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The Ngātahi Project
competency development for the vulnerable children's workforce

Abstract

Ngātahi is a three-year project aiming to identify and embed the additional competencies needed for the children's workforce to work with families experiencing intimate partner violence, child abuse and neglect, mental illness, addictions, poverty and poor supports. Māori tamariki (children) and whānau are over-represented in this client group. Collective impact, appreciative inquiry and a robust tikanga inform the project. A formal Treaty of Waitangi partnership with the local iwi, Ngāti Kahungunu, provides cultural leadership at all levels of the project. Twenty-seven agencies or services representing 441 practitioners have engaged in the project in Hawke's Bay. The three priorities for competency development identified are: engaging effectively with Māori (EEWM), mental health and addictions (MHA) and trauma-informed practice (TIP). Within the TIP work stream, addressing practitioners' burnout, fatigue and vicarious trauma is the first priority. The three work streams are currently developing curricula and identifying leaders to deliver training locally, and delivering activities to embed the new competencies into practice and metrics to demonstrate the impact of the new competencies on practice and on outcomes. Qualitative interviews demonstrate high commitment from the workforce and its leaders, consistent priorities for development of additional competencies and important lessons learnt. We suggest that this model may be helpful for policymakers considering other collaborative activities to address 'wicked' or complex problems, and offer some lessons learnt to date.

Keywords innovation, collaboration, intersectoral, children, Māori, workforce

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Introduction

As the intention of this article is to describe the practical actions undertaken in this project and the policy lessons stemming from them, its treatment of the relevant academic literature is necessarily brief.

In 2015 an expert panel reviewed New Zealand's then statutory child protection service, Child, Youth and Family (Modernising Child, Youth and Family Panel, 2016). There were a number of reasons that the care and protection system failed vulnerable children and their families, and recommendations were made to address these issues.

Children of parents with mental illness, with addictions and in violent

relationships ('vulnerable children') are at high risk of poor health, education and social outcomes. Māori are highly over-represented among these families/whānau. The government accepted all of the panel's recommendations.

A new programme was created to reform the way these families are supported (Ministry of Social Development, 2017). It included:

- changes to legislation and accountabilities of ministry chief executives;
- dissolution of Child, Youth and Family and creation of the Ministry for Vulnerable Children Oranga Tamariki (later renamed the Ministry for Children Oranga Tamariki);
- implementation of ten multi-agency children's teams throughout New Zealand;
- additional funding; and

- changes to expectations and monitoring of all agencies with a part to play in supporting such families.

In addition to these structural changes, the expert panel acknowledged

the need for a shift from rules, compliance and timeframe-driven practice to professional judgement based on an evidence-based understanding of the impact of trauma on children and young people, the science of child development and attachment, and best practice approaches. (Ministry of Social Development, 2017, p.65)

The project … assumes that developing the skills of a diverse workforce, with different cultures, languages, registration and continuing professional development requirements, is not a simple, 'technical' problem, but an adaptive problem …

There are now many reports (Office of the Children's Commissioner, 2000, 2003; Laming, 2003; Smith, 2011) that recommend a focus on additional knowledge and skills ('competencies') for practitioners working with vulnerable families. These competencies include the ability to identify vulnerable whānau and families, assess both strengths and risks, formulate an assessment, design and implement a plan with families, and work collaboratively with the agencies involved. The Ministry of Social Development's Children's Action Plan Directorate therefore began a programme of work to develop a vulnerable children's core competency framework, in partnership with sector leaders from education, health and social services. Hawke's Bay is piloting the Ngātahi project, using the draft framework.

Methods

Funding was obtained in 2016 from the Hawke's Bay District Health Board, Ministry of Social Development and Lloyd Morrison Foundation to progress the project. Royston Health Trust provided additional funding in 2018. Funding allowed a senior psychologist at the Hawke's Bay District Health Board's Child, Adolescent and Family Service (CAFS) to be appointed as project manager in March 2017 (Bernice Gabriel), initially at 0.8 FTE (full-time equivalent) in year one, reducing to 0.5 FTE in years two and three, an administrator to be appointed 0.5 FTE in years two and three, and senior clinician-teachers to be brought in for specific modules, and supports the evaluation, catering and stationery. Costs of most venue hire, projector and computer use, staff and most tutor attendance at training, additional administration and the project sponsor's (Russell Wills) time are supported in kind.

Tikanga

The Hawke's Bay District Health Board has a formal Treaty of Waitangi relationship with the mana whenua in Hawke's Bay, Ngāti Kahungunu Iwi Incorporated, through its Māori Relationship Board. The DHB's Māori Health Unit provides cultural advice to its services and programmes. The Ngātahi project sponsor involved the Māori Health Unit from the outset of the programme. Tikanga for the programme was developed in partnership with the Māori Relationship Board and kaupapa Māori providers through two hui. Programme reporting includes twice-yearly reports to the Māori Relationship Board.

Collective impact, appreciative inquiry and adaptive leadership

Collective impact (Kania and Kramer, 2011) is a framework for addressing complex social problems in a collaborative way. The agencies and services agreed that our common agenda was to identify and improve the competencies our workforce believed they needed to identify and address the complex social issues they faced every day in practice. We agreed on mutually reinforcing activities to achieve this, measures to demonstrate whether we

were indeed improving the competencies and outcomes for families, that the Hawke's Bay District Health Board would be the backbone organisation for the project, and strategies to communicate our decisions and actions to all interested stakeholders.

Appreciative inquiry (Cooperrider and Whitney, 2001), as applied to this project, assumes that the solutions to improving the quality of service we deliver to our families lie within our workforce already: our practitioners understand the workload and the competencies they need, including those they do not yet have. We have local people who are excellent practitioners and leaders, and good relationships with national expert practitioners on whom we can call if necessary. We simply needed to provide a system to support them to identify and address those development needs.

The project also assumes that developing the skills of a diverse workforce, with different cultures, languages, registration and continuing professional development requirements, is not a simple, 'technical' problem, but an adaptive problem (Heifetz, 1994). The solutions were not self-evident at the beginning. Leaders and experts did not have all the answers. Instead, we would have to mobilise the workforce through agreed goals and values, ask questions rather than propose answers, challenge old beliefs, experiment, and learn as we went along.

Hawke's Bay District Health Board Child, Adolescent and Family Service (CAFS)
The Hawke's Bay District Health Board's CAFS is a multidisciplinary team of 30 staff working with children and young people with moderate to severe mental illness and their families. Many of these children and young people have experience of abuse, neglect and parental violence, and developmental issues such as foetal alcohol spectrum disorder. CAFS staff work with the most complex of these children and families and accept referrals from all the other 26 agencies or services involved in the Ngātahi project.

CAFS staff completed their competency assessment against the Ngātahi framework and the *Real Skills Plus CAMHS* (child and adolescent mental health services) competency framework (Werry Workforce Whāraurau, 2014) early in 2017, ahead of the rest of the workforce. Priorities for staff development were identified and experienced clinician-trainers recruited to deliver training for CAFS. Trainers were asked to give particular thought to integrating clinical and cultural competence, prioritise examples of practice with Māori tamariki and whānau, and advise on subsequent activities to support CAFS staff to integrate the new competencies into everyday practice. Māori Health Unit staff assisted with briefing the trainers. CAFS Māori staff attended the training. Peer review groups, including those Māori staff, now meet regularly to review cases and are the primary mechanism to integrate the new competencies into everyday practice. In addition, external supervision by experienced clinician-trainers is currently provided to further embed the training into practice.

Five training sessions have been completed to date: assessment and formulation; attachment and trauma; emotional regulation/dialectical behaviour therapy;[1] acceptance and commitment therapy;[2] and family therapy supervision.
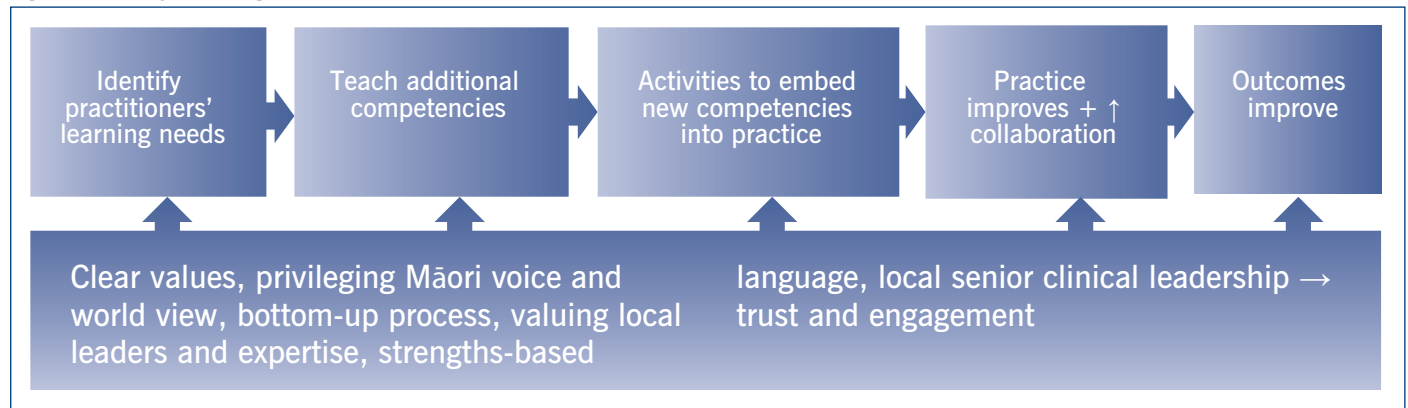
Wider workforce
In May 2017 a one-day hui involving of 72 leaders from health, education and social services, including kaupapa Māori, mainstream, government and non-governmental organisation (NGO) services, was held by the Hawke's Bay District Health Board. The hui agreed on the competencies and tiers of competency that each sector required of its staff. Some competencies were added to the original vulnerable children's workforce competency framework and some were moved between tiers. The revised competency framework included 289 competencies in three tiers: foundation, practitioner and leader of practice. The original six domains and 12 sub-domains from the framework were retained. The full framework is available on request if required.[3] A Survey Monkey tool was created from the framework for practitioners to identify the competencies they did not need (N/A), already had (Y), needed and partially had (P) or needed and did not yet have (N). Staff completed the tool online or on paper between 1 July and 30 September 2017; paper copies were entered into the Survey

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Monkey tool by a data administrator. Results were copied into the IBM Statistical Package for the Social Sciences (IBM, n.d.) and analysed, with a focus on the number of staff in each service and across all services recording P and N responses (see Table 1). Most practitioners also entered demographic data, including discipline and years since graduation.

Ethical approval
Ethical approval was granted by the Eastern Institute of Technology Hawke's Bay Research Ethics and Approvals Committee. Locality assessment approval was provided by the Hawke's Bay District Health Board. This project was carried out under the aegis of the Eastern Institute of Technology's research protocol for working with Māori. In addition, cultural and resource support was provided by institute's Māori and indigenous research professor, David Tipene-Leach, and Dr Anne Hiha, a senior Māori educationalist and member of the

Figure 1: Theory of Change

Identify practitioners' learning needs → Teach additional competencies → Activities to embed new competencies into practice → Practice improves + ↑ collaboration → Outcomes improve

Clear values, privileging Māori voice and world view, bottom-up process, valuing local leaders and expertise, strengths-based ... language, local senior clinical leadership → trust and engagement

evaluation team. This included guidance regarding safe and respectful practice with Māori participants. Cultural practices such as karakia, mihi, the sharing of food and the offering of koha were used as appropriate to researchers and participants.

Qualitative research

Eastern Institute of Technology was contracted to independently interview project staff, leaders and practitioners in year one of the project (2017) to understand the process to date, assess manager and staff engagement, what had worked well and what could be improved in this first phase of the project, and identify any additional themes that would inform the next steps (for details see Morris Matthews, Hiha and Bevin, 2017). The project manager and project sponsor have also kept logs of lessons learnt, which are reported below.

Theory of Change

Our theory of change is essentially as shown in figure 1 above.

Results

Qualitative research

Key themes from staff interviews have included:

- *High levels of engagement of managers and staff*
  Both groups agreed that the competency framework worked well to identify the competencies staff needed. While the 289 competencies initially looked onerous to assess, most staff took only an hour to do so and most found the process helpful.
- *Value of clinical leadership*
  There was high agreement that the project manager, due to her clinical

credibility and general approach, made the process accessible and understandable and generated high trust in the process, and that these factors were likely to generate more accurate and reliable responses that would in turn lead to training that would be of value.

- *High levels of practitioner stress*
  High levels of burnout, fatigue and vicarious trauma were noted in many interviews. Self-care competencies were identified as a high need by many staff, which was a gap in the competency framework.

Lessons learnt

Bicultural approach

- Tamariki Māori are 70% of the target population for this project so it was agreed that tikanga Māori and Māori voices would be privileged, particularly those of mana whenua. Initial face-to-face meetings with Māori leaders to agree on tikanga and values provided wise advice and guided the development of the project.

Engagement, values and language

- Initial face-to-face engagement with managers and practitioners is crucial and needs to be led by people who enjoy a high degree of trust and credibility in the region.
- Presenting to all staff in a service before mapping the competencies was crucial to get consistent messaging out and to stress values and philosophies.
- Neutral, non-judgemental language was more successful in engaging staff: e.g., 'mapping/needs analysis' of competencies rather than 'performance appraisal'; 'additional' needs, rather than 'deficits'.

- The importance of trust and confidentiality with practitioners was stressed.
- There was honest and open acknowledgment of NGOs' difficulty with sharing resources and intellectual property in an environment of competing for funds from the same funding pool.

Reliability of competency mapping

- Competency mapping was more reliable when done with a senior staff member who is trusted and knows staff well.
- For the leaders of practice tier, it would have been helpful to remind practitioners (in person and in Survey Monkey) to answer N/A if not applicable to their role.
- Self-assessment on mapping is not enough. Most people tend to underestimate their competencies and a very few overestimate them.

Pioneering

- Many of the lessons above were learnt from early adopter services and agencies, which changed our subsequent messaging and prevented lessons from having to be repeated.
- Dedicated administration and event co-ordination is crucial.

CAFS training

Five training sessions were attended by 140 CAFS and NGO staff working in child and adolescent mental health. Key lessons from focus groups following these training sessions included:

- Insights into the work of staff from other agencies, and the rapport and collegiality of joint training, were highly valued.

- Free, mandatory, high-quality supervision was highly valued and contributed to improved practice.
- Early indications of changed practice were reported, along with barriers to and enablers of changing practice.

Priorities for competency development

In the final analysis, 441 practitioners from 24 agencies or services mapped their competencies against all 289 competencies. A further three agencies have since engaged and agreed to map competencies for their staff. The number and proportion (out of 441) of practitioners identifying that they needed but did not have (N) or partially had (P) each competency was ranked. Only those competencies with more than 25% responding N or P were further analysed. Competencies scoring highly were then grouped into themes that are naturally practised and taught together (Table 1).

The competency with the greatest number of practitioners identifying themselves as N or P was: 'Has an awareness of the legislation relating to addiction issues' (258; 59%). Addiction and mental health competencies were the highest-ranked by the sector overall.

Next steps

Work stream development

On 6 November 2017, sector leaders met again to agree on the training and development priorities for the Ngātahi project in 2018 and 2019. Because staff release time is limited and there is a large workforce to put through the training, three areas were prioritised: engaging effectively with Māori (EEWM), mental health and addictions (MHA) and trauma-informed practice (TIP). Self-care was agreed as the first priority of the trauma-informed practice work stream.

Sector leaders joined or nominated staff to join one or more of the three work streams. Work stream members agreed on chairs, membership and terms of reference, and committed to attending and contributing to their work streams. They are empowered to recommend what will be taught, how and by whom, follow-up activities to embed the new competencies into practice, and how each competency should be assessed. We aim to use a mixture

Table 1: Highest-ranked competencies by theme (range, number responding N or P and %)

Competencies (theme)	Number	%
Mental health and addictions	113–258	26–59%
Working effectively with Māori	110–220	25–50%
Trauma-informed practice	112–196	26–45%
Professional practice, self-care, UN Convention on the Rights of the Child	109–178	25–41%
Child health and development, engaging effectively with children and young people	110–164	25–37%
Assessment, formulation, treatment planning	114–163	26–37%
Networking, liaison, legislation, policy, information sharing	110–148	25–34%
Child protection, family violence	115–142	26–32%
Engaging families, whānau and caregivers	111–127	25–29%

of local tuakana (expert teachers) wherever possible and external trainers where local expertise needs to be augmented, in a train-the-trainer approach to develop local capacity. EEWM work stream members are supporting the other two work streams by advising on the cultural competency aspects of the training.

Table 1 and the detailed analysis suggests that for each programme of learning, up to 250 practitioners may wish to attend training and enter a programme to embed the new competencies into practice. Our experience in teaching assessment of child protection and family violence is that this is best achieved in small groups of no more than 20, particularly when role play is involved, so we may expect registrations for up to 12–15 courses for each theme. The estimated number of registrants for the EEWM and MHA training programmes is 250 for each. The competency survey did not allow the estimation of the likely number of registrants for the self-care training, but the research interviews indicate that this will be high-demand training and we estimate approximately 300 registrants. This could mean in total approximately 800 registrations and 40 training programmes for groups of 20 people.

Pedagogy

At the time of writing (November 2018), all three work streams have agreed that the knowledge content for each work stream can best be met through online learning. We have partnered with Werry Workforce Whāraurau (https://www.goodfellowunit.org/werry), who are specialist online content developers for the

primary care workforce in New Zealand. For the mental health and addictions online learning, the workstream agreed that the their Foundations in Infant Child and Adolescent Mental Health online programme offered an excellent foundation-level introduction to the area. Werry's Childhood Trauma Workforce Development online programme offers a solid understanding of childhood trauma, and we have asked national experts in the field to write a further module specifically focused on self-care. Our EEWM work stream agreed that the Mauri Ora online programme (https://members.mauriora.co.nz/mauriora-courses/) offers excellent foundation-level knowledge for this area of practice. All offer free registration, flexible use, and a multiple choice test and certificate on achieving a standard. Local leaders told us that this accountability was highly desirable to them.

Practical skills will be developed through one-day wānanga (workshops). Leaders agreed that this was the best balance of adequate time to model and practice new skills and impact on service delivery. At the time of writing we have delivered two pilot mental health workshops. We are testing different numbers (12 and 18 so far) of participants and surveying attendees so we can continuously improve content and teaching. All wānanga are co-taught by tuakana in clinical practice and tikanga Māori to ensure both clinical and cultural competency, with a learner teacher (teina) in attendance to grow a sustainable tuakana workforce.

The new competencies will be embedded in wānanga ita (learning circles), using a peer coaching methodology. To

date, two wānanga have been held and four wānanga ita of six–nine members each established. By December 2019 we expect 27 wānanga to be completed covering all three workstreams, and 54 wānanga ita established for around 400 practitioners.

Managing the impact of turnover of leaders and staff

In the 14 months since we mapped competencies in our 441 staff and 24 agencies, turnover has been up to one third of agency leaders and one third of staff in some agencies. We also have three new agencies which have engaged. Informal discussions suggest that this rate of turnover is a little higher than usual, but it needs to be accounted for in planning for introducing new staff and managers

minutes for all work stream meetings, and communicate each work stream's decisions and actions to the other work streams and to the steering group. They also produce a regular newsletter sent to all practitioners, and communicate with funders and agency executives. A communications strategy to share the recommendations with service leaders, practitioners and our community is currently being worked through in partnership with our Māori Health Unit and kaupapa Māori providers. Feedback will be sought from all stakeholders and included in the curriculum.

Potential for scaling-up

Hawke's Bay is the first region to undertake workforce development across the vulnerable children's workforce at this

(Eppel, Matheson and Walton, 2011) note that complexity theory suggests that it will be impossible to predict the exact effect on families and children of the programme as there are too many confounding variables. Like them, we also found that our system is beginning to self-organise – e.g., into wānanga ita – and surprises have occurred – e.g., the high turnover of staff and leaders. Working across the socially constructed boundaries between the health, education and social service systems required a deep understanding of the cultures of each system – for example, finding language that engaged (and did not disengage) diverse practitioners. It was not possible to fully design the process at the beginning; design and implementation are continuous and iterative, as each informs the other.

Following Hughes and Smart (2012), we have focused on the outcomes of this process, rather than inputs or outputs. Measurement is based on evaluation rather than reporting; we have shared accountability for delivery; and we are focused on delivery over the medium term, rather than the short term. We aim to deliver practical, 'real', intermediate goals (a workforce with given competencies) rather than unachievable and unmeasurable goals (safer children and families). In the vulnerable children's workforce there is a culture based on common values, such as children's right to be safe, which has allowed us to make mistakes, learn and move on.

We would also agree with Ryan et al.'s (2008) analysis of the important roles in successful inter-sectoral collaboratives in New Zealand. We have found no shortage of 'public entrepreneurs', frontline leaders in small agencies used to working collaboratively and seeking new opportunities to do so. Similarly, we engaged 441 'fellow-travellers', like-minded people keen to join and support a project that fits their values. The project sponsor filled Ryan et al.'s 'guardian angel' role – finding dedicated funding, managing the authorising environment, mentoring, advising and advocating – freeing up the project manager and other leaders to lead and deliver the project.

Burnout, fatigue and vicarious trauma were common in this workforce and require a comprehensive plan to address

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into the programme, and for mapping the competencies of newly appointed staff. This is likely to be after around three months of practice, when staff should have a clearer sense of the competencies they have to effectively engage, assess and support vulnerable families and those they would like to develop further.

Evaluation of training and practice change

Eastern Institute of Technology has been appointed as the independent evaluator and 'critical friend' for the programme, with an emphasis on mātauranga Māori. All lessons learnt and outcomes will be assessed by the independent researchers, and disaggregated by ethnicity. We are particularly interested in indicators reflecting improved outcomes for tamariki Māori specifically.

Communications

The project's sponsor, project manager and administrator attend and take the

scale and in this way, so we have agreed to undertake the programme in partnership with the Ministry for Children Oranga Tamariki and share the lessons we learn with all relevant ministries and other regions. The original proposal has been discussed with and is supported by leaders in Oranga Tamariki, the Ministry for Social Development, Hawke's Bay District Health Board, the Ministry of Education and non-governmental social services in Hawke's Bay working with vulnerable children, who have a well-established history of collaborative working. We believe that this project could become a template for development of the vulnerable children's workforce nationally.

Discussion – policy implications

The Ngātahi programme demonstrates the potential impact of a collective impact, appreciative inquiry, adaptive leadership, tikanga-informed approach to addressing a 'wicked problem'. Eppel and colleagues

(Best Start Resource Centre, 2012). Burned-out workers cannot achieve the best results for very vulnerable families and children. The trauma-informed practice online learning and wānanga will address both personal factors (e.g., improving practitioner resilience) and factors in the work setting (e.g., adequate resources, effective leadership, open and honest communication).

Finally and importantly, Ngātahi offers a model of public sector partnership with iwi to improve outcomes for tamariki and whānau Māori. The project leaders engaged with the Hawke's Bay District Health Board Māori Health Unit from the outset. The Māori Health Unit enabled discussions with iwi leaders, kaumātua and kaupapa Māori providers. A specific tikanga was established for the project, which has informed all aspects of delivery. Iwi-mandated leaders are partners in all decision-making groups. Decision making has privileged Māori world views and voice. This in turn led to high engagement of both Māori and non-Māori practitioners across diverse disciplines and seems likely to lead to improved clinical and cultural practice.

We believe Ngātahi offers a new approach to inter-sectoral collaboration in Aotearoa New Zealand.

1   Designed as a treatment for people experiencing chronic suicidal thoughts as a symptom of borderline personality, dialectical behaviour therapy is used to treat people who experience a range of chronic or severe mental health issues, including self-harm, eating and food issues, addiction, post-traumatic stress and borderline personality.
2   Acceptance and commitment therapy is an evidence-based approach for young people experiencing anxiety, depression and/or addiction.
3   From Dr Russell Wills, Ng tahi project sponsor, Russell. wills@hbdhb.govt.nz.

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