

**CAREER PATHWAYS AND  
CORE COMPETENCIES IN  
MĀORI MENTAL HEALTH NURSING  
TRM/03/04**

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**TE RAU MATATINI**  
AOTEAROA MĀORI MENTAL HEALTH WORKFORCE DEVELOPMENT

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## **1. Introduction**

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Māori mental health workforce development is a high priority area for the mental health sector. It is also evident from various reports that Māori are under represented in the mental health workforce area, particularly in the specialist professional occupations<sup>1</sup>. The following report, undertaken by Moko Business Associates for Te Rau Matatini, reviews relevant literature pertaining to Clinical Career Pathways and associated core competencies for nursing in New Zealand. The review identifies and analyses existing Clinical Career Pathways (CCPs) for nurses and mental health workers in New Zealand, paying particular attention to the content, structure, strengths, criticisms and applicability to the development of a CCP for Māori registered nurses to work in Māori mental health (NGO organisations).

This report is part of Te Rau Matatini's current work on the development of a career pathway for Māori registered nurses with mental health work experience to work in NGO, community settings. It is a preliminary report, based on existing literature. A subsequent report will be released later detailing the career pathway developed by Te Rau Matatini, with strong guidance and input from Māori mental health nurses and the wider Māori mental health sector.

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## **2. Clinical Career Pathways For Nurses In New Zealand**

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From the extensive literature available it is difficult to determine a succinct definition of a clinical career pathway. For the purposes of this report Jones (1997, p. 2) provides the following constructive definition:

*A clinical career path programme provides a structure for career development for nurses involved in practice, and advancement in such a structure provides recognition and reward for increasing expertise in front-line work with patients/clients.*

Underpinning this definition are several factors:

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<sup>1</sup> Health Workforce Advisory Committee (2002). *The New Zealand health workforce: A stocktake of issues and capacity 2001*.

- the respective pathways will define different levels of practice, for example novice, competent, advanced and expert
- the levels of practice incorporate particular performance expectations
- the nurse's job description outlines the necessary core competencies required to perform to expectation, and
- the appraisal process through which performance is reviewed and improved or rewarded.

Essentially, the structure of clinical career pathways is derived from setting criteria to distinguish higher levels of performance from expected competence. The criteria that make up the structure focus on programme content, competency, clinical skills, knowledge base, team roles within the unit, and extra organisational/professional responsibilities<sup>2</sup>.

From a management perspective, structure is intrinsically linked to an organisation. A clinical career pathway cannot exist in isolation of the organisation in which it operates. Herein is an inherent difficulty with CCP structures in New Zealand as the Nursing Council determines the CCP structure for nurses. It is regulated, prescriptive and reliant on adherence to a national set of criteria.

Implementation of an external imposed prescribed structure within an organisation does little for employer commitment to provide a supportive environment that encourages nurses to meet the defined criteria for advancement. In their research Fuller and John (1994, cited in Prebble, 2002, p. 6) found one reason for employer non-compliance was that "company specific norms tend to take precedence". Furthermore, where employer motivations are not trusted there is also likely to be resistance and distrust in the implementation of such a structure.

Jones (1997) asserts the need for the following inclusions into the general structure of a CCP:

- adequate job descriptions that have been negotiated between both parties, the organisation and the nurse

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<sup>2</sup> Jones (1997).

- professional development for the nurse
- performance management
- competency assessment
- remuneration, retraining, disciplinary action, and
- advancement procedures.

Jones (ibid) reinforces the importance of having robust systems in place to properly embed a new nurse workforce structure. Jones also maintains that the established system must support and reward the development of clinical expertise and knowledge, as well as more generally recognise and respect the contribution of nurses to health services. While the role of the nurse has historically been subservient to that of the doctor and other health specialists, there have been major shifts in the nursing field in the perception of the nurse's role, from one of subservience to one of genuine value adding. Recognition of such input has made it even more important for the creation of new career pathways with new appraisal processes.

However, Hine and Trim (1996) see the above criteria as organisational prerequisites that need to be in place before the establishment of an effective nursing workforce structure. They would also add:

1. continuing education
2. quality assurance programmes
3. a preceptor programme<sup>3</sup>, and
4. a coordinator<sup>4</sup> of the new programme.

The progression of a nurse through a workforce structure can be made seamless if not effortless by having these systems in place. Furthermore job descriptions outline the competencies required of the practitioner at a certain level of development. Regular performance appraisals give the practitioner a tangible benchmark with which to monitor progress. It also leads to continual improvement in the delivery of nursing services to clients. Continued education is also a basis for continual improvement.

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<sup>3</sup> Hine and Trim define a preceptor programme as an intensive one-to-one orientation programme based in a clinical setting. Therefore, preceptorship refers to the comprehensive induction a new nurse undertakes when entering into an organisation.

<sup>4</sup> It is the role of the coordinator to manage the change over into the new nursing workforce construct.

The quality assurance programme guarantees a specific level of performance both at a service delivery level as well as at an organisational level, for example, quality of employment practices, staff development practices, administration and review. An effective preceptor programme helps acclimatise the new nurse faster, which in essence means less down time in terms of effective service delivery. And the coordinator's position is pivotal in terms of embedding the new workforce structure and managing the 'seamless' transition from the old to the new. This requirement is based on a clinical institutional setting and may not be possible within a NGO or Māori organisation due to staff capacity and resourcing limitations.

Performance management processes are the key to linking the structure and content of a CCP. Paterson (1998) defines the performance management process as being cyclical, with the following six stages:

1. definition of expectations
2. performance plan
3. performance coaching and development feedback
4. self review
5. peer review, and
6. performance appraisal.

To progress along a CCP, a nurse must undertake a performance appraisal as well as an assessment on the relevant competencies. However, in implementing the structure of a CCP the following factors were identified both in the case studies undertaken by Paterson and in the research literature as key issues in performance appraisals and competency assessments:

- **Simplicity:** A complex assessment creates barriers to participation
- **Transparency:** The processes must be open and subject to scrutiny and review
- **Objectivity:** The assessment must be fair and consistent
- **Acceptability:** Those undertaking the assessment must be fully accountable to the organisation and the nurses for their decisions, and
- **Flexibility:** Those responsible for the assessment process must see it as learning and evolving process and be prepared to make changes when necessary.

A major omission from the analysis of the assessment is cultural appropriateness. The assessment must be inclusive of the organisation's culture as well as that of the individual nurse. The flexibility factor is the closest link Paterson (1998) has to the incorporation of cultural perspectives. However, the issue of culture warrants specific attention. Additionally, in the context of Te Rau Matatini's work the inclusion of Māori cultural values is a prerequisite for making the process acceptable to, and effective for, the Māori workforce.

O'Brien et al. (2002a) developed clinical indicators for the mental health nursing standards of practice in New Zealand. This work defined the indicators that demonstrate whether a nurse is practising competently. This work is revolutionary as it is one of only three such studies worldwide and so comparison with other works is difficult. Additional to this work was the publication of a step-by-step assessment booklet (O'Brien et al., 2002b) for the auditing of mental health service facilities, of which nurses are a part. This booklet assesses whether or not the facilities delivering mental health services are competent (see Table 1).

*Table 1: Clinical Indicator, Consumer Notes Clinical Indicators Audit Booklet for Audit of Mental Health Service Facilities.*

No.	Clinical Indicator	Yes	No	Comments/Rules
1 CE	<b>Tangata Whaiora</b> is given a <b>choice</b> of whether they <b>want their cultural issues addressed.</b>			If 1 is YES, also answer 18. Clinical notes must be provide clear evidence of a <b>choice being given to identify cultural issues</b> and this includes the nurse's recording of an issue such as ethnicity. A person has the right to identify or not their particular ethnicity.

In his address to the 1998 Forum for the New Zealand Nurses Organisation, Warr (1998) identified that two types of contracts are established in the implementation of a CCP. The first, a formal written contract, holds all the legally binding mechanisms of the relationship. The second contract is the unwritten one of partnership. The idea of partnership invokes images of trust, cooperation and mutual benefit. These are the intangible aspects of contract negotiation and should be of equal importance when considering the process as a whole.

Warr (ibid) also stressed that although the intangible factors are important; they should not detract from the final written document. This document should contain the following factors:

1. The basic structure of the CCP should be clearly defined with particular attention being given to the remuneration schedule
2. If this model is replacing an existing one, the method of transition needs to be defined
3. Identification of those people who are eligible to access the CCP
4. The ramifications of a nurse changing his or her clinical focus
5. The resource implications to be addressed
6. A clearly defined process for auditing the system at predetermined intervals and by appropriate auditors
7. Disciplinary measures for less than acceptable levels of clinical practice, and
8. A clearly defined process for changes to the CCP, as well as review and appeal systems should they be required.

Ultimately, the written document must be:

- clear in terms of how the system is to function
- consistent in terms of how it responds to individual application
- predictable in terms of there being nothing surprising to either party beyond all reasonable outcomes, and
- definite in terms of when criteria have been satisfied, i.e. there is a certain outcome.

In summary Lawless (1998) found the critical success factors for implementing a CCP structure and content were either cultural or structural. Cultural factors<sup>5</sup> in this instance refer to the commitment of both the nursing staff and the organisation to making the career pathway work. Structural factors include the dedication of appropriate resources (both human and financial); comprehensive communication strategies; elimination of artificial barriers to participation; flexibility of the proposed model; linking educational infrastructure to the career pathway; the establishment of

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<sup>5</sup> Cultural factors in this context refers to organisational culture rather than Māori culture.

an objective assessment system; and the development and negotiation of a remuneration schedule.

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### **3. Analysis of Core Competencies within a Nursing Career Pathway**

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Competency-based occupational standards are concerned with the demonstration through performance in the workplace, of an individual’s competent performance. In 1992 the Australian National Office of Overseas Skills Recognition defined competence as “the ability to perform the activities within an occupation or function to the standard expected in employment”<sup>6</sup>.

The core competencies for the profession of nursing in New Zealand were strongly influenced by international models of competency, in particular Benner’s (1984) framework embedded in practice with identified levels of practice from novice to expert’ (see Table 2).

*Table 2: Levels of Nurse Council Competencies<sup>7</sup>.*

<b>Nursing Council Competencies</b>	<b>Clinical Career Path/Professional Recognition Program</b>	<b>Levels of Practice Patricia Benner ‘From Novice to Expert’</b>
Entry to registration	Level Two	Competent
Specialty	Level Three	Proficient
Advanced	Level Four	Expert
	Level Five	

The Nurses Act 1977 and Nurses Regulations Act 1986 established the Nursing Council of New Zealand as the registration authority for nurses. The Nursing Council determines those competencies required for nursing practice at registration. The competency framework links all activities undertaken to a set of core competencies and accompanying performance criteria from entry to registration, specialty and

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<sup>6</sup> Prebble, K. (2002, p. 5). *Competencies for the New Zealand Mental Health Workforce*.

<sup>7</sup> The Nursing Council of New Zealand (2002a).

advanced levels of practice within an area of nursing. Their use potentially provides a more rational basis for initial and continuing nurse development as well as objective assessment of achievement in the work setting.

The literature review of core competencies within the nurse profession has a consistent theme: achievement of core competencies within the context of the registered nurse's practice area. Assessment of core competencies is based on demonstrated application of nursing knowledge, reflective practice and professional judgement within the defined scope of nurse practice<sup>8</sup>.

While it is acknowledged that the framework provides a consistent approach to ensuring appropriate standards of practice are maintained and enhanced, there is a danger that the profession will adhere too rigidly to its own clinical/practice paradigm and be unable to respond to the rapidly changing external environment. For example:

- are the needs of specific consumer groups met by the existing core competencies?
- are core/generic competencies considered within the changing patterns of service delivery?
- is an NGO looking at a generic clinically focused registered nurse when there is a much greater community focus evidenced through the emergence of increasing numbers of Māori provider organisations and NGOs across the health sector?

The strongest criticism of the core competency framework is whether it equips the nurse to practice adequately within both a clinical and community setting. There is already debate in the mental health sector as to whether core competencies for nurses are adequate for the mental health sector when "no system can be set in concrete and still be appropriate when all around changes"<sup>9</sup>.

Furthermore, the literature reveals core competencies for cultural safety are not apparent throughout the various areas of nursing. For example, the requirement to practice in a culturally safe manner is not evident in the core competencies for

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<sup>8</sup> Nursing Council of New Zealand (2002b).

<sup>9</sup> Jones (1997, p. 93).

enrolled nurses. This raises issues about the responsiveness of the framework to deliver to the needs of the Māori consumer and workforce. This is a potential major barrier to encouraging Māori nurses to seek a nursing career pathway in Māori health.

Post-registration, all registered nurses are required to maintain and renew their level of nurse practice competencies before the issuing of a certificate to practice. The process for maintaining registration is very prescriptive, beginning with a standardised application to practice form. There are four or five major elements, including maintaining recency of practice requirements within the last 5 years, demonstrating current competence in the area/scope of practice, maintaining a personal professional profile with details of professional activities, a declaration of competence that requirements have been met, and the provision of evidence when requested for audit purposes by the Nursing Council. The advantage of a national standardised approach to maintaining registration is that there is consistency in the process.

If a nurse has been out of practice for 5 years or more he or she is required to undertake a 'return to practice' programme. This programme enables the nurse re-entering nursing practice to update those knowledge and skills necessary to meet the competencies for registered nurse practice. This requirement, however, can be a barrier in terms of cost for the nurse seeking to return to the workforce on a part-time basis.

If a nurse is registered with the Nursing Council of New Zealand and works overseas using her or his registered nurse qualification, this professional practice is acceptable for maintaining the Nursing Council practicing certificate. This process for maintaining nurse competencies reflects international trends in ensuring that beyond initial entry to the register, mandatory requirements to practice are met<sup>10</sup>.

Movement from one level of the competency framework to another is normally through an assessment conducted in the workplace by an internal review panel comprising senior members of the nursing profession. Application for progression is normally through the clinical nurse leader/coordinator. There are several key points

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<sup>10</sup> Nursing Council of New Zealand (1998).

made in the literature in relation to assessment panels. First, employer commitment to resource the process is essential from the outset. Second, the literature outlines the importance of trained assessors on the panel. Third, members of the resource panel should not be from the nurse's direct chain of reporting.

From case studies and examples of assessment, some nurses have reportedly felt the inclusion of a senior reporting colleague could be detrimental and it was important that the process was seen to be as objective as possible. Case studies of the assessment process in the nurse's workplace reveal this can be facilitated by the inclusion in the nurse's personal professional profile of performance appraisal reports. Issues related to the availability of trained nurse assessors within the workplace were also reported in the literature. The issue of trained assessors and resources to implement the process can be an effective barrier to nurses seeking to advance a career pathway and to a community-based NGO.

Case studies from nurses on the development of personal professional profiles illustrate that this can be daunting for a nurse, particularly if the process is bureaucratic and unwieldy. The assistance of professional nursing bodies such as the Nursing Council, to ensure the nurse profile meets requirements would assist not only the individual nurse but also those NGOs that might not have the necessary resources available in the workplace. Nursing Council guidelines provide a level of consistency in terms of what is required within the profile, while ensuring there is room for flexibility in the presentation and format style at a local level. However, caution needs to be exercised to ensure local interpretation levels still meet national requirements.

It is also noted that there is flexibility within the competency framework for educational equivalence, particularly in relation to advanced core competencies. Educational equivalence is important for registered Māori nurses who wish to work in mental health in that it recognises nurses may achieve advanced practice through other pathways (such as Māori health) rather than solely through formal Nursing Masters preparation. However, as it stands, the applicant must undertake a Master's programme that has direct relevance to his or her scope of practice.

In terms of post-entry career advancement, each area of nursing has its own levels of core competencies, for example, obstetric nursing and advanced psychiatric mental health nursing. However, reference documentation appears to question portability and transferability of the levels of competency from one field of nursing to another. This is most clearly demonstrated in designated specialist and advanced levels within the different fields of nursing. For example, an expert, registered, obstetric nurse is designated Level Three of the obstetric nurse competency framework, which appears to be below the advanced level prescribed in the Nursing Council requirements for advanced nurse registration. If salary is added to the equation, the issue of portability becomes significant and a barrier for nurses seeking to transfer their competency levels to another field of nursing or to undertake specialties.

The portability and transferability of competencies across the specialty areas and health sector is a matter of concern. There are additional specific mental health competencies in the Comprehensive Nurse Core Competency Requirements. A graduate comprehensive nurse is assessed under the nursing competency framework as being a Level Two competent practitioner. However, in the literature there is debate, particularly within the mental health sector, as to whether these competencies adequately prepare the comprehensive nurse for entry into the mental health practice field.<sup>11</sup> Workers must achieve Level One of the mental health competency framework to practice in the mental health area. Suggestions that the entry point into mental health nursing practice will be completion of a post-registration ‘entry to specialty practice’ programme only serves to add confusion to the issue<sup>12</sup>.

These issues, particularly in relation to specialty areas, were recognised by the Ministerial Taskforce on Nursing, who identified barriers to expanding the scope of nursing including the “lack of consistent national standards within the competency framework to demonstrate nurse’s level of practice and specialty (advanced) knowledge” (Ministerial Taskforce on Nursing, 1998, p. 76). The Taskforce further added that the task of developing, recognising and validating nursing competencies

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<sup>11</sup> Prebble (2002); Mason Report (1996).

<sup>12</sup> The New Zealand Branch of the Australian & New Zealand College of Mental Health Nurses (1995).

belongs with the Nursing Council, and that the Nursing Council needs to establish a framework for specialisation<sup>13</sup>.

However, changes within the health sector and the profession show this type of unilateral approach to the development of core competencies in areas of specialties, such as Māori mental health, would not be successful. Key stakeholders in the profession and other occupational professions, Māori providers, NGOs, employers and education-training providers, need an integrated approach when contributing to the framework. This would ensure any core competencies developed for a specialty area have a national consistency and relevancy to the workplace setting.

Employer (NGO) commitment in terms of time and resources is important to the successful implementation of a competency framework. This literature review identified that where there is employer dissatisfaction there is likely non-compliance with the system. The major reasons for non-compliance include:

- how well competency standards reflect industry standards
- company-specific norms tend to take precedence<sup>14</sup>
- reluctance by employers to participate in work-based assessments because of bureaucratic and time-consuming demands<sup>15</sup>, and
- some trainers rely on established customs and practices, or subvert them by working with alternative measures based on traditions and practices of assembling knowledge through craft<sup>16</sup>.

An integrated approach involving the key stakeholders would allay some of the concerns highlighted in this analysis of nurse core-competency career pathways.

Reference documentation highlighted additional issues surrounding competency-based education and training, generated largely from Australia and United Kingdom where competency frameworks are most long standing. Opponents of competency-based training and education argue it is reductionist, narrow, rigid, atomised and

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<sup>13</sup> Nurse Council of New Zealand (2002b).

<sup>14</sup> Fuller & John (1994).

<sup>15</sup> Hyland (1995).

<sup>16</sup> Mulcahy (1996).

empirically and pedagogically unsound<sup>17</sup>. Both sides of the debate agree these are valid criticisms if a behavioural approach is taken in the development and implementation of competencies<sup>18</sup>. Supporters of a competency-based approach to education and training claim it enables industry advisors to give clear guidelines to educators and thus ensures greater relevance of vocational education to industry needs as well as increasing public confidence in all occupations.

**In summary**, the core competency framework is the key thread that links the basic, specialist and advanced career pathway for nurses in New Zealand. It defines a set of core competencies for initial and continuing nurse development. The framework has led to the establishment of a nationally recognised structure and process to assess and review clinical nurse practice and knowledge from entry level to registration and post registration. There is flexibility within the core competency framework for specialties to link to existing Nursing Council standards for registered nurses. A positive feature of the core competency framework for registered nurses at an advanced level of practice is the recognition of educational equivalency where a nurse may wish to develop pathways other than those of clinical practice.

The main criticism is the inadequacy of the core competency framework to prepare nurses for practice in settings other than a hospital setting, such as NGOs, community providers and community mental health. Additionally, there is a lack of identification of core competencies required for nurses to develop their practice in specialties such as Māori health.

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#### **4. Māori Mental Health-related Core Competencies**

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In the literature on Māori mental health-related competencies, key criteria often centre on the Treaty of Waitangi and cultural safety. A report by the National Mental Health Workforce Development Coordinating Committee (1999) outlined that all mental health workers practicing in the mental health sector are expected to demonstrate culturally appropriate practice at a basic competency, advanced

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<sup>17</sup> Chappell (1996); Hyland (1994).

<sup>18</sup> Prebble (2002).

competency and specialist competency level. They defined the performance criteria as competence to:

- apply the principles of the Treaty of Waitangi to mental health services
- recognise the impact of the mental health service on a consumers' belief system
- establish and maintain a supportive relationship with consumers and their families/whānau or significant others
- evaluate own practice in relation to cultural appropriateness
- identify own cultural value base and its impact on that of the consumer
- avoid imposing own belief system on consumers and others, and
- recognise and respect the differing values and beliefs of individual consumers and groups.

Similarly, competencies for entry to the register of comprehensive nurses outline specific mental health competencies including a component on cultural safety<sup>19</sup> that resembles the competencies for the mental health workforce outlined above. Key attributes are values, attitudes, knowledge and understanding of the cultural context of mental health illness, its impact on mental health nursing, and critical thinking in relation to cultural safety principles. This component is deemed fulfilled when the applicant practises nursing in a manner the tangata whaiora determines as culturally safe.

Standard Five of the Criteria for Endorsement of Specialty Practice Standards (Nursing Council of New Zealand, 2002b) makes explicit that the standards must incorporate the principles of the Treaty of Waitangi in nursing practice. Included in the standard is reference to the principles of Māori health and nursing practice. This provision is important for groups within the profession such as Māori registered nurses seeking Nursing Council support to establish Māori health as a specialty practice with its own standards in mental health nurse practice.

In linking the Endorsement of Specialty Practice Standards to the Framework for Post Registration Nursing Practice Education (2001) there are opportunities to work with

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<sup>19</sup> Nursing Council of New Zealand (2001).

key stakeholders including Māori organisations, training institutions, employers and nursing bodies to establish a national direction for formal development and recognition of a pathway of educational preparation extending from post registration through to advanced nursing practice for Māori registered nurses working in mental health and seeking to specialise within the area of Māori health.

The introduction to the Competencies of Advanced Practice in Psychiatric Mental Health Nursing in New Zealand<sup>20</sup> begins with a statement about the importance of the Treaty of Waitangi and the principles of partnership, participation, protection and tino rangatiratanga as fundamental to advanced practice. The advanced practitioner is expected to provide support to colleagues on Treaty of Waitangi based relations and ensure consumers and whānau have access to culturally safe care, including the creation of an environment that is respectful to differences.

At the centre of psychiatric health nursing is the ability to engage in relationships at a meaningful level. Cultural safety is integral to each defined relationship within the competency framework, beginning with the nurse, the consumer, colleagues and the profession. A major assumption of cultural safety competency requirements outlined above is that there are effective internal workplace processes to provide quality tangata whaiora feedback to the process of assessment. The use of written client satisfaction surveys, particularly if they are long and detailed, does not elicit the quality responses for Māori tangata whaiora. A further assumption is that the assessment panel has Māori who are skilled in alternative methods, other than those prescribed by Nursing Council, of gaining the necessary information.

While Benner's (1984) framework embedded in practice laid the foundation for the competency framework of nursing in New Zealand, it has limitations in its ability to develop a highly skilled Māori workforce able to work from both a competent clinical as well as community perspective. A competency framework for specialty areas such as Māori health or Māori mental health requires its own theoretical constructs firmly embedded in indigenous models and Māori mental health.

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<sup>20</sup> New Zealand Branch, Australian and New Zealand College of Mental Health Nurses (2002).

The major criticisms in relation to existing Māori mental health-related competencies are that:

- cultural competence is identified as a set of behaviours associated with the completion of performance (tasks) criteria that in themselves constitute competency, and
- application of the principles of the Treaty of Waitangi and other such principles is too broad. Without specific measures of the knowledge, skills and values that operate those principles such competencies can be viewed as nothing more than a ‘touchy feely’ experience that can be gained by attending Treaty based programmes.

Māori mental health competencies should begin with the fundamental questions raised by Prebble (2002). For example, what is the purpose of developing Māori competencies, how will such a framework support Māori workforce development, how will it be implemented, what sort of competency framework does the sector require, and how would implementation of the competencies be monitored or evaluated?

Fundamental to this, Māori competencies must be developed within the cultural context to which the required competencies will be employed. According to Chappell (1996), the development of competency is not dependent on a single outcome but performance can rather be demonstrated or defensible in various contexts. “A good set of competency standards should provide a clear statement of what is considered to be important in competent performance for the workforce. Partial demonstration cannot be considered adequate.”<sup>21</sup>

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## **5. Strengths and Criticisms of Clinical Career Pathways**

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Jones (1997) points out the differences between the types of systems that can be implemented. She proposes two types of systems. An open system is one that fosters self-directed learning and increasing contribution, and has no restrictions other than

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<sup>21</sup> Hager (1992), cited in The National Mental Health Workforce Development Coordinating Committee (1999, p. 57).

meeting the defined and agreed on criteria for advancement. The problem with this system is that it carries resource issues if all nurses meet the requirements. The positive is that it openly values competency and equity amongst nurses exists.

A closed system caps the number of nurses that can advance to the upper levels. This allows effective resource planning because there are a specified number of nurses going through the system. However, this approach creates inequity amongst the nurses and competition is high as the candidates vie for a finite number of positions. The capped system is contrary to principles such as encouraging development and equity.

Jones proposes systems previously implemented were often based on the resources available to the organisation. Open systems were more preferable because every nurse had the same opportunity to advance as his or her colleague. However, analysis was normally carried out before commencement to see whether or not, given resource constraints, the organisation could 'afford' to advance all or only a few candidates involved in the programme. If only a few could be advanced, due to resource constraints, a closed system was usually implemented.

Jones also maintains that apart from different types of systems, different types of movement can occur within a system, and that these can either be vertical or lateral. Vertical movement is the ascent to the next level of the workforce structure due to exceptional performance at the current level. This is normally reflected by an increase in responsibility and rewards. Additionally, this movement up the ladder of hierarchy is normally associated with a decrease in patient contact, as these nurses take on a more supervisory and educational role. Lateral career movement refers to the specialisation nurses can achieve within a particular level of the nursing construct.

The types of nursing activities have also been divided into two categories of action:

1. **direct activities:** hands on or face-to-face nursing care of clients, and
2. **indirect activities:** those the nurse undertakes through working with colleagues and within organisational systems. These activities are not in direct contact with the tangata whaiora but have a bearing on him or her.

Jones maintains the optimal situation is one where the nurse is proficient in both types of activities as this leads to a well-rounded provision of service to tangata whaiora. However, she criticises nurses as excelling in direct activities and not indirect. This is to be expected as the philosophy of nursing is about caring for people and not complying with organisational policies, procedures and systems. The mind shift that needs to occur among nurses is that indirect activities are just as important for the holistic care of tangata whaiora as they result in a more seamless progression through the health care system.

Olsthorn (1998) outlined the following barriers to participation in the CCP:

- i) **Organisational culture and history:** an organisation needs to consider whether aspects of its culture and history are 'natural' barriers to the establishment of a new CCP
- ii) **Non-involvement of the professional organisation:** the New Zealand Nursing Organisation has to be involved in some form or fashion with the establishment of a new CCP as this pre-empts problems that arise from the lack of consultation
- iii) **Problems of access and eligibility for some groups:** the demographic shape of the workforce and working patterns may affect the nurse's ability to progress through the pathway. Demographics incorporate factors such as age, work place location, family situations, etc. Working patterns refer to those nurses who are part-time, casual or on fixed duties
- iv) **Lack of equivalence and transportability within the organisation:** the pathway needs to be equivalent and transparent throughout the organisation or it will cause barriers as a nurse moves between departments. The lack of ability to apply learned knowledge in another organisational setting will also cause a barrier to participation
- v) **Inadequate support and resourcing:** the organisation must allocate adequate support and resources to the establishment of CCPs or nurses will not want to participate in the process
- vi) **Lack of integration between performance management and the CCP:** the organisation's systems of appraising an employee's performance must fit with the career pathway's emphasis on professional development

- vii) **Poorly managed organisational change:** restructuring will have an effect on the nurse's ability to participate fully in the development of a CCP. The status of the effect (positive or negative) depends on the effectiveness the organisation shows in managing this change
- viii) **Imposing a CCP model without staff involvement:** the pursuit of a career pathway is very personal and to impose this on people without their input into the process will cause a reactionary barrier. This can be avoided should appropriate consultation and feedback facilitation be undertaken by the organisation
- ix) **Losing focus on professional development for nurses and midwives:** the lack of clear direction of professional development for nurses and midwives may be a major barrier to the uptake of a CCP in an organisation, and
- x) **Barriers to progression:** these impede access to any level by a nurse who meets the agreed criteria, for example, closed career pathway systems cap the number of candidates who progress, which can act as a major barrier to uptake by the nurses.

One of the greatest criticisms levelled at the creation of CCPs is the lack of model portability from one organisational setting to another. Trim (1998) maintains that because programme structures, processes and nomenclature differ across organisations, nurses and employers cannot readily relate one CCP to another. For example, were a nurse to exit a particular organisation and join another, an assessment process to integrate the new nurse into the new career pathway structure would probably be considered necessary. The level of that nurse's competencies would have to be assessed to relate them to the new organisation's scale. Additionally, from an employer's perspective, the organisation would incur expense for this assessment. Trim (ibid) maintains there needs to be national agreement on competencies as well as on common understanding and use of descriptive terms. Common policy would also help advance the situation.

O'Brien et al. (2002c) undertook an evaluation of nursing workloads in acute mental health inpatient units. It was established that no nursing workload measurement has been effective in improving key outcomes. Workload is commonly allocated based

on 'judgement and intuition'. Additionally, the level of acuity of the nurse also has a bearing on workload allocation. It was proved that most mental health units operate at capacity and sometimes over capacity. Apart from being dangerous in terms of clinical practice, this immense workload was probably not signed off in the negotiation stages of the establishment of a CCP if indeed such a system had been in place. The literature suggests therefore that researchers are still coming to grips with the way mental health nursing workload is allocated in units and that no work has been carried out to date that focuses on how those workloads affect the development of a CCP programme.

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## **6. Conclusion**

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Obviously mainstream institutions have been grappling with CCP concepts for sometime. To a larger degree, New Zealand's efforts have been based on the work done by Benner (1984) in the United States of America. Key stakeholder bodies in the nursing, mental health and general health fields have adapted Benner's model of levels of competence to a New Zealand context. Unfortunately, the contextual application of these CCP concepts seem to be limited to mainstream institutions, and little if any work has been done on the applicability of these concepts in a NGO and more specifically a Māori NGO construct.

The definition of a CCP is relatively simple. The establishment of a programme, however, can be very complex, even though the content and structure of that programme are easily defined. However, no structure exists in isolation and without the input of organisational members. Therefore, the quality of the CCP is often derived from the quality of the organisation it exists in or the ability of the people trying to implement it.

Analysis of the core competencies, both nursing and mental health, has revealed that the field of nursing has become a highly specialised field of health practice. However, issues were identified when nursing standard competencies did not align with those of mental health. In the context of this project, there is an underlying assumption that as a nurse progresses through his or her CCP, the formal education undertaken by the nurse will effectively integrate the two sets of competencies.

The major strength of the literature is that it provides a benchmark for the establishment of CCPs. The literature identifies a number of prerequisite features needed before the establishment of the CCPs. However it would be useful for NGOs still adjusting to the concepts of CCPs if the literature examined this area in greater detail.

The major limitation of the literature is that it identifies only the prerequisite systems in a mainstream institutional setting and not in the construct of NGOs. It is unwise to assume NGOs are at a level comparable to mainstream institutions in infrastructural robustness, since NGOs encounter resource constraints that mainstream institutions are unlikely to encounter to the same degree.

The draft CCP for Māori registered nurses to work in mental health will suffer from two major inadequacies should it be based solely on the literature. These inadequacies are highlighted by the fact that the literature is based on an institutional not GPO context and that the assessment identified in the literature stems from the availability of clinical expertise to the mainstream institutions. It is unclear whether or not NGOs have access to this clinical expertise, although they would need access should they wish to implement a CCP.

Finally, the inducements for Māori registered nurses to pursue a career pathway in mental health need to be articulated at the outset of the undertaking. Inducements need to be real and to reflect adequately the skill and competency required to operate in the specialised mental health field. Māori registered nurses need to know they will be rewarded should they opt for this career pathway. Additionally, the organisation needs to know that ascending the competency framework will not be at the expense of clinical contact with tangata whaiora.

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