8 September 2017

State Sector Productivity Enquiry
New Zealand Productivity Commission
P O Box 8036
The Terrace
WELLINGTON 6143

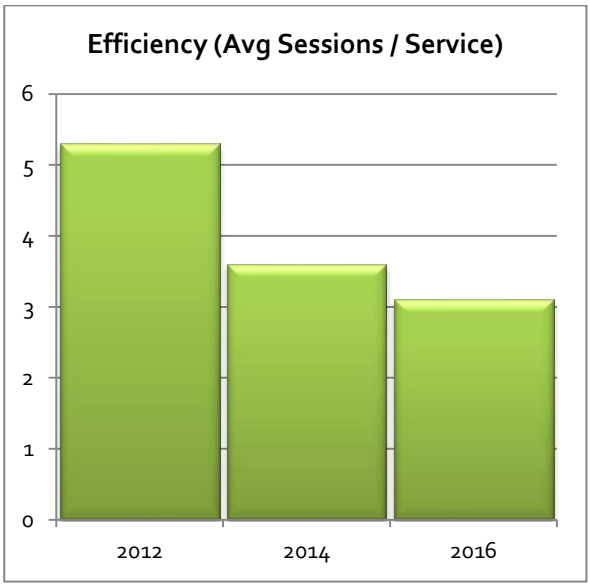
methodist themission
Te Haahi Weteriana o Aotearoa

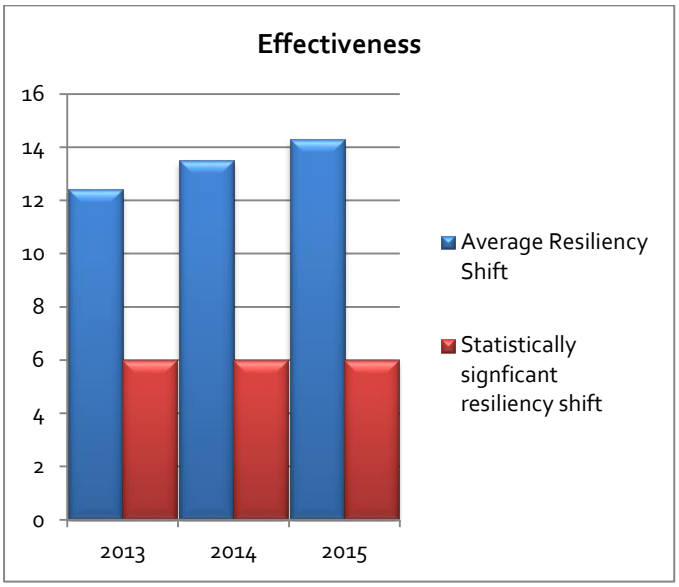
Postal PO Box 2391
South Dunedin 9044
Web www.mmsouth.org.nz
Main Office 03 466 4600
Little Citizens 03 466 3223
Next Step Training 03 487 7959
The Hub 03 466 3407

Introduction

The Methodist Mission's experience of moving to our in-house quality assurance system (QualityWorks), reliant on a logic model, linking to and providing specific, evidence-backed values for inputs, outputs, and outcomes, has been transformative.

The Mission has seen significant improvements in both efficiency and effectiveness. A sample from recent annual reports:





While the Mission's use of specific engagement tools (PCOMS for social work and foundation education, learning and development milestones for ECE) has been at the core of these improvements, an equally if not more significant ingredient has been our use of **real-time monitoring across KPIs** focussed on the appropriate use of the tools that the evidence shows will deliver the outcomes we seek (the "recipe").

These KPIs for our social workers and educators include:

- 95% application of the tools
- 95% number of sessions where client progress is reviewed with the client
- 95% number of clients for whom the reason for service remains the same throughout
- 95% number of clients for whom a written client plan is agreed by the 2nd session
- 95% number of clients plans that identify a threshold for service completion

Along with our contracted outcomes, we seek:

- 60% number of clients above clinical cut off by 3rd session
- 95% number of clients above clinical cut off by 6th session

In ECE our recipe includes:

- 100% of children measured within 2 weeks of age milestone
- 100% of children below 80% of milestone benchmark have an approved plan
- 100% of required plans are in place within 2 weeks of measurement being undertaken

QualityWorks updates 3 times a day and provides clients, our workforce, and managers with an appropriate-to-their-interest access to performance data in a dashboard format (easy to read gauges, graphs) rather than tables.

Our experience of the use of inputs and outputs by Government (including but not limited to contracts with the former Community Investment Service, Work & Income, the Tertiary Education Commission, and the Ministry of Education) has often left us confused about how services are to be delivered to maximum effect for both the client and the contract, although there has been some welcome changes more recently in some of those investors with the emergence of the Social Investment model.

Providers throughout the country will have stories to illustrate this gap; for the Mission these include:

- Being penalised if Youth Guarantee or Student Achievement Component funded Foundation Education students leave the course early because they have secured work;

- Extensions to contracts for highly specific add-ons (e.g. two one-hour budget advice sessions) that are not necessarily wanted or needed by the clients but which a mandatory number must undertake for the contract to be fulfilled;

- Parents seeking the Work & Income subsidy for Early Childhood Education (a priority group for ECE enrolment, known by multiple government departments to have lower literacy skills) having to complete a 28 page, 70+ question, form;

- TEC funded prison education making no allowance for Corrections' management of the muster (providers are individually contracted, but prisoners are frequently moved between sites);

- Presenting an innovative method for meeting outcomes and being advised to give it to a competitor who currently holds the contract that would cover that innovation if they had come up with it (twice in 2016 alone);

- Being asked to coordinate the applications of 20+ competitors for a fixed amount that we were also applying for (in 2015);

- Being awarded a six figure one year contract only to find the measures changing considerably on us (from outcomes to outputs) during the contract negotiation period (2014);

- Only once having access to an underlying logic model (Building Financial Capability, 2016, MSD);

- Being routinely told that in putting together our response to an RFP we cannot talk – at all – to government partners in our region with whom we would have to collaborate on the design of roll-out and the ongoing front-line implementation of service delivery.

- The Results Based Accountability regime adopted by the then Community Investment Service providing little if any rigour even within the individual reporting regimes adopted by providers, but absolutely no comparative or summative data across providers, and so which is unable to be used as an outcomes tool in the context of social investment.

Government investors have historically seemed to focus most closely on the process of **managing** their funding while relying upon a concerning misapprehension about how results are produced, i.e. that high level outcomes targets are best represented at the level of the client in *exactly the same form*.

As an illustration, the government has significant and proper interest in reducing recidivism. But it is neither wise nor productive to sit with a soon-to-be-released prisoner and discuss how they will not commit any more crime. Research *does* show, however, that engaging with the same offender in regards their employment opportunities is likely to significantly increase the average time between incarcerations (i.e. reduce recidivism)[1].

In its most unhelpful guise, this misapprehension also presents the demand that **each client behave as the average client**, a market model that works to exclude the outliers that predominate in social services as variability amongst clients is the norm rather than the exception. Clients who have experienced these types of services previously have, in the Mission's experience, a raised resistance to future services predicated on this very simple modelling that are sent their way.

The explanation for this may lie in another way that social services are not like a true market: dissatisfied social services customers aren't driven to abandon inefficient or poor quality providers (as they would be in a classic market). As a result government investors don't have the ability to compare and contrast alternative providers using comparable metrics, or to measure the effectiveness of products and services against tangible life benefits, and so are perhaps less aware of the prevalence of outliers than should be the case.

As social services are also atypical for a market with no metric to establish *value*, and *price* usually set to mandated by the monopolistic investor, it is simply not possible to say whether the their money is doing good or if clients are just putting up with services until they are discharged.

Why Measure?

After 120+ years of operating on the basis of good intentions and generating extremely modest results, for the Mission contemplating how to justify our ongoing operation, this was the easiest question to answer. In the simplest terms: to *know.* What works, what doesn't, and why. Who to reward, who to coach. What to scale, what to close. How to do better, within the overall objectives we had *finally* realised were essential for any momentum to be achieved.

> "Would you tell me, please, which way I ought to go from here?"
> "That depends a good deal on where you want to get to," said the Cat.
> "I don't much care where—" said Alice.
> "Then it doesn't matter which way you go," said the Cat.
> "—so long as I get SOMEWHERE," Alice added as an explanation.
> "Oh, you're sure to do that," said the Cat, "if you only walk long enough."[2]

The literature across disciplines into the positive productivity effects of measurement, and in particularly monitoring, is extensive, well known to the Commission, and needs not be referenced fully here.

However, from the Mission's perspective monitoring not only gave us an information flow on our activities as we were undertaking them but as per Larsen and Callahan in 1990 (again confirming the Hawthorne Effect[3]) we found that performance monitoring has an equal and independent effect on work behaviour by influencing the perceived importance of the monitored task.[4]

---

[1] https://www.researchgate.net/publication/26701424_Is_Employment_Associated_With_Reduced_Recidivism

[2] Chapter 6 of Lewis Carroll's Alice's Adventures in Wonderland

[3] https://en.wikipedia.org/wiki/Hawthorne_effect

[4] http://psycnet.apa.org/psycinfo/1991-08591-001

Of course all measurement faces the risk of producing meaningless data[5]. For the Mission these included:

- Poor design: lacking rigour the results are equally uninformative or worse, produce perverse incentives, such as when CYFS decided in the 1990s that their primary success measure would be the number of family group conferences held, leading to some families enduring more than a dozen such interventions (without result) or the current promotion of Results Based Accountability by MSD from which (by design) no comparative inter-agency data can be produced. For the Mission with little experience or formal capability this meant a period of trial and error.

- The (easier to manage) focus on the individual to the exclusion of a group dynamic or other externalities, such as the link between leaded fuels and the youth crime rate in the USA[6], and biases in the data: as when all new heart medicines were tested on men, assuming incorrectly that the results will apply equally to women[7], and the more recent under recognition of gender specific traits in those with autism[8]. For the Mission this meant finding tools that had already been reliably tested on diverse populations.

- A general lack of mastery in the area being studied and / or basic statistical skills. In New Zealand, both the social services provider and investor arms are notably lacking in statistical, analytic, and quantitative research skill sets, and rarer still are those who have the additional ability to translate their insights into actionable choices. The Mission chose latterly, and continues to choose, to hire additional capability.

But we were reassured by knowing that measurement, analysis, and interpretation of complex human behaviour are possible and are routinely achieved, not least by initiatives such as the Dunedin Multidisciplinary Health and Development Study.

Ten years ago it was not valid to claim that measurement in social services is too difficult or that there are no tools, and it most certainly is not reasonable to do so now.

The Current Common Information Standard

Most reports received by Government Investors on the performance of funded social services initiatives rely upon worker self-report.

For instance, current social work practice emphasises the value and importance of assessment, reflection, of checking and rechecking progress. What it does not do is use anything much beyond practitioner intuition to do these things.

This is seen by the profession as a positive. Luoma in the Journal of Australian Social Work (2010)[9] is representative: *this article discusses an evolving context for intuition found in the literature on the spiritual dimension in social work practice, transpersonal theory, and practice wisdom. It also reports the results of an exploratory investigation of social work students' attitude toward intuition. They were highly positive about the existence of intuition and the importance of studying the intuitive capacity of the human being in order to enhance social work practice.*

The 45 core competencies specified by the New Zealand Social Workers Registration Board[10] do not reference measurement at all, and speak only once to the use of research and never to the use of evidence.

---

[5] http://www.hefce.ac.uk/pubs/rereports/Year/2015/metrictide/

[6] http://www.bbc.com/news/magazine-27067615

[7] https://psmag.com/is-medicine-s-gender-bias-killing-young-women-4cab6946ab5c

[8] https://www.stuff.co.nz/life-style/well-good/motivate-me/94963769/the-women-who-dont-know-theyre-autistic

[9] http://www.tandfonline.com/doi/abs/10.1080/15426432.1998.9960225

[10] http://www.swrb.govt.nz/competence-assessment/core-competence-standards

Yet while there is strong reliance in the social service sector upon worker intuition, research shows that intuition is best only in certain situations, where there is no clear science or logical decision-making process to arrive at the "right" answer. (For instance, when choosing which ice cream is "best.")[11]

Otherwise, reliance on intuition even by trained professionals undertaking routine tasks can be dangerous: research across 7,688 patients published in 2009[12] shows that when surgical teams heeded a simple checklist patient-mortality rates were cut nearly in half and complications fell by more than a third.

Anker, Duncan, and Sparks (2009) showed that even good practitioners struggle to identify when clients are going downhill.[13]

Dew and Riemer (2003) asked 143 counsellors to grade their job performance on a scale from A to F; 66% rated themselves as A or better. None saw himself or herself as below average.[14]

Below average practitioners never rate themselves accurately, and even good practitioners overrate themselves (Walfish, McAlister, O'Donnell, and Lambert 2012)[15]. Wampold and Brown (2005) report that it *[is] not surprising to find that therapists are not particularly adept at identifying treatment success and failure[16].*

As a result, the design of interventions is similarly weak. Gluckman (2010) writes that *Too many programmes appear to have been started on the basis of advocacy rather than evidence or have characteristics which cannot scale. As a result opportunities are being lost and funds are being wasted on programmes that will not achieve their objectives.[17]*

However, client self-assessment of their own capability or competence has been repeatedly found to be highly valid across a range of disciplines[18] [19].

Duncan and Reese (2015)[20] report on multiple double-blind randomised clinical trials research into the use of client self-assessment on both the client estimate of progress and the client estimate of value (of service) using the PCOMS measure (see below) and conclude that both are utterly reliable.

Intuition and practitioner self-report are not only the weakest possible forms of measurement, when relied upon as the sole indicators of performance, they will in all likelihood produce unreliable and even deceptive results.

When combined with the significant restrictions on clients being able to "vote with their feet" as classic consumers would, it is no wonder that it is not possible to tell whether much if any difference is being made by social services.

---

[11] http://www.chronicle.com/article/The-Trouble-With-Intuition/65674

[12] http://www.nejm.org/doi/full/10.1056/NEJMsa0810119

[13] https://www.ncbi.nlm.nih.gov/pubmed/19634962

[14] Dew, S., & Riemer, M. (2003). Why inaccurate self-evaluation of performance justifies feedback interventions. In L. Bickman (Chair), Improving outcomes through feedback intervention. Symposium conducted at the 16th Annual Research Conference, A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, University of South Florida, The Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

[15] https://www.ncbi.nlm.nih.gov/pubmed/22662416

[16] http://www.safranlab.net/uploads/7/6/4/6/7646935/wampold_2005.pdf

[17] http://www.pmcsa.org.nz/wp-content/uploads/Improving-the-Transition-report.pdf

[18] http://www.cade.uic.edu/moho/resources/files/OSA%20research%20brief%20study%201-3.pdf

[19] https://www.tepou.co.nz/uploads/files/resource-assets/Preliminary-Report-to-the-Development-of-Self-Assessed-Measure-of-Consumer-Outcome.pdf

[20] http://www.sken.ca/wp-content/uploads/2015/07/DuncanReese2015.pdf

Monitoring, Evaluation, and Bridging the Gap

Evaluation of social services, while valuable, has an uneven worth when we understand the time frames associated with high quality social investment products. For example, there is a clear link between reduced adolescent morbidity and the development of executive functioning in the preschool years[21]. The time between the delivery of the executive function intervention and the achievement of a measurable impact is ten to fifteen years. Evaluation in this case, would mean waiting a generation to find out.

An intervention logic model[22] is a *testable theory of causation with linked if-then statements and action/reaction pairs; a chain of conditions to be achieved if the ultimate outcome is to arise, showing intermediate outcomes and immediate impacts that act as a basis for confirming performance.*

A good intervention logic model acts as a testable map of the anticipated journey to an outcome, and is validated in the immediate by strong, purposeful, monitoring.

By design, such monitoring would be to short and medium term indicators that are known to contribute strongly toward the final outcome. Such indicators are unlikely to be miniatures of that eventual outcome; in the case of adolescent morbidity, the signal indicator is the ability of a 4 year old to resist eating a treat for 10 minutes. The relationship between that achievement and choosing not to graffiti bus shelters at age 16, while very strong, is not immediately apparent to the casual observer.

However, the greatest risk in the adoption of measurements to improve state sector productivity likely lie in the example of Community Investment's Results Based Accountability regime, for two interlinked reasons:

- The silo walls between (and sometimes within) the various delivery and funding arms of the state are arbitrary, historically embedded, and often as not have significant political consideration in their construction.

- The clients' experiences of the issues they face are not similarly divided or encapsulated, nor are their issues necessarily fixed or static.

A measurement regime that does not recognise these risks and which instead allows for the creation of multiple tools, multiple methods of deployment, even within a single Vote allocation let alone across Votes, will fail. It will signal nothing and produce no useful information.

What Clients Want

There is only a little research available on client objectives for their experience of social services.

Duncan, Miller and Sparks (2004) [23] show that clients want change. And the Australian National Centre for Vocational Educational Research (Waterhouse 2008, quoting Osborn 2006)[24] also states: *people want to change*. The NCVER goes on to suggest (via a list of strength-based practice principles) that clients do not benefit from deficit-oriented process:

> *The solution is already there (although not always visible).*
> *The focus is the future and the present, rather than the past.*
> *The practitioner–client relationship is very important.*
> *The practitioner shifts the client's thinking and language from problems to solutions.*

---

[21] Gluckman http://www.pmcsa.org.nz/wp-content/uploads/Adolescence-transition-interim-report-release-1Jul101.pdf

[22] Karen Baehler, Victoria University of Wellington for the State Services Commission, 2001 fin.ssc.govt.nz/pathfinder/secure/InterventionLogicWorkshop.ppt

[23] Duncan, B.L., Miller, S.D., & Sparks, J. (2004). The heroic client: Principles of client-directed, outcome-informed therapy (Rev. ed.). San Francisco: Jossey-Bass

[24] https:// www.ncver.edu.au/__data/assets/file/0024/5586/nl05005.pdf

Insight and knowledge of the problem is not necessary; the focus is on solutions

Research into Rogerian Therapy principles has demonstrated that client led therapy is more effective than practitioner directed therapy.[25] [26] [27]

In 2010 Dan Pink speaking at the Royal Society, reported that the three factors that lead to better performance (at work) are: autonomy, mastery, and purpose[28]. Contra Maslow whose debunked hierarchy of needs[29] still underpins much of the sector's tacit logic, despite its strong inference that "self-actualisation" is a by-product of every other need being met, not as Pink evidences, **concurrent** with every other need.

In 1992 Michael Lambert[30] summarised psychotherapy outcome research and grouped the factors of successful therapy into four areas with an approximation of the factors' contribution to successful treatment:

- Extra-therapeutic (40%), those factors that are qualities of the client or qualities of his or her environment and that aid in recovery regardless of his or her participation in therapy;
- Common (30%) that are found in a variety of therapy approaches, such as empathy and the therapeutic relationship;
- Expectancy (15%), the portion of improvement that results from the client's expectation of help or belief in the rationale or effectiveness of therapy;
- Techniques (15%), those factors unique to specific therapies and tailored to treatment of specific problems.

With 55% of the change factors in client hands, and another 30% dependent on the client's experience (of their alliance with the practitioner), research showing client-led work is more effective than that led by the practitioner, and some evidence that clients do genuinely want change; the client's objective(s) should dominate the practice relationship.

A Standard Metric

Costing of any bulk purchase in a scarce market requires an estimation of value for money, which in established industries generally relies on a standard unit for pricing. Crucially these standard units also expresses a quality of product, in the case of gold this is that each ounce will be 24 carats, for milk it is the fat content, and for a credit on the NQF it is the time spend learning and the level of the learning completed. Examples of standardised metrics used in human services in New Zealand include:

Education	credit[31] (as the eventual basis of an equivalent full-time student[32])
Literacy	points (LNAAT)
Psychometrics	points (e.g. Stanford-Binet IQ, OR45, PCOMS / FIT)
Health	quality-adjusted life year

Standard measures support price or value discounting (as in the case of training in scarce labour supply

[25] Raskin, Nathaniel J., Rogers, Carl R., and Witty, Marjorie C. (2008). Client-Centered Therapy. In Raymond J. Corsini and Danny Wedding (Eds.), *Current Psychotherapies* (pp. 141–186). Belmont, CA: Thomson Higher Education.

[26] Rogers, Carl R. (1957). The Necessary and Sufficient Conditions of Therapeutic Personality Change. Journal of Consulting Psychology, 21. Retrieved from http://www.shoreline.edu/dchris/psych236/Documents/Rogers.pdf

[27] Rogers, Carl R. (1980). Way of Being. Boston: Houghton Mifflin.

[28] https://www.thersa.org/discover/videos/rsa-animate/2010/04/rsa-animate---drive

[29] http://www.bbc.com/news/magazine-23902918

[30] Lambert, Michael J *(1992). "Psychotherapy outcome research: implications for integrative and eclectic therapists". In* Norcross, John C*; Goldfried, Marvin R. Handbook of psychotherapy integration (1st ed.). New York:*

[31] Equal to 10 hours of learning for an ordinary student at a given level

[32] 120 credits per year or 1200 hours of learning

markets e.g. quantity surveyors) and allocation decisions (whether those credits are delivered at level 1 or level 7 on the framework and in what subject(s)). Standard measures allow for comparisons of producer performance (quality and volume), and support a direct relationship between price and value, that is inputs and outcomes.

It is instructive to look at the New Zealand National Qualifications Framework (NQF) when considering a standard metric for human services. In 1958 Bradford[33] described the teaching-learning transaction as: *a human transaction … Teachers and learners engage together in a complex process of exploration and diagnosis of needs for and resistances to learning and change; of experimentation and fact-finding; of testing and planning for utilization of learning and change in the life of the individual … the target of education is change and growth in the individual and his behaviour; and thus in his worlds.* In comparison, the University of Otago's Department of Sociology, Gender, and Social Work describes the purpose of social work as: *to promote well-being and develop potential by working with individuals, families and groups to create positive change in people's lives.*[34]

Both teaching and social work are a process of one person engaging with another to change how that second person thinks, with the practitioner adjusting their practice to feedback provided by the student / client.

New Zealand has a long established (25 years and counting) mechanism that provides a *definitive source for accurate information [] to benchmark [] skill and knowledge and [] compare qualifications*[35]*.* The New Zealand Qualifications Framework was one of the first of its kind in the world, launched in 1991 and with enhancements post 2009 in response to the 2008-09 review. The framework uses quality assured unit and achievement standards to ensure that:

- Clear outcomes are recognised
- Nationally consistent standards apply to the outcomes that are recognised

The NQF is divided into 10 levels, according to the complexity of learning required, and has 17 fields from Agriculture, Forestry and Fisheries to Social Sciences. Each of these fields has a number of sub-fields, which themselves have a number of domains. In each domain there are a number of assessment standards, each at a given level of complexity (1-10) and each measured with a number of credits (an estimate of the time needed to learn the content of the standard).

The awarding of NQF credits to students is nationally moderated to ensure valid and consistent assessment. As a measure of learning progress, students' completion of units on the Framework are visible to students, parents and caregivers of students, teachers, TEO and TEI managers, the New Zealand Qualifications Authority (the quality assurance manager), the Tertiary Education Commission (the investor), and the Minister of Education. Equally visible are whether the composition of units has led to the completion of a plumber's apprenticeship or a diploma in Nursing, whether a foundation level certificate or a degree, and to whom it has been delivered, bio-data and meshblocks and all.

The value and the pricing of units, or their bundled form – qualifications, is relatively easily established and iterated for market conditions. Providers are incentivised to innovate for effectiveness, while quality has robust external oversight. In doing so, the NQF has produced a quantitative description (numeric data) of a qualitative state (learning); allowing for rich analysis of everything from teacher performance through to future labour market shortages.

It must be possible to construct a similar system for social services that can provide a rigour and an analytical base for decision making that will ensure the most effective delivery.

---

33 http://journals.sagepub.com/doi/abs/10.1177/074171365800800303?journalCode=aeqa

34 http://www.otago.ac.nz/sgsw/study/socialwork/

35 http://www.nzqa.govt.nz/studying-in-new-zealand/understand-nz-quals/nzqf/

While Government is of necessity focused on ROI and reduction in costly poor life outcomes, long term, this change is unlikely to be achieved by the "fixing problems" approach so dominant in current practice (although of course emergency needs must be addressed) with its strong focus on the symptomology of individual and whānau dysfunction.

A focus on building and utilising the strengths present in the whānau system ("strengths-based practice") is a widely held tenet of the social services sector. However, with little monitoring to ensure it is implemented coherently and with rigour "strengths-based practice" risks being more platitude than a reality.

Notwithstanding this, the limited research undertaken into genuine strengths-based practice has been positive. Barwick in 2004 for the Ministry of Youth Development[36] reported that … *programmes were shown to have widespread and long-lasting beneficial effects when they were long enough to encourage full involvement, they challenged young people with specific goals, they provided quality feedback on participation and they created an environment for participants to reflect on, discuss and understand their experiences.*

The Mission's position is that services are more likely to reverse a negative trajectory when they seek to increase the capability and capacity of individuals and whānau to deal constructively with the causes of high morbidity, that is, by increasing their resiliency. The proposition is that it is not so much that bad things happen to whānau that government need take an interest in, but the degree to which whānau are able to pre-empt or overcome those bad things positively and independently, that should be the focus of government interest.

In the deficit model, services concentrate on reducing the probability of negative events occurring. This is the problem solving approach, which frequently leaves whānau with an overwhelming sense of their own failure (by its nature focussing on all of the symptomology indiscriminately) and never develops any kind of transferrable resiliency.

In the strengths-based model, services concentrate on improving capacity and building transferrable capability.

One of the greatest drags on many clients' resiliency comes from the constant drain on their willpower. As reported in the New Republic[37] in 2011:

In the 1990s, social psychologists developed a theory of "depletable" self-control. The idea was that an individual's capacity for exerting willpower was finite—that exerting willpower in one area makes us less able to exert it in other areas. [Since 1998] these results have been corroborated in more than 100 experiments. Exerting self-control on an initial task impaired self-control on subsequent tasks: Consumers became more susceptible to tempting products; chronic dieters overate; people were more likely to lie for monetary gain; and so on. Taking this model of willpower into the real world, psychologists and economists have been exploring one particular source of stress: the level at which the poor have to exert financial self-control, is far lower than the level at which the well-off have to do so. Purchasing decisions that the wealthy can base entirely on preference require rigorous tradeoff calculations for the poor.

In the strengths-based model, simplifying decision-making and the focus of change attention, while resolving as many practical deficits as possible, quickly, improves client capacity. But it is in addressing client *capability* that the greatest gains in resiliency can be had: capability is the sphere in which future stressors can be pre-emptively avoided.

[36] https://www.mentalhealth.org.nz/assets/ResourceFinder/Resources-young-males-strengths-based-and-male-focused-approaches.pdf

[37] https://newrepublic.com/article/89377/poverty-escape-psychology-self-control

Much self-defeating behaviour is hard-wired responses to times of short supply (Karelis[38] 2007; Nettle[39] 2011), and is fundamentally an unconscious shift from longer-term objectives to shorter-term strategies, including palliative acts (use of drugs and alcohol), shifts in the dietary value of food consumed, and use of loan sharks for short-term resource relief.

Whānau and/or social group cultures of poverty can then arise (Lareau[40] 2011) hallmarked by inter-generational adaptations e.g. critically for childhood development of executive functioning capabilities (the self-regulation that a successful adulthood generally relies upon), low-income households will typically shield their children from an adulthood they understand to be nasty, brutish, and short by indulging their impulses. And so the hard-wiring becomes confirmed and replicated.

To be meaningful, government investment in social services requires the monitoring and iteration of:

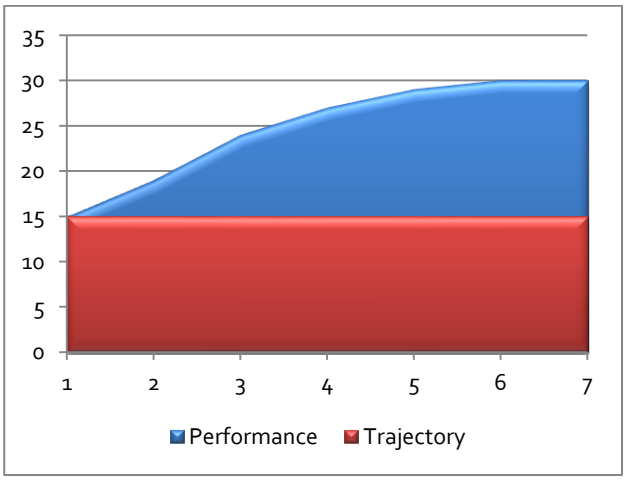
- Targeting (who and when)
- Intervention design (effectiveness)
- Intervention deployment (resource allocation)
- Delivery techniques (efficiency)

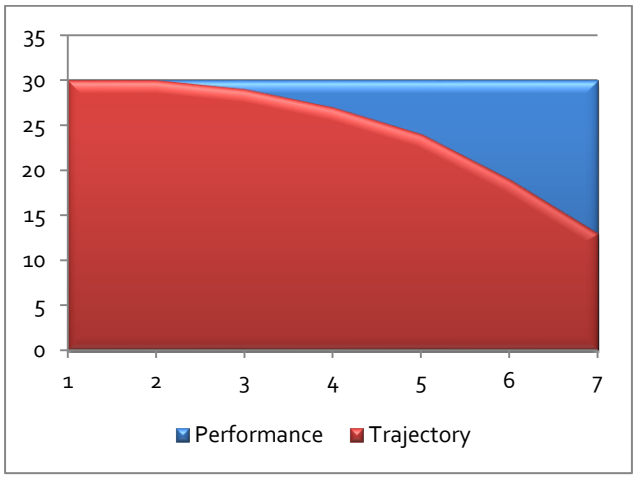
While a wide range of performance information will be required, only a common metric acting as a Rosetta Stone can support comparative evaluations. Such a metric must be:

- Common to all social investment delivery
- Able to be linked to any other performance measures
- Linked, visible to, and easily understood by all actors: the client, the practitioner, provider management, the investor(s), and any quality assurance agencies
- Focused on elements predictive of change
- Derived from client self-report
- Research-supported as to fidelity and validity
- Robustly constructed so as to be able to be reliably and easily administered by a frontline workforce

The proposal is for a "unit of change" or "unit of resilience" comparable to the unit of learning that underpins the NQF, to provide this functionality. Such a unit would measure the shift in client resilience over and above the otherwise expected trajectory.

In the graphs below the utility of the "units" is shown in blue, the expected trajectory in red.





[38] http://yalepress.yale.edu/book.asp?isbn=9780300120905

[39] http://www.staff.ncl.ac.uk/daniel.nettle/pt.pdf

[40] http://books.google.co.nz/books?id=JuQuoPKMPF4C&printsec=frontcover#v=onepage&q&f=false

The Mission's Story

In 2007 the Mission did not know if our work had any impact for those we worked with and had no tools to support staff performance. Amongst other services we were running:

- A community café in a nearly closed mall with no pedestrian flow at a loss of $100k p.a.;
- A food in schools scheme no-one seemed to want;
- A an aged-support service funded from reserves that another provider had a contract for (but was referring their clients to us);
- An Early Childhood Centre in what would now be an unlicensible building, with undetermined occupancy, and with a "child-led development" philosophy that had teachers standing around chatting to each other for large parts of the day;
- A social work services where the best guess is that on average our workers saw clients for 13-14 sessions before they quietly discharged themselves (but we had been seeing some clients for more than 5 years to no discernible benefit);
- And where they may have had as little as 5 client facing hours of work per week.

In 2008 we adopted the PCOMS[41] engagement tools across our Foundation Learning, Early Childhood, and Social Work divisions, and began to build what has become our quality assurance system, QualityWorks. PCOMS was attractive because it is easy to administer, has a very strong evidence base, and delivers high quality quantitative information on client and worker performance.

Managers thought that implementation would be simple, but that was not the case.

During our first roll out (2008-11) it took 3 years to get to good data.

In one six month period, 75% of our social workers left.

In hindsight, the resistance from our workforce was the result of two factors in combination:

- The first was our piecemeal implementation:
  - We had to introduce the workforce to client management software (their first), the system wasn't intuitive (few were at that time) and the workforce wasn't computer-friendly;
  - We had to introduce the workforce to client formulation and assessment process and client plans separately and part way through;
  - We didn't implement KPIs for the first year;
  - Electronic monitoring took another two years – we had to build the extraction and dashboarding package;
  - It took another 6 months to build the bit of the system that could spot garbage in / garbage out (of which there was quite a lot);
  - It was another couple of years before we built the recruitment and induction processes that ensure new staff were appropriately prepared.

  The constant changes and new processes were wearing for staff, who didn't know what to expect next and who kept being told that we had just found out they were doing it wrong, and for managers who couldn't believe that something as simple as two forms with four 10 cm lines on each required such an architecture to ensure compliance.

[41] www.pcoms.com

- The second factor was the gap between the expectations and work practices of our workforce and the new requirements:
    - Our workers were used to holistic practice based on philosophical models of power and enquiry, and most of all on relying upon their gut.
    - Our new tools were based on evidence which largely refuted the holistic practice, worker intuition, build a trusting relationship first, problem solving model so common in social services.

Put simply, our new way of working was implemented in a way almost guaranteed to be existentially threatening to our established workforce.

This is very much not the case for the workforce recruited since that time; it appears that they start their jobs normalising the Mission's expectations, and usually their PCOMS data quickly – within months – reaches the norms set by the Mission's KPIs.

Notably, when we implemented three years ago with our early childhood education team, it took 2 months and nobody quit. Similarly when we implemented our system with two other providers, while the early results showed relatively poor performance, productivity rapidly increased with little in the way of industrial issues.

The differences in our subsequent approaches can be described as follows:

- We launched when we had a complete system at a reasonable level of detail:
    - Front line tools and ways for them to be deployed across a variety of client situations,
    - Aspirational KPIs (again focussed on the recipe, not the outcome) to provide plenty of coaching moments,
    - A full CMS, and monitoring software, and the hardware to run it on,
    - Practice leadership;
    - A regular and intensive schedule of group and individual coaching sessions using data from the monitoring software to catch bugs, create new "scripts" (for conversations with clients).
- We informed staff that while we were interested in iterating the system, there would be no changes for 6 months, communicating our expectation that they would adapt to rather than attempt to edit the system;
- In explaining the rationale for the changes we focussed less on what was wrong (e.g. that child-led development in ECE has been largely debunked) but on the opportunities for our whānau that the new system would provide;
- While we expressed acceptance for the industry's expectation that every Early Childhood Teacher will have their own philosophy, we insisted that the Mission have an overarching philosophy which we supplied to staff and which we expected would dominate;
- We showed the evidence base for the changes and how the KPIs and the monitoring system would deliver to that evidence ;
- We implemented rapidly – staff were given only a couple of months to get up to speed, with the KPIs applying from day 1;
- We explained that participation was not optional and that the Mission was prepared for the unlikelihood of employment consequences;

- We used the scheduled coaching sessions to celebrate successes and give ownership to staff as they crafted delivery nuances.

The Mission Management Team and I would be happy to talk further with the Commission on any aspect of this submission, if that would be useful.

Yours sincerely

Laura Black
Director