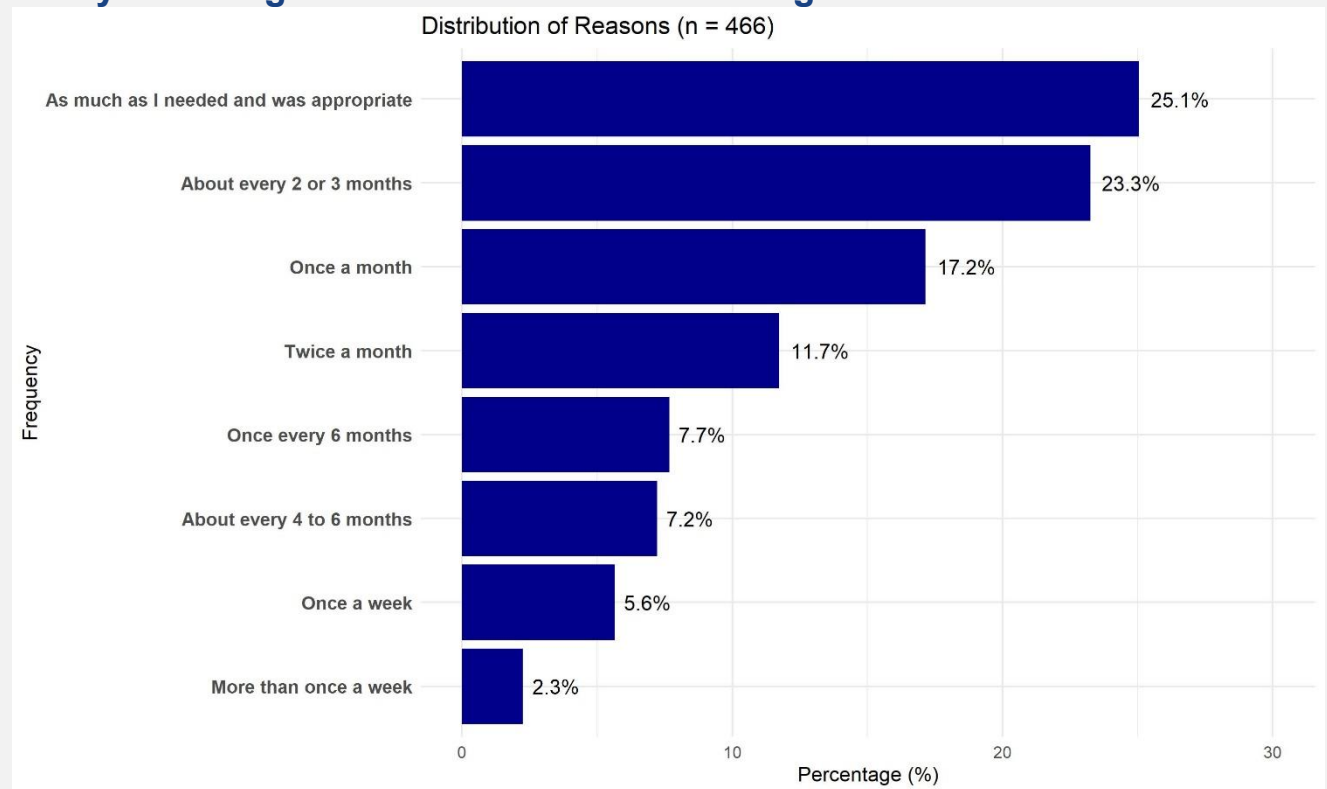
Regarding contact from their **caregiver social worker**, **Figure 13** shows strong majorities across both **whānau (73%)** and **non-whānau (76%)** that the frequency of contact with their caregiver social worker meets their needs.

Figure 13. How satisfied are you with the frequency of contact from your caregiver social worker? (n = 448)



Delving deeper into the topic, **Figure 14** presents the reported frequency of contact from **caregiver social workers**. Contact patterns vary widely. Roughly one-quarter (**25.1%**) feel they have enough contact when required, while nearly another quarter (**23.3%**) see their social worker just four to six times a year

Figure 14. In the last 12 months how often have you had contact with your caregiver social worker from Oranga Tamariki?



Summative Interpretation: There is variability in contact with caregiver social workers, suggesting caregiver social worker resource constraints or mismatched expectations with caregivers.

Table 3 summarises caregivers' satisfaction with various aspects of **caregiver social worker practice**.

Overall **high satisfaction** was seen across the measures for caregiver social worker practice, such as: contact frequency, communication, respect, reliability, and inclusion, **68% to 80%** of caregivers rate their caregiver social worker positively.

Table 3. How would you rate your satisfaction with your current caregiver social worker on the following:

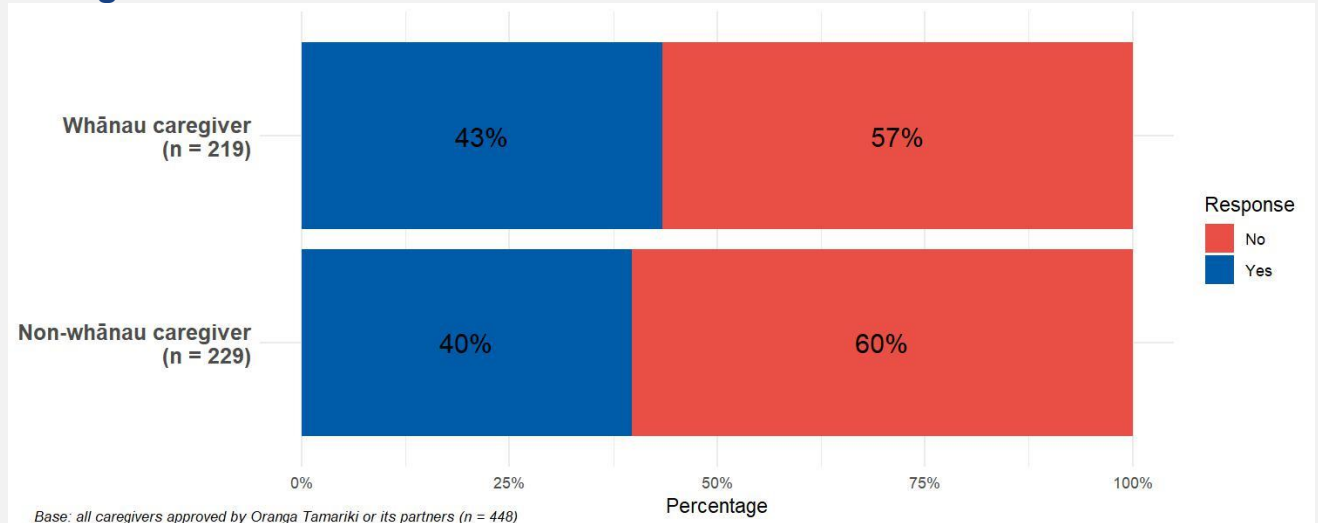
Aspect of caregiver social-worker practice	Whānau caregivers “Satisfied, or Very satisfied”	Non-whānau caregivers “Satisfied, or Very satisfied”	Key Observation
Communicating with me	75%	74%	Strong ratings for both groups, with whānau slightly more satisfied generally
Respecting and listening to my knowledge of the child	80%	79%	Highest satisfaction overall for both groups; Listening is a clear strength for caregiver social workers
Doing what they say they will do	73%	76%	Solid majority satisfaction for both; with non-whānau slightly leading
Involving me in decision-making	73%	68%	Lowest of the four measures, especially for non-whānau caregivers, suggesting room to deepen partnership with caregivers

Note. Refer to Appendices to view full figures and results for each measure.

Summative interpretation: These results suggest caregiver social workers demonstrate strong communication and delivery in practice, but caregivers still want more input into decisions made about the child’s welfare.

Figure 15 reports the proportion of caregivers who experience a change in their caregiver social worker during the past 12 months.

Figure 15. In the last 12 months, has your caregiver social worker changed?



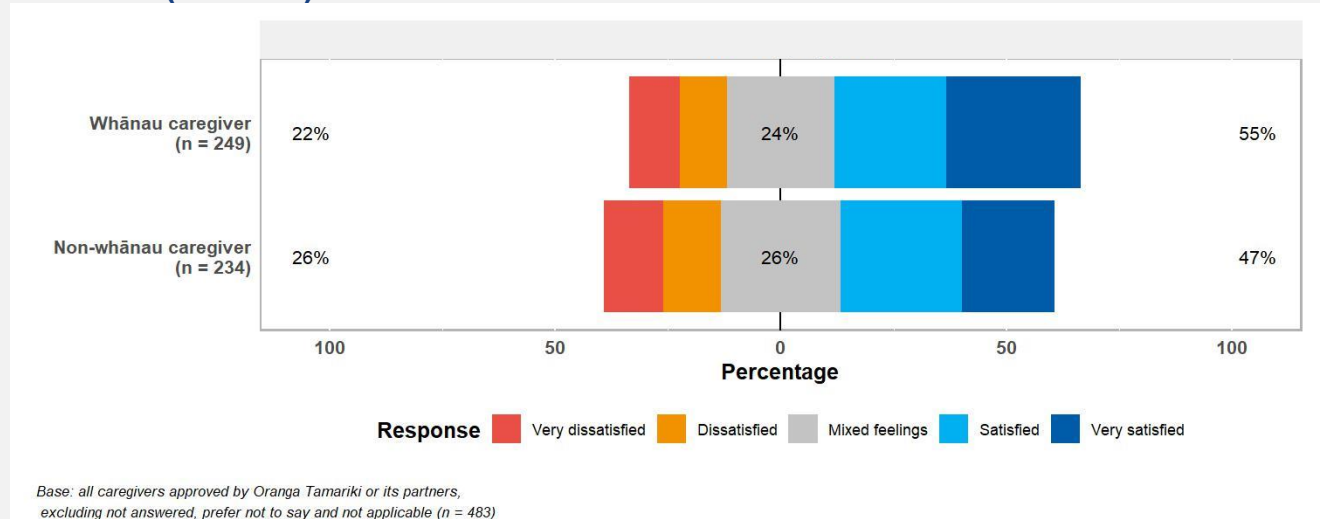
Key takeaway is continuity risk: Frequent social-worker changes affect a majority of caregivers and may erode the otherwise strong satisfaction ratings with caregiver social worker practice. Continuity may also affect follow-through on requests.

Further understanding of the impact of caregiver social worker change on caregivers should be explored in the subsequent annual survey.

6.2 Child's social worker support – what caregivers experience

Regarding support from the **child's social worker**, from the caregiver's perspective, just over half of **whānau** caregivers (**55%**) are satisfied, but this drops below half (**47%**) for **non-whānau** caregivers (**Figure 16**).

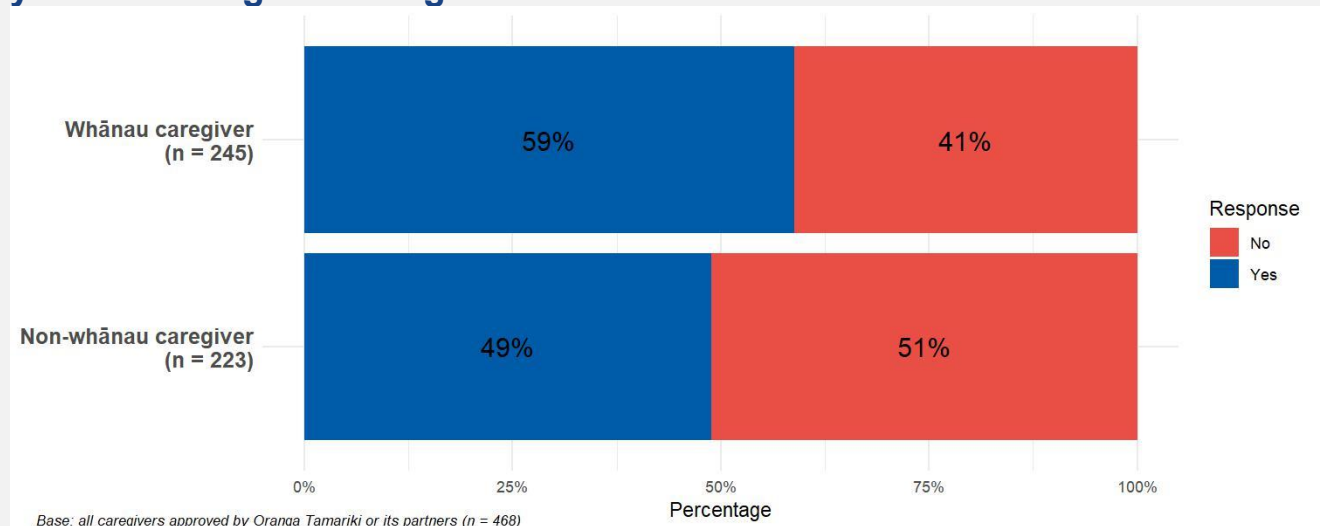
Figure 16. How satisfied were you with the support from Oranga Tamariki social workers for the child or children in your care overall? (n = 483)



Key finding: Support from the **child's social worker** is a notable gap for caregivers. Satisfaction with child social worker support is middling. Barely half of caregivers feel well-supported by the child's social worker, with non-whānau caregivers least satisfied.

Figure 17 shows that **child social worker** turnover affects roughly three out of five **whānau** caregivers and one out of two **non-whānau** caregivers.

Figure 17. In the last 12 months, has the social worker for a child you are caring for changed?



Key findings: Child social worker turnover is a drag on confidence. A change in the child's social worker is common – especially for **whānau** caregiver placements – which may undercut relationship building and continuity of support for the child and caregiver involved.

6.3 How children's social worker practice falls short for caregivers

The following are qualitative themes aggregated from caregiver quotes regarding why some caregivers (n = 329) are dissatisfied with the child's social worker practice.

Question: Would you like to comment further about your experience with a child's social worker?

High turnover and poor hand-overs:

"We've had 13 social workers over time."

"We are averaging a new social worker roughly every 4 months, so nothing gets done, none of them read CYRAS so I am constantly repeating the same answers to questions that are in the children's file."

"My child does not accept people very well. It takes a bit of time for him to talk to people. There has been a continual change of social workers sometimes he hadn't even got to the stage of talking to them before a new one came along. The current one is fabulous and is getting on very well with the child. Long may it Last."

"The continuous changing of social workers is exhausting having to re tell our story over and over and the trauma our child and us have experienced due to incompetence by your social workers."

"Social worker on leave and holiday and the one taking over admitted that his knowledge of the case was minimum which means Oranga Tamariki has a poor system."

Slow or no communication:

"No contact from them at all. To be fair we were only doing respite care, but for the same child, but we never had any interaction with them [social worker]."

"We were told that the social worker was changing in late 2023. It took some months for us to be informed who the new social worker was. Having received that name - emails have gone unanswered and questions about progress on a matter have gone unanswered."

"Only hear from them when they want me to do something."

"Referrals weren't put through in a timely fashion."

Lack of follow-through:

"1st social worker was useless provided no support, false promises; 2nd social worker was amazing, provided support, got clothing, financial assistance for me; 3rd social worker okay - lacks communication and takes forever for anything to get accepted. I feel because child is doing amazing with me that I'm just left to it."

"We are now over two years waiting for a gateway assessment and birth certificate."

"They are glorified sales reps. Tell you what you want to hear at the time and then walk away with no follow up."

"Did not act on our calls for support for the child."

Not listening or caregivers feeling ignored:

"At first we seemed to be working together for the care and wellbeing of the children we were very happy to have her in our home. but over time the communication stopped, meetings were cancelled, phone calls ignored, misinformation was given, questions from both us and daycares were ignored or flogged off. her agenda seemed to have changed which totally confused everyone involved."

"There have been lots of changes, and people we have come in to contact with have been great and some not so great. We have raised concerns previously about contact arrangements which have been ignored, at times putting our child at risk. We then find out information further down the track which makes it unfathomable as why things were allowed to continue the way they were. It has taken someone else's view from a very good social worker to ask the questions and sort things out. This is not acceptable."

Limited trauma and neuro-developmental understanding:

"Needs further training around developmental trauma and the impact that has on the child, how it manifests, and what specific supports are needed for that child."



Perceived bias or cultural insensitivity:

“I felt like he was racist, and he made it seem like everything I done was wrong and not good enough for him.”

“He said, she said, I said and you said situation is not good for [consistency] and what is best for the tamariki based on what could be presumed as personal bias OR personal opinions.”

Overwork and burnout:

“They’re clearly overloaded. Often know nothing about the child. Make decisions based entirely on convenience and pressure from higher ups or whānau.”

“I think she is over worked and has too many children to look after, therefore is stretched thin. So when I don’t hear back, I don’t blame her, I know it is a systematic issue of having a very large workload.”

“The social worker for child is over worked - this is very obvious. As a result, the child does not always receive the support they should have (e.g., the visits do not occur as they should or checking in).”

Summative Interpretation: Regarding experiences with the **child’s social worker**, caregivers expressed deep frustration with high social worker turnover, describing repeated disruptions, poor handovers, and the emotional toll of having to retell their stories again and again.

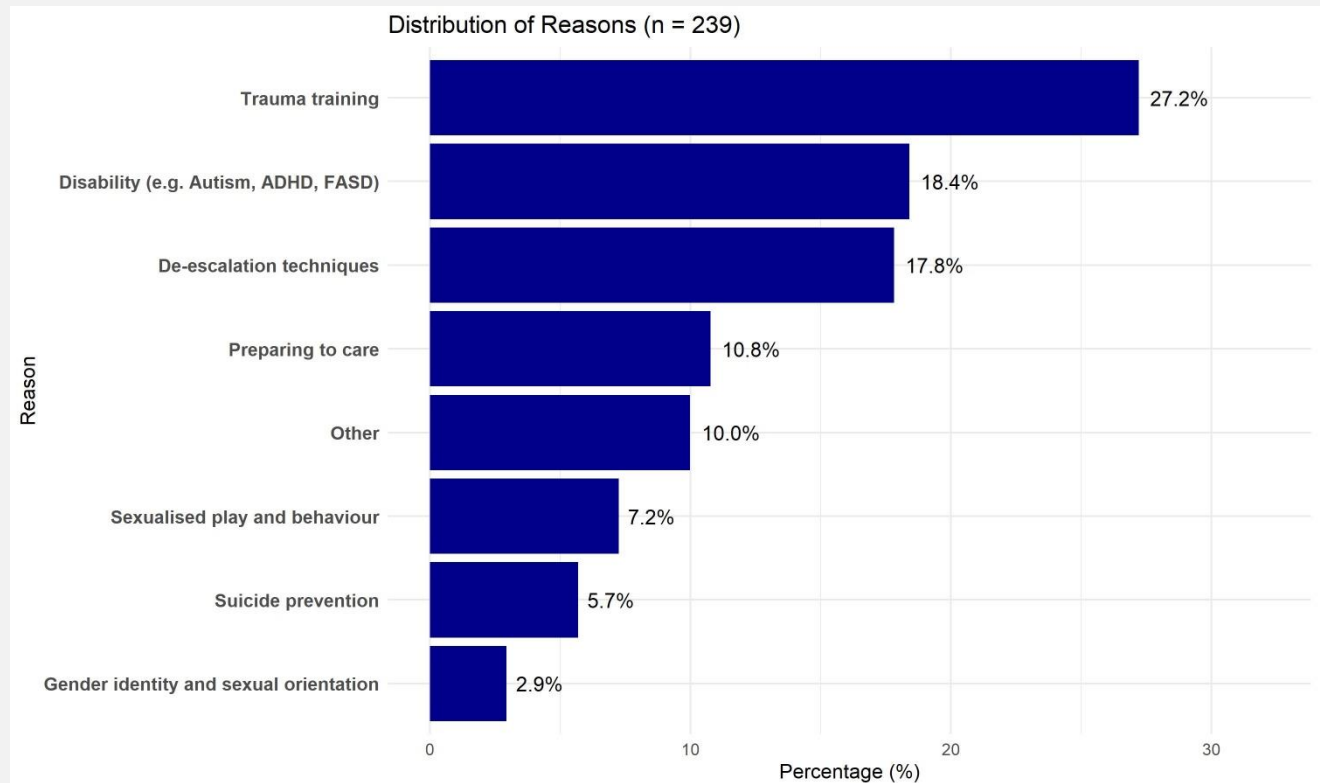
Many felt ignored or unsupported by delays in response, or lack of follow-through by the child’s social worker.

Concerns were also raised about the child’s social workers’ limited understanding of trauma and neurodevelopmental needs, and decisions driven by convenience rather than the child’s best interests.

7. Caregiver training – what is needed, what’s missing?

Figure 18 gives a breakdown of caregivers who reported needing training or learning. Heavily weighted toward behaviour-related skills, of the top three, just over a quarter (**27.2%**) need trauma-informed training – the largest category, while a further **18.4%** want ‘**Disability**’ focused learning, and another **17.8%** want learning on de-escalation techniques.

Figure 18. In the last 12 months, have you felt the need for more training or learning about any of the following topics to help care for a child?



Note. CATA multiple-response question – results use a total response approach accounting for all respondent selections presenting each category's share of the overall total (100%).

The **'Other' (10%)** training and learning themes reported by caregivers included requests for specialised training such as:

Management of challenging behaviours and dynamics: Caregivers request deeper support in dealing with manipulation, stealing, device addiction, alcohol and drug use, and sibling-group dynamics.

"Maybe some course to support when you are dealing with more than one child from the same whanau."

"Have more professional counsellors available. Help to get child's behaviour diagnosis."

"I have voiced my concerns as I have cited her choosing anger as this is a symptom of Fragile X syndrome, but nothing really came of it."

"Manipulation aggression stealing."

"How to deal with the family dramas and parents who are in active addiction."

Need for ongoing and in-person learning: Caregivers dislike one-off webinars; they want follow-up sessions and local, face-to-face courses.

"[Provider Name] courses are online which do not suit. There is little follow up after courses are completed."

"Some topics do not appeal, most delivered online which is not my preferred way of learning or participating."

"I have attended three caregiver training sessions this year...On two occasions I was the only participant attending. I am experienced in supporting people with disabilities and received some excellent training over my thirty years working in this field. I think ongoing training is a must for all caregivers and would expect it to be compulsory for all caregivers to attend at least one course a year to keep upskilled."

Parenting and safety: Interest in responding to sexual trauma, de-escalation and general parenting refreshers.

"I have done nearly all the trainings again this year just not on topic [of] sexual play and disclosures. [It is] Not offered."

"Support coordination of caregivers for de-escalating behavioural issues. Believing me that I need help with de-escalation and creating a safety plan for birth family visits."

Disability and trauma specific content: Continued demand for ADHD, FASD, sensory-disorder modules, and responding to trauma-related concerns.

"Needs further training around developmental trauma and the impact that has on the child, how it manifests, and what specific supports are needed for that child."

"Funny I think it is Oranga Tamariki that needs more training especially with FASD."

"We don't have a Caregiver Social Worker when we did, he did not follow up on the trainings we were interested in e.g. ADHD or FASD neurodiversity etc."

Caregivers report barriers to accessing training – training times clash with jobs; courses cancelled due to low numbers; social workers unaware of options; and online formats unpopular.

“We have not been told of any training. Nothing has been offered. You can't engage if you don't know what's available.”

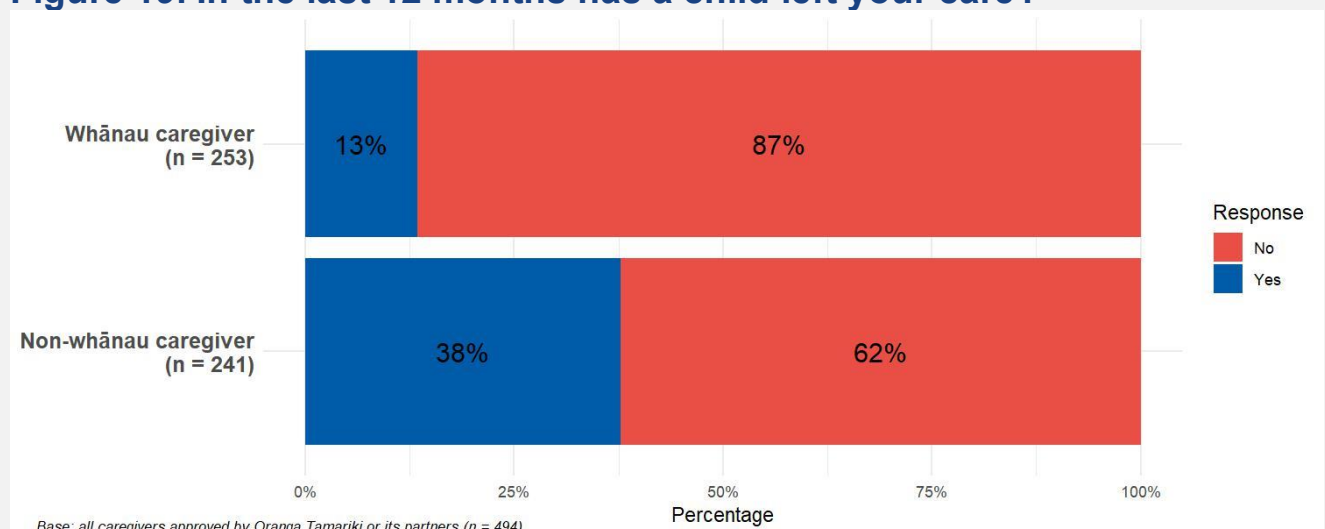
“A baby now toddler keeps you very busy, makes getting to trainings difficult.”

“Most training during the day which doesn't work for working carers.”

8. Child or youth transitions – how the hand-over felt

Figure 19 reports the proportion of children or young person who transitioned out of a caregivers' placement in the last twelve months.

Figure 19. In the last 12 months has a child left your care?

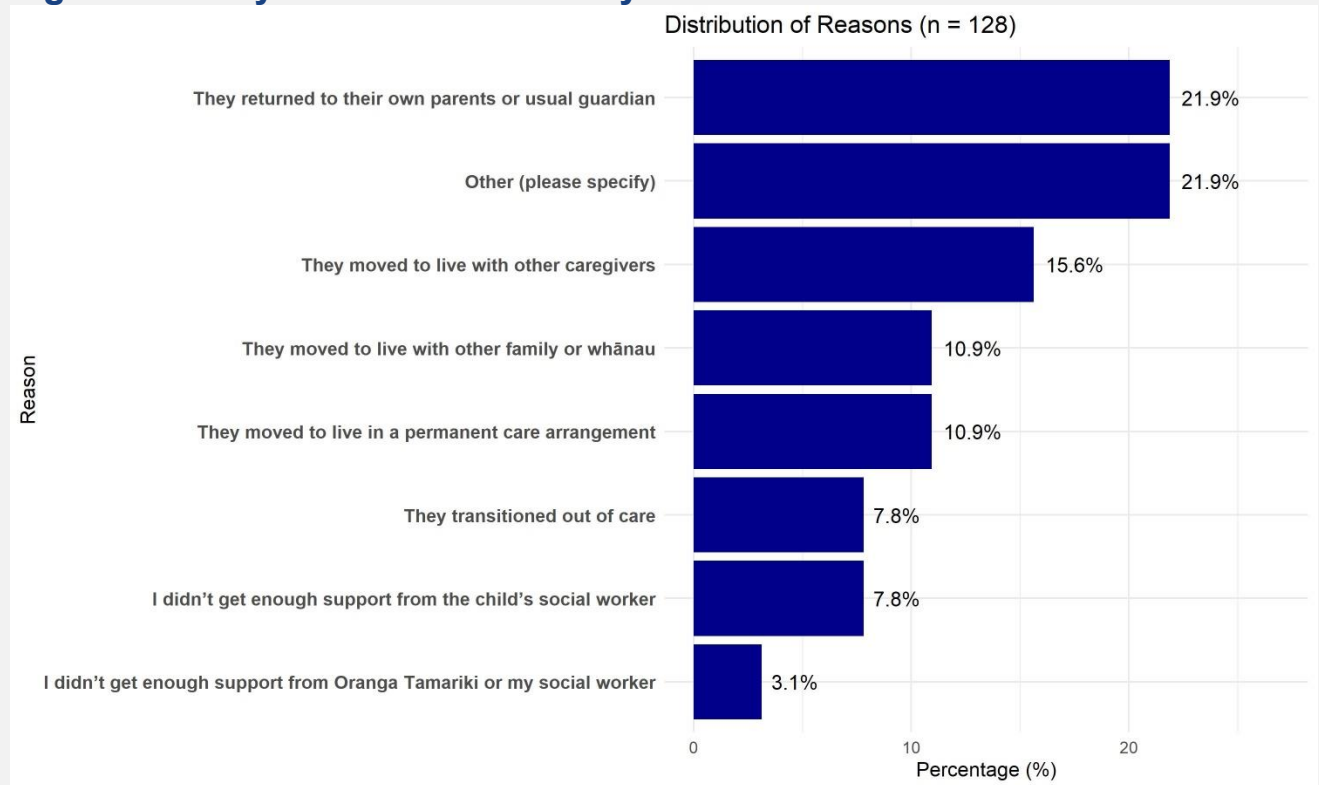


Results suggest children and young people in care are nearly three times more likely to exit **non-whānau** placements than **whānau** ones.

8.1 Why did children leave their care?

Of the 128 caregivers who reported reasons for a child transitioning, **Figure 20** shows top reasons were split between **planned reunifications with whānau (21.9%)**, and a mix of **'Other' (21.9%)** circumstances.

Lack of formal support is reported by one in ten caregivers (e.g. **'I didn't get enough support from the child's social worker' = 7.8%**, **'I didn't get enough support from Oranga Tamariki or my social worker' = 3.1%**).

Figure 20. Why did the child leave your care?

Seven main themes emerged from caregiver's open-text responses for **'Other' (21.9%)** reasons why the child or young person transitioned out of their care:

Planned short-term or respite placement: Exit from care was expected once the agreed period ended.

"They were all short term placements with us - most going back to caregivers, some to new caregivers, one to family, one to Oranga Tamariki support."

Issues involving the child's whānau: Abusive or unsupportive behaviour, parental objections to routines (e.g. daycare), sibling conflict.

"Due to the abusive behaviour of the child's whanau towards me and lack of respite or support [the child left my care]."

Child's own high-risk behaviour: Safety concerns such as absconding or violence toward others.

"I stopped [being] the respite [carer] of several years after I was assaulted."

Inadequate formal support: Insufficient resources, respite, or specialist help to meet complex needs – leading to caregiver burnout.

“I don’t think there was any one thing that led to the placement breaking down, but I would attribute it to the fact we didn’t have any support for 3 months, I was raising a stranger not yet a caregiver.. so not having any of the information or support we both needed.”

“Placement failure, rangatahi absconded. Due to lack of specialised Caregivers 1:1 the child had to be removed for the safety of others. Lack of support to ensure the safety of the child including others.”

Logistical barriers: Long travel for medical appointments, housing constraints, or relocation for specialised therapy.

“They moved to a group home in a different region to relieve therapy support etc.”

“We were a fair distance from hospital for weekly appointments and felt it would be beneficial for babies to be closer.”

Young person moved to independence or returned to whānau: Natural step-down in care placement.

“They are living independently in their own home close by. I still support them, take them shopping etc. they are now part of my family unit.”

“[The child transitioned] to be close to whanau in a different city.”

Social worker practice issues: Perceived incompetence or poor communication that destabilised the placement.

“The placement fell down due to high stress the social worker placed on the child.”

High-stress exits (e.g. behavioural crises and placement breakdowns) drew the lowest satisfaction scores.

“I become stressed and asked for OT to take my niece. I was getting no support from OT with external respite outside of my Mum. A year ago my

Mum become ill. OT knew this. I had alot of pressure and responsibilities. As a result, I've become stressed and decided that the child causing the most stress needed to go. I had a total of five kids."

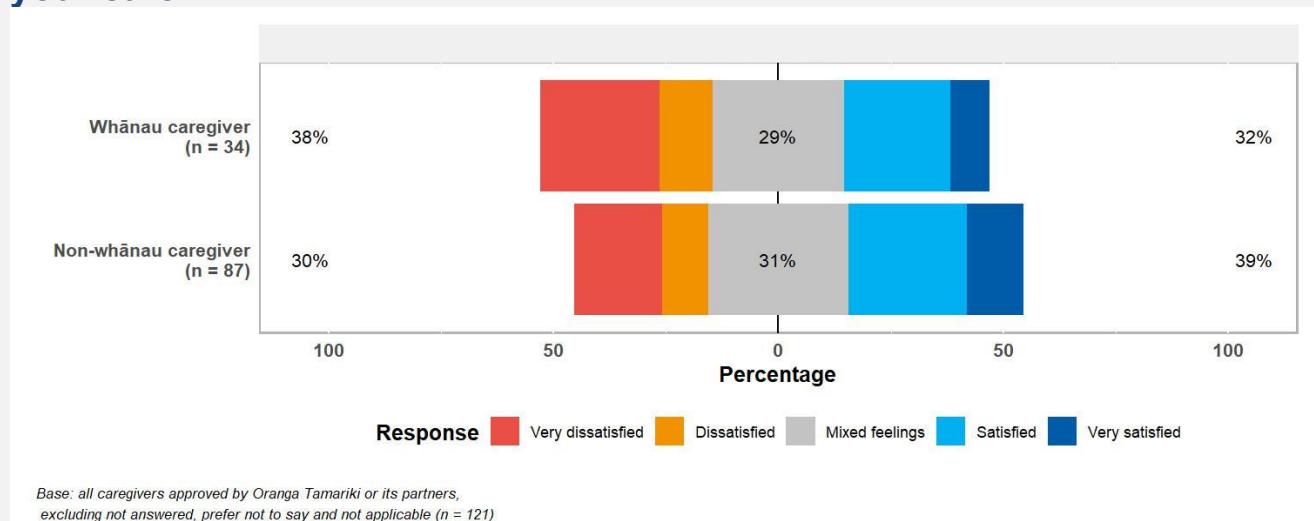
Among some cases, **planned, well-supported moves** (e.g. reunification with whānau) were reported and gathered more positive feedback, especially when social workers communicated early and coordinated services.

"Moved to a family member, and then two weeks later, to his guardian."

Figure 21 shows fewer than **40%** of caregivers, who reported a **child transitioning out of their care**, were satisfied with the support Oranga Tamariki provided during the transition.

Regarding **transition support** dissatisfaction levels were high and nearly equal across groups – **38%** for **whānau** caregivers, and **30%** for **non-whānau** caregivers. While around **30%** of both groups reported having mixed feelings.

Figure 21. How satisfied were you with the support Oranga Tamariki provided during the child's or children's transition out of your care?



Summative interpretation: Transition support is the weakest-rated stage of the caregiving experience – highlighting a continuing support gap.

Reasons for transition were largely due to reunification with birth parents or guardians, but an equal proportion were due to **'Other'** reasons, revealing case-specific placement breakdown factors.

Practical Suggestions

Table 4 summarises a list of practical actions that can be taken to improve the journey of caregivers working with Oranga Tamariki.

Table 4. Practical actions from the findings overall

Area	#	Practical actions caregivers, Oranga Tamariki, and partner agencies can implement
1. Caregiver preparation	1.1	Reinforce the expectation that every caregiver must receive an up-to-date All About Me Plan and key care information at the time of placement, including in emergencies. Supervisors must follow up within an agreed timeframe to confirm it was provided, accurate, and recorded in CGIS.
	1.2	Schedule a first-week and first-month check-in for every new placement, with both the child's and caregiver's social workers present. These must be documented in the Support Plan, linked to the AAMP, and monitored for follow-through.
	1.3	Explore how to provide a range of accessible resources (e.g. short videos) on key issues such as trauma, birth family contact, and stress as supplementary support—not a replacement for in-person training—and pair modules with tailored follow-up where needed.
2. Information and communication	2.1	Use existing tools—AAMP and Support Plans—as the single, shared communication plan for each child. Focus on consistent implementation and follow-through.
	2.2	Reinforce the need to ensure the AAMP includes clear, individualised information on behavioural triggers, past neglect, and health needs and review it at every placement change.
	2.3	Explore improvements to the caregivers claims process with consideration for an online process and a dedicated contact for support and approvals.
	2.4	While some activities to address this have occurred since the survey, it is important to continue to support consistent collaboration between the child's and caregiver's social workers to ensure caregivers are treated as informed partners by providing clear guidance on their decision-making role, and timely access to key information.
3. Support plans and documentation	3.1	Reinforce the importance of developing and reviewing Support Plans with the caregiver—recording their involvement and preferred way of receiving it. Explore the use of existing systems (e.g. CGIS) to track delivery and implement a simple quality check to confirm caregiver input.
	3.2	Develop a simple checklist in multiple formats to suit different language and literacy needs, and ensure social workers review it with caregivers.
4. Financial supports	4.1	Explore options to host caregiver related content (e.g. caregiver entitlements and tamariki entitlements) and develop supportive resources (e.g. claim examples and links to forms) in a specific location on an accessible webpage (e.g. Practice Centre or Oranga Tamariki website).

Area	#	Practical actions caregivers, Oranga Tamariki, and partner agencies can implement
	4.2	Explore the potential to assign a dedicated contact person to support first-time caregiver claims, with clear responsibility for guiding caregivers through the process and approvals.
	4.3	Explore payment models to reflect higher payments for those supporting children with disabilities and complex needs.
5. Respite care	5.1	Review and consider opportunities to simplify the assessment process for caregiver-nominated respite providers.
	5.2	Expand use of relationship-safe respite options, like in-home respite or involving familiar whānau, offer emotional support plans for children sensitive to separation—resourcing will be key.
	5.3	Consider the need to develop and fund a national Caregiver Recruitment Plan, with flexible regional delivery to respond to local needs.
6. Education support	6.1	Promote and support caregivers, within their rights, to participate with schools on IEPs, attendance and wellbeing plans. Raise the issues to health and education advisors – with schools and RTLB to support caregiver–school collaboration on IEPs, attendance, and wellbeing plans—resourcing this role is key.
	6.2	Access to appropriate supports (e.g. speech language therapy) is challenging for social workers. To progress this, we recommend that opportunities to improve the Gateway model based on the 2024 review under the Oranga Tamariki System Action Plan are considered as part of national improvements agreed by Ministers and funded within baseline or considered as part of the future pilot for Gateway ¹² .
7. Health support	7.1	Prioritise social skills and communication support—such as speech-language and peer interaction programmes—through the rollout of national improvements to the Gateway model under the Oranga Tamariki System Action Plan or considered as part a future pilot for Gateway.
	7.2	Explore opportunities to expand and deliver wraparound coaching for tamariki in care things like daily living skills—through care providers under the Care System Action Plan.
	7.3	The new proposed Gateway aims to improve timely access to health services. Implement the Gateway’s redesigned solution for gaining medical consent, utilising whānau navigators and hospital liaisons. Fund, pilot, and scale this evidence-based initiative under the Oranga Tamariki System Action Plan.
8. Training and learning	8.1	Explore opportunities to expand, strengthen and deliver training with existing partners (e.g. Caring Families) by offering modular, in-person courses with after-hours options, regular refreshers, and peer learning aligned to NCS expectations.

¹² Valdivia, L. A., Ransfield, A. K., Yee, M. W. W., Samuel, E., Wood, R., Pōtiki-Clune, K., & Notoa, F. (2024). Gateway Assessment Review: Key Findings. Wellington, New Zealand: Oranga Tamariki – Ministry for Children.

Area	#	Practical actions caregivers, Oranga Tamariki, and partner agencies can implement
	8.2	Consider how to provide more flexible training (e.g. evening and weekend in-person training), with recorded sessions available for catch-up, to ensure access for working caregivers.
	8.3	Promote the existing regional training calendar more effectively by assigning caregiver communications to a dedicated team—ensuring caregivers know what’s available and can plan ahead.
9. Social worker practice and continuity	9.1	Prioritise caseload stability and flag high-turnover cases for review under the existing Workload Management Strategy, as part of the National Care Action Plan.
	9.2	Ensure contact frequency is agreed in the initial Support Plan and reviewed quarterly.
	9.3	Explore opportunities to strengthen handover processes when a new social worker is assigned to reduce the need for tamariki and caregivers to repeat their stories and ensure continuity of support.
10. Transition planning	10.1	Standardise the use of existing tools—like Life Story Books and ‘Welcome to Home’ boxes—into a consistent exit process covering logistics, emotional preparation, and post-move follow-up. A clear ‘exit playbook’ would help ensure these resources are used effectively for both child and caregiver through transitions.
	10.2	Consider the current policy and guidance settings in relation to transition planning and whether clear timeframes and mandatory caregiver consultation are required for planned transitions.
	10.3	Promote and properly resource the existing Oranga Tamariki after-hours hotline so caregivers can access 24/7 support during the first week of a child’s transition—ensuring they know it exists and can rely on it when needed.
11. Cultural support	11.1	Consider opportunities to connect non-whānau caregivers with a cultural mentor or iwi liaison as part of the Caregiver Support Plan, to strengthen cultural understanding and connection.
	11.2	Provide bite-sized resources on whakapapa, language, and cultural protocols relevant to the child, and include these in the caregiver Support Plan where appropriate.
	11.3	Scale up successful regional practices—like caregiver hui, morning teas, and peer gatherings—by learning from what’s working, and supporting social workers to lead these community connections nationwide.
12. Monitoring and feedback	12.1	Explore the benefit and opportunities of tools like pulse surveys after key caregiver milestones (e.g. placement, plan review, respite) to identify issues early, celebrate successes, and gather insights on what’s working—informing system-wide improvements.
	12.2	Consider the publication of six-monthly caregiver experience dashboards based on data captured from the pulse surveys, to track progress on key measures like response times and training uptake.
	12.3	Present findings from all annual stakeholder engagement surveys as drop-in sessions across all workstreams—not just within specific business units but across organisation—to raise visibility and drive collective action.

Conclusion

Caregivers told us what works – responsive social workers, clear and accessible information, timely payments – and where the system still frays: behavioural guidance, respite access, awareness of caregiver plans, and transition support.

To better support caregivers, we must ensure both timely identification of children's needs and swift access to services and support. When support is delayed or unavailable, it places a heavy burden not only on the lives of tamariki, but also on the caregivers' doing their best to provide care.

The actions above present concrete steps that can be pilot tested, measured and scaled if proven successful. By focusing on speed, transparency and continuity of care, Oranga Tamariki can transform caregivers' experiences towards a consistently supportive journey for every caregiver and child.

The final quote is an example of hope, of what can be accomplished with the right supports in-place. The caregiver's quote underscores that supporting children in care requires services to be triaged and delivered in partnership with other children's agencies and care providers – not by Oranga Tamariki alone.

"Behaviour issues at previous school resulting in being stood down. When nephew came in our care, school would not enroll him due to behaviour issues at previous school. Instead, the school put us onto a corrective pathway to TAC where he got the help he needed. Through a support system of School, TAC, Oranga Tamaki Social Worker, VOYCE and us as his carers, we supported the child along the right path to get him reinstated back into Co-ed school education. Great outcome with lots of support. Outstanding work and real commitment by [the] child I must add. As well as outstanding dedication to all supporters involved."

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Appendices

Appendix 1. Caregiver satisfaction with information received

The following figures represent caregiver satisfaction with the quality of information shared by Oranga Tamariki from **Table 1**.

Question: How satisfied are you with the information provided from Oranga Tamariki about the following?

Figure 22. Your child's learning and developmental needs

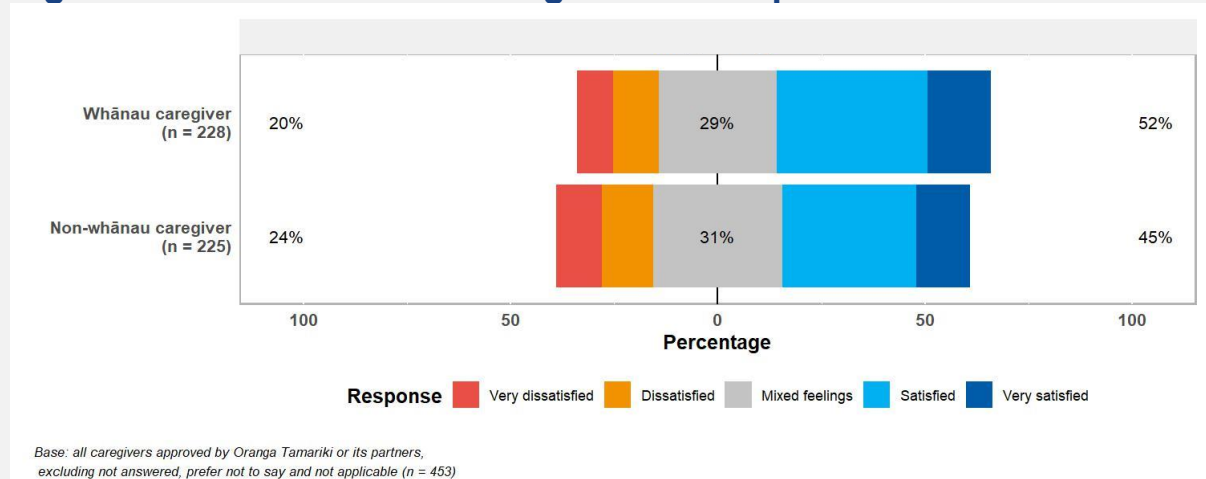


Figure 23. Your child's disability needs

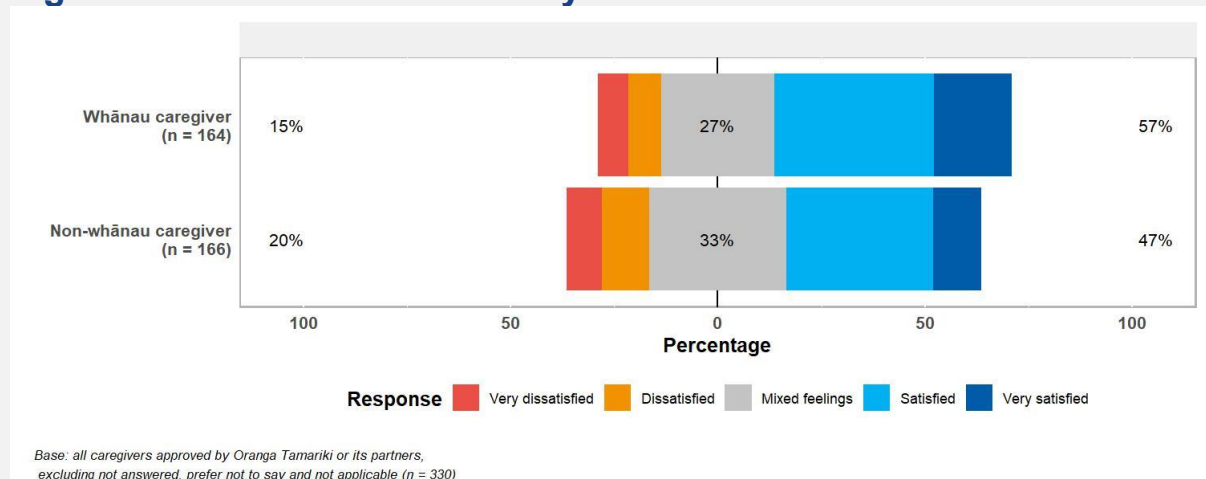


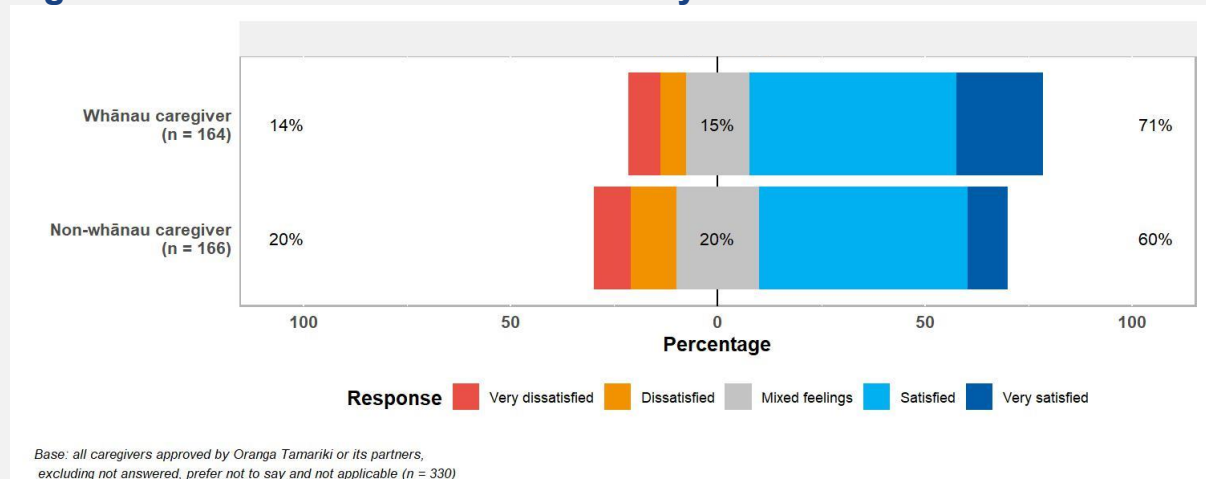
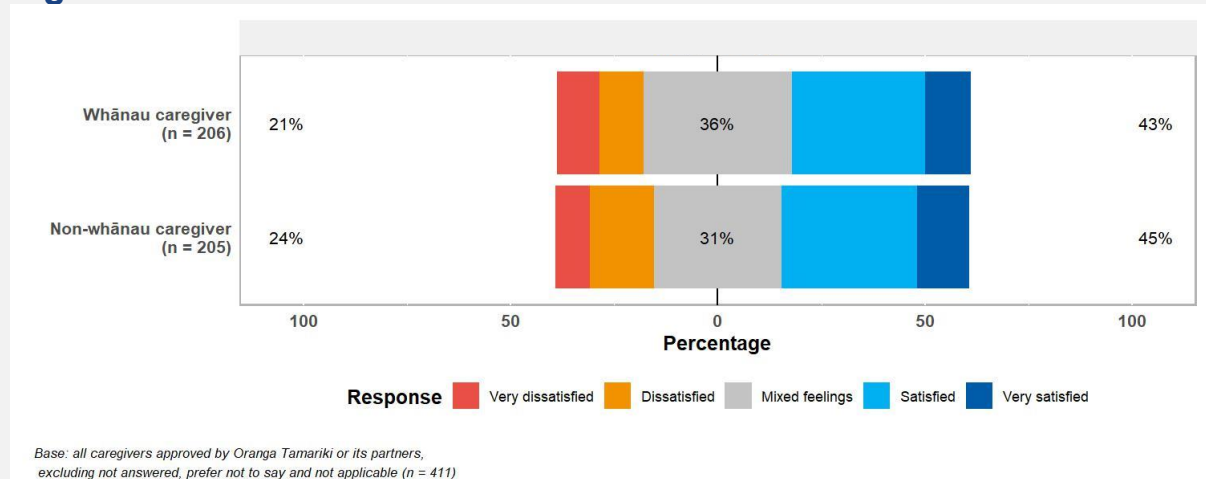
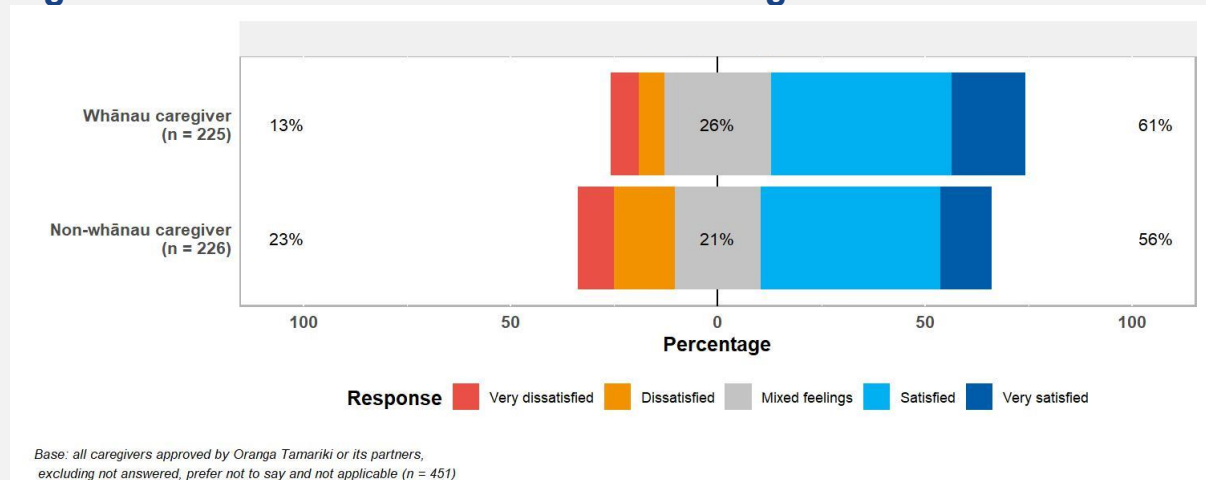
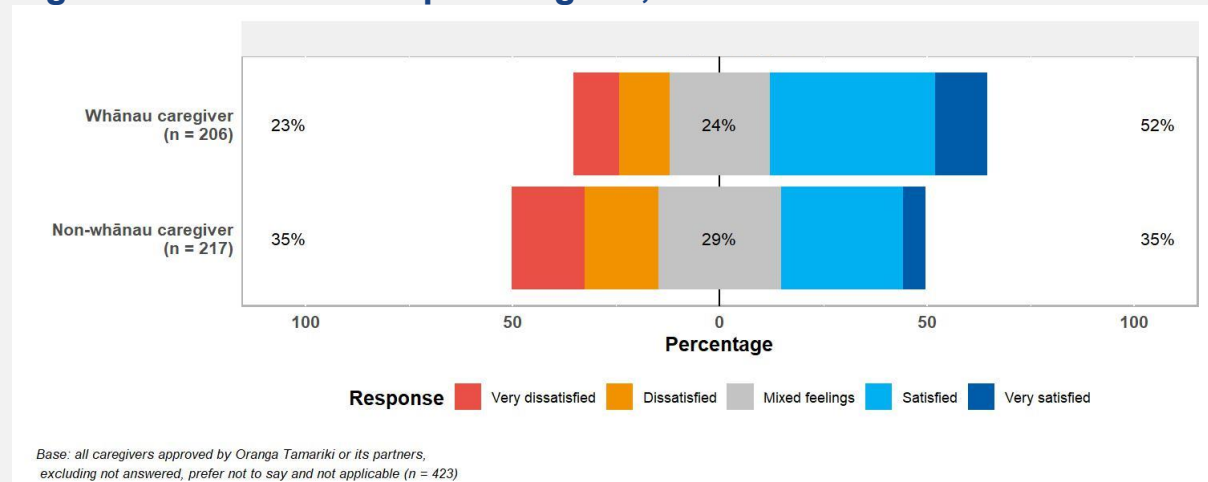
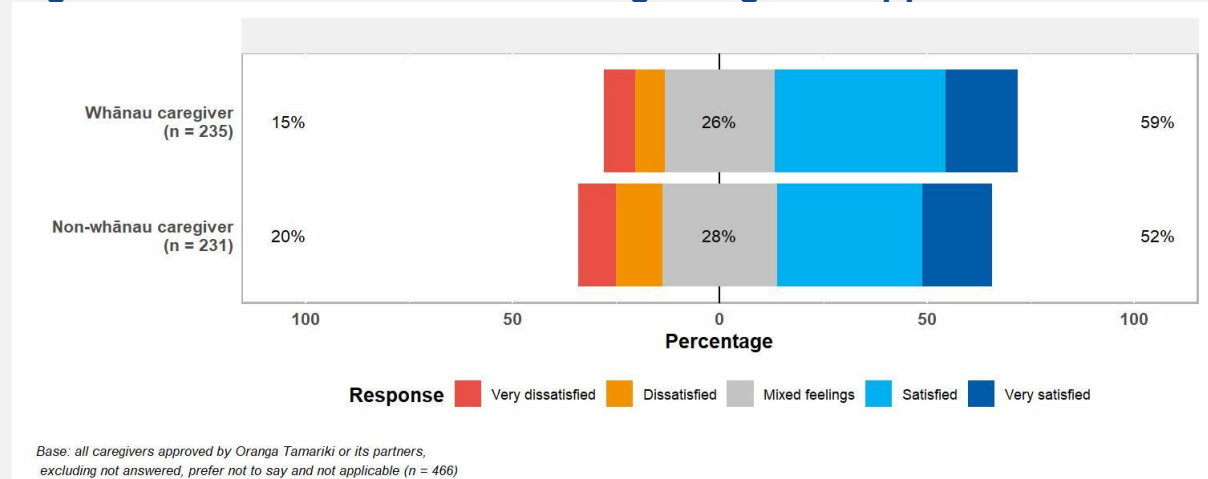
Figure 24. Your child's cultural identity**Figure 25. Your child's behavioural needs****Figure 26. Your child's health and wellbeing**

Figure 27. Your child's past neglect, abuse or trauma**Figure 28. Information on accessing caregiver support**

Appendix 2. Caregiver satisfaction with financial supports

The following figures represent caregiver satisfaction with selected aspects of financial support from Oranga Tamariki, refer to **Table 2**.

Question: Thinking about the allowances, reimbursements and extra payments from Oranga Tamariki, how satisfied are you with:

Figure 29. Time it takes to receive reimbursements and extra payments

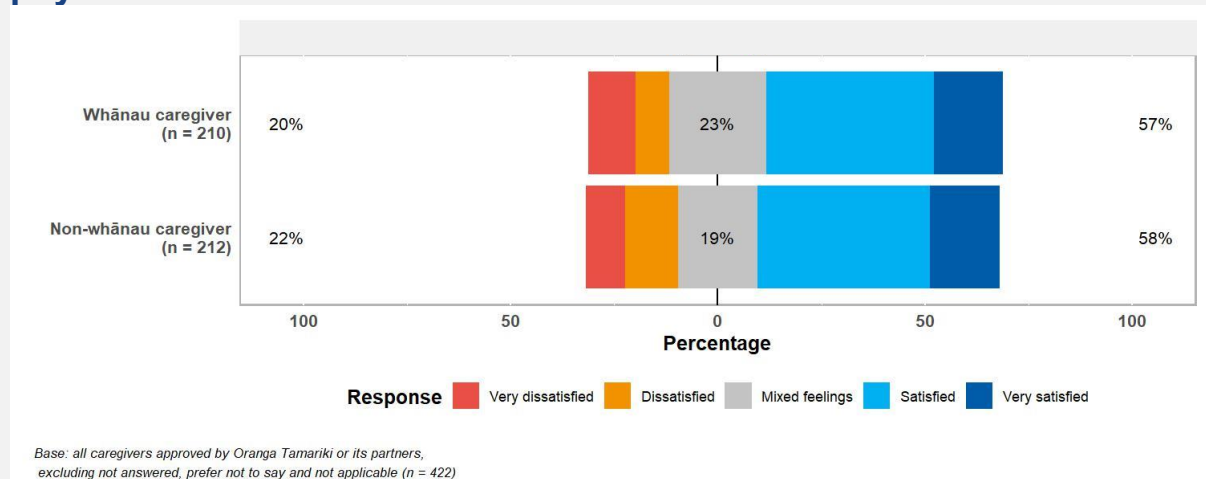


Figure 30. Ease of accessing reimbursements and extra payments

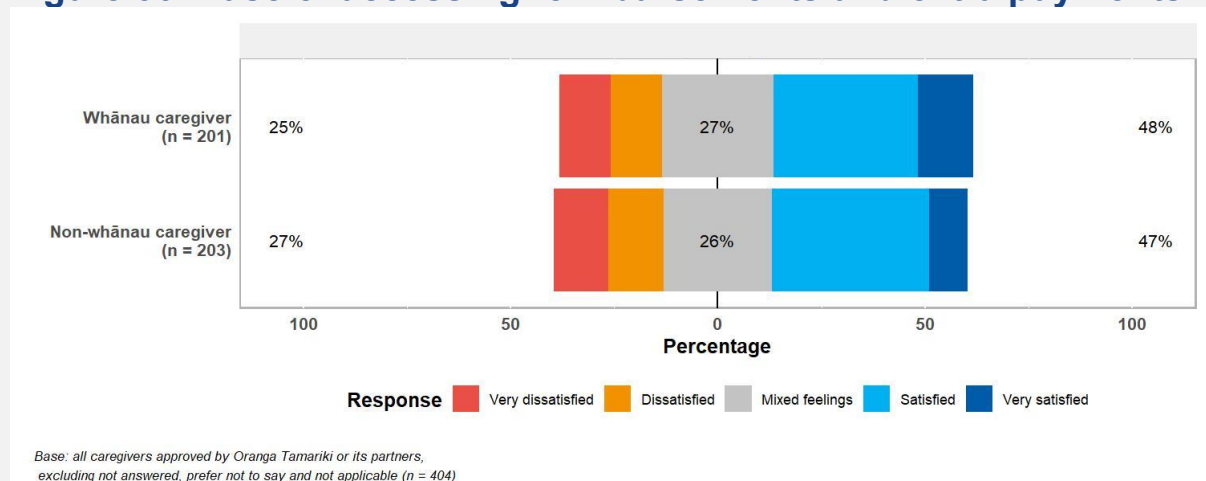
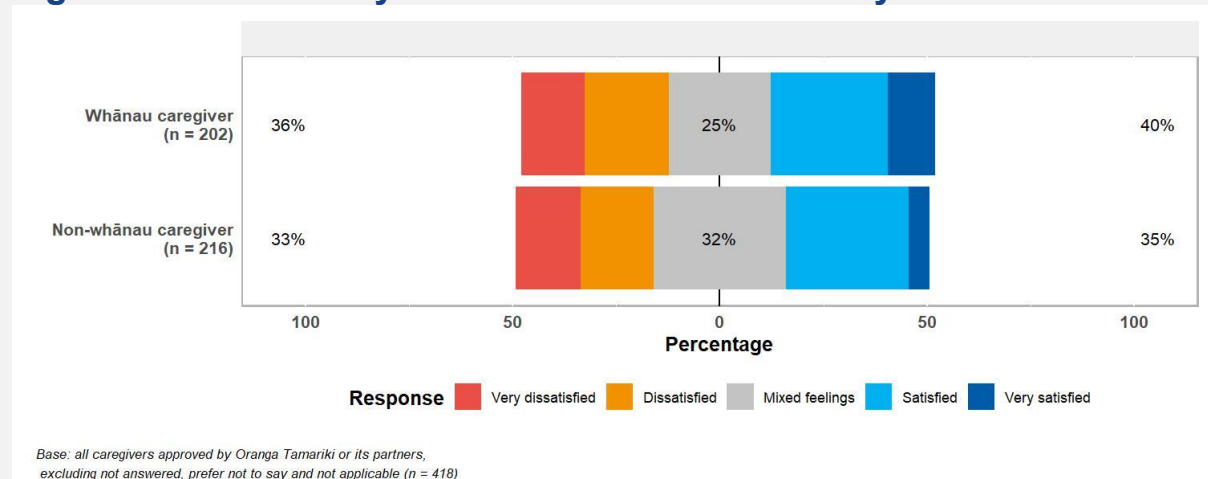


Figure 31. Availability of information on what they're entitled to

Appendix 3. Caregiver satisfaction with their social worker

The following figures represent caregiver satisfaction with critical areas of support from their caregiver social worker, refer to **Table 3**.

Question: How would you rate your satisfaction with your caregiver social worker on the following:

Figure 32. Communicating with me

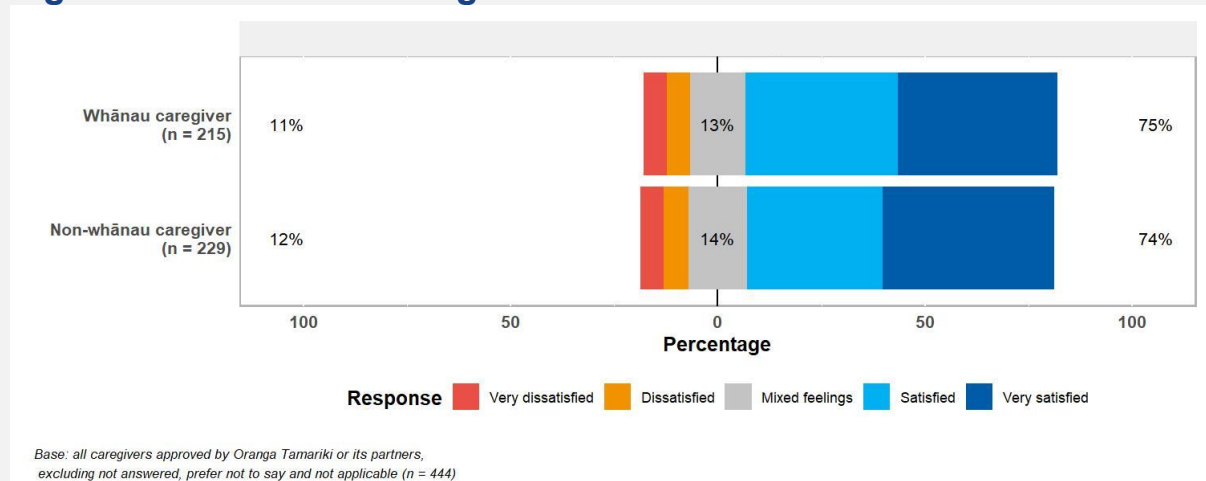


Figure 33. Respecting and listening to my knowledge of the child

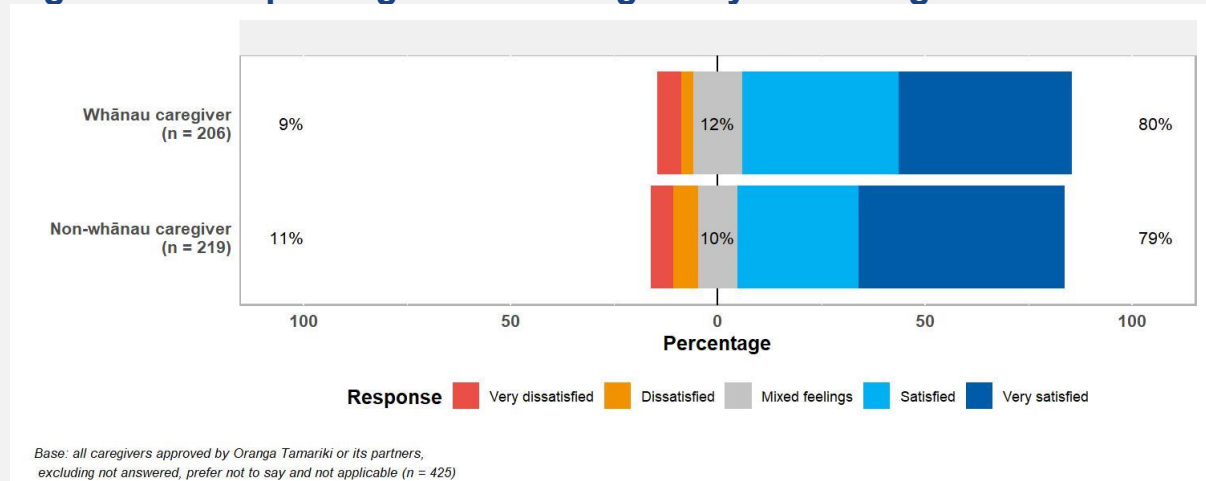
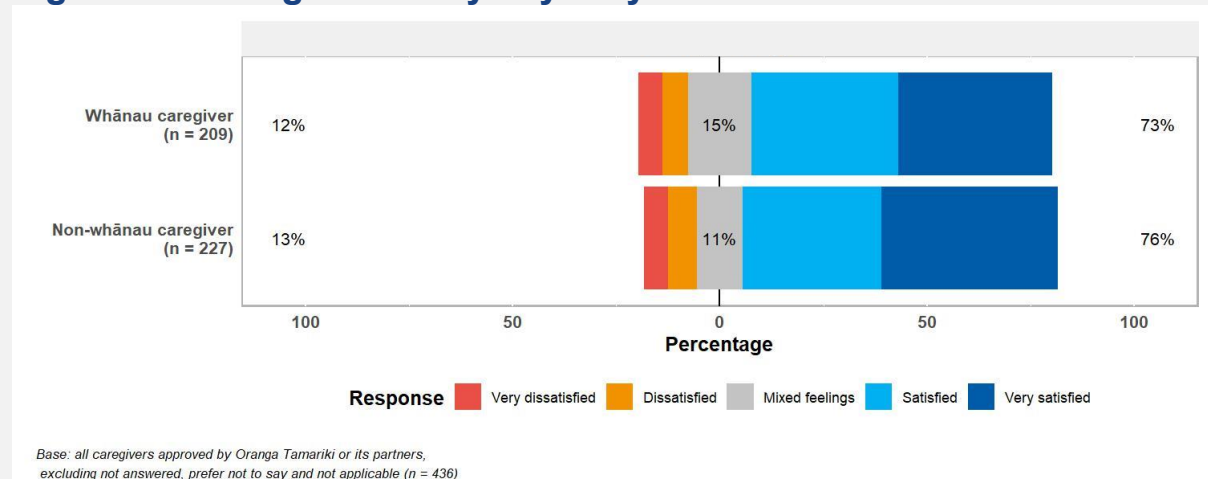


Figure 34. Doing what they say they will do**Figure 35. Involving me in decision-making**