

---

# DISABILITY SUPPORT SERVICES

## WORKFORCE TRAINING NEEDS AND BARRIERS



# **DISABILITY SUPPORT SERVICES**

## **WORKFORCE TRAINING NEEDS AND BARRIERS**

March 2011 by Te Pou o Te Whakaaro Nui  
The National Centre of Mental Health Research, Information and Workforce Development  
PO Box 108-244, Symonds Street, Auckland, New Zealand.

Web [www.tepou.co.nz](http://www.tepou.co.nz)  
Email [info@tepou.co.nz](mailto:info@tepou.co.nz)



# EXECUTIVE SUMMARY

Workforce training ultimately contributes to safe and high quality care for disabled people (Ministry of Health, 2009b). A key objective in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) is building a competent workforce through training and development, and improving the accessibility and sustainability of this for disability support workers. Surveys carried out in 2004 as part of the *Quality and Safety Project* suggested there was large scope to improve the knowledge and skills of disability support workers (Ministry of Health & University of Auckland, 2004a). As part of the response to support access to workforce training, Te Pou's Disability Workforce Development (DWD) service has been contracted to administer grants on behalf of the Ministry of Health.

## PURPOSE

To better understand current workforce training needs and barriers, and inform future workforce development this report:

- describes disability support workforce needs and barriers identified in earlier workforce surveys
- summarises sector feedback on needs and barriers gathered by regional facilitators
- identifies key types of learning and development activities applied for in 2010 training grants
- suggests possible solutions for addressing disability support workforce needs and barriers.

This project intended to review learning needs and barriers specifically for Māori, Pacific and rural populations, but this was limited by the information currently available.

## KEY RESULTS

Disability support workforce training needs include:

- short courses to develop minimum knowledge and skills (such as first aid, fire safety, emergency procedures) required in different service settings (such as home and community support services)
- formally recognised qualifications to develop core generic skills and those for specialist areas
- improved disability knowledge and awareness (such as autism spectrum disorders, comorbid conditions<sup>1</sup>, behaviour support and dementia)
- cultural responsiveness to meet the needs of Māori, Pacific and consumers of other ethnic groups
- consumer leadership and development (such as self-advocacy).

Organisational training barriers include:

- an ability to support and encourage staff (for example, funding and providing time off)
- responding to diverse workforce characteristics (such as literacy issues, adult learning needs, English as a second language, and preferred learning styles)
- awareness of learning programmes and activities available
- the availability of relevant courses and programmes (such as access to training in local area co-ordination and individualised funding)
- developing a sustainable infrastructure (for example, accessing suitably qualified and skilled trainers and assessors, dedicated learning support, and sufficient allocation of resources).

---

<sup>1</sup> Such as mental illness among disabled people.

Individual barriers include:

- confidence, skills and motivation (for example, literacy issues and previous learning experiences)
- time and resources (such as computer access and other commitments).

## RECOMMENDATIONS

A number of suggested actions for improving access and overcoming training barriers are outlined below.

### MINISTRY OF HEALTH GRANT FUNDING

1. Continued for formally recognised qualifications and non-NZQA short courses.
2. Continued for leadership development with a key focus on workforce development.
3. Continued for consumer leadership development.
4. Future targeting of home and community support services for non-NZQA grants.
5. Opportunities for expanding grant criteria explored by DWD with the Ministry of Health.

### WORKFORCE DEVELOPMENT INFRASTRUCTURE

6. A central disability training directory developed collaboratively by DWD.
7. Incentives explored and successful initiatives shared with the sector by DWD and Careerforce.
8. Services supported to network and share resources by DWD and Careerforce.

### TRAINING DELIVERY

9. Disabled people included in relevant programmes and courses.
10. Programmes and courses reflect the diverse characteristics of the workforce.
11. Making this report available on the DWD website to gain feedback, including:
  - a. what training needs or barriers are not captured by this report?
  - b. which potential solutions offer the greatest benefit and should be prioritised?
  - c. what additional strategies would support future workforce training?

# CONTENTS

EXECUTIVE SUMMARY .....	4
PURPOSE .....	4
KEY RESULTS .....	4
RECOMMENDATIONS .....	5
BACKGROUND .....	8
DISABILITY WORKFORCE DEVELOPMENT .....	9
PURPOSE .....	9
LITERATURE REVIEW .....	10
WORKFORCE TRAINING .....	10
MINIMUM REQUIREMENTS .....	10
FORMALLY RECOGNISED TRAINING .....	11
TRAINING NEEDS .....	12
DIFFERENT SERVICE SETTINGS .....	12
NEW DISABILITY MODEL .....	13
DISABILITY KNOWLEDGE AND AWARENESS .....	14
CONSUMER CULTURAL RESPONSIVENESS .....	15
CONSUMER LEADERSHIP AND DEVELOPMENT .....	17
ORGANISATIONAL BARRIERS .....	18
STAFF SUPPORT AND ENCOURAGEMENT .....	18
RESPONDING TO DIVERSE WORKFORCE CHARACTERISTICS .....	18
SUSTAINABLE INFRASTRUCTURE .....	19
INDIVIDUAL BARRIERS .....	19
CONFIDENCE, SKILLS AND MOTIVATION .....	19
TIME AND RESOURCES .....	19
SECTOR FEEDBACK and GRANTS .....	21
TRAINING GRANT APPLICATIONS .....	21
SECTOR FEEDBACK .....	23
DIFFERENT SERVICE SETTINGS .....	23
DISABILITY KNOWLEDGE AND AWARENESS .....	23
CONSUMER CULTURAL RESPONSIVENESS .....	23
CONSUMER LEADERSHIP AND DEVELOPMENT .....	24
ORGANISATIONAL BARRIERS .....	24
INDIVIDUAL BARRIERS .....	25
SUMMARY .....	26
TRAINING NEEDS .....	26
MINIMUM REQUIREMENTS .....	27
DIFFERENT SERVICE SETTINGS .....	27
DISABILITY KNOWLEDGE AND AWARENESS .....	28
CONSUMER CULTURAL RESPONSIVENESS .....	28
CONSUMER LEADERSHIP AND DEVELOPMENT .....	28
TRAINING BARRIERS .....	29
ORGANISATIONAL BARRIERS .....	30
INDIVIDUAL BARRIERS .....	33
CONCLUSION .....	34
STRENGTHS AND LIMITATIONS .....	34
APPENDIX A: BIBLIOGRAPHY .....	36
APPENDIX B: CAREERFORCE NATIONAL TRAINING .....	38
APPENDIX C: GENERAL POPULATION DISABILITY .....	40
REFERENCES .....	41

# LIST OF TABLES

Table 1. <i>Benefits of Training for the Disability Support Workforce</i> .....	8
Table 2. <i>Training that would help Support Workers to a Better Job</i> .....	14
Table 3. <i>Disability Workforce Training Needs</i> .....	26
Table 4. <i>Disability Support Services Training Needs Mapped with Level 2 and 3 Qualifications</i> .....	27
Table 5. <i>Disability Workforce Barriers</i> .....	29
Table 6. <i>Careerforce Health and Disability Nationally Recognised Training</i> .....	38
Table 7. <i>Careerforce Qualifications Currently Being Developed</i> .....	39

# LIST OF FIGURES

<i>Figure 1. The main types of training provided overall by 330 disability support services.</i> .....	11
<i>Figure 2. Importance of training reported by 57 disability support service providers.</i> .....	12
<i>Figure 3. Level of sufficient and recognised training in disability support services.</i> .....	13
<i>Figure 4. Primary impairment of consumers by age group.</i> .....	15
<i>Figure 5. Ethnic diversity of people with disabilities aged under 65 in 2006, N = 440,000.</i> .....	16
<i>Figure 6. Ethnic diversity of people with disabilities aged 65 and over in 2006, N = 220,300.</i> .....	16
<i>Figure 7. Barriers to successful training of disability support workers.</i> .....	18
<i>Figure 8. Training grant applications for individual workers in 2010, N = 1842.</i> .....	21
<i>Figure 9. Open round training grant service provider applications in 2010.</i> .....	22
<i>Figure 10. Training motivators reported by disability support workers.</i> .....	31
<i>Figure 11. Type of disability among children aged 0-14 years in 2006.</i> .....	40
<i>Figure 12. Type of disability among adults aged 15 years and over in 2006.</i> .....	40

# BACKGROUND

Factors contributing to the delivery of high quality services to disabled people in community home and residential support service settings were investigated in the *Quality and Safety Project* (Ministry of Health & University of Auckland, 2004a). As part of this project, surveys and interviews were carried out with disability support services, the workforce and consumers. Survey findings suggested there was large scope to improve the knowledge and skills of the disability support workforce. The *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) was developed in 2009 in response to workforce issues identified in part through the Quality and Safety Project (Ministry of Health & University of Auckland, 2004a).<sup>2</sup> A key objective outlined in the workforce action plan for disability support services<sup>3</sup> is building a competent workforce through training and development, and improving the accessibility and sustainability of this for disability support workers (Ministry of Health, 2009b).

The *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) recognises the development of support workers can ultimately contribute to safe and high quality care. Workforce training is associated with improvements in knowledge, skills, confidence, job performance and interest in further training among individual workers, as well as in organisational performance, effectiveness and staff turnover (Aguinis & Kraiger, 2009; Health Outcomes International, 2007).<sup>4</sup> <sup>5</sup> The provision of learning and development opportunities may also contribute to the workforce feeling valued by their organisation (Aguinis, 2009; cited in Aguinis & Kraiger, 2009; Health Outcomes International, 2007). These potential benefits have been highlighted in interviews with disability support services as summarised in Table 1. A key action outlined in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) is therefore ensuring all workers have access to orientation, training and professional development opportunities.

**Table 1.** *Benefits of Training for the Disability Support Workforce*

INDIVIDUAL BENEFITS	ORGANISATIONAL BENEFITS	SERVICE USER BENEFITS
<ul style="list-style-type: none"> <li>• Greater insight into client needs</li> <li>• Better able to identify changes in need levels</li> <li>• Better able to pick up on medical problems in their clients</li> <li>• More aware of health and safety procedures and regulations</li> <li>• More confidence in their abilities</li> <li>• Greater self-worth</li> </ul>	<ul style="list-style-type: none"> <li>• Workers more committed to their position, resulting in lower absenteeism and turnover</li> <li>• Improved trust in workers with greater responsibilities</li> <li>• Support workers aware of expected standards</li> </ul>	<ul style="list-style-type: none"> <li>• Workers treated clients more appropriately, especially if they understood the specific challenges of disability and aging</li> <li>• Happier clients</li> </ul>
Source: (Ministry of Health & University of Auckland, 2004a).		

<sup>2</sup> The Ministry of Health Disability Support Services provide support to people primarily under the age of 65 with long-term physical, sensory, and/or intellectual disability disabilities meeting eligibility criteria (Health Workforce Information Programme, 2010).

<sup>3</sup> The *Disability Services Workforce Action Plan* has a principal focus on development of the disability care and support workforce in Ministry of Health funded services. Disability support workers make up about 85 per cent of the disability workforce (Health Workforce Advisory Committee, 2002). Overall size is estimated to be between 19,000 and 22,000 for disability support funded services (Ministry of Health, 2009b). Health professionals working with people with impairments include audiologists, clinical psychologists, neurologists, occupational therapists, optometrists, paediatricians, physiotherapists, psychiatrists, rehabilitative medicine specialists, social workers, and speech language therapists, and will not necessarily work exclusively with disabled people (Ministry of Health, 2003).

<sup>4</sup> The evaluation of home based support services training initiative found 77 per cent of support workers who had completed the programme were interested in pursuing further training opportunities (Health Outcomes International, 2007).

<sup>5</sup> The 2009 report prepared by the PSA and SWFU provided some evidence to suggest training reduces staff turnover among disability support workers. A Home Health Association informal survey in October 2008 found staff turnover for a sample of graduates of the Home Based Support Services Training initiative introduced in 2005 was only 16 per cent compared with 22 per cent for residential disability support workers the previous year (Ministry of Health, 2009b).

## DISABILITY WORKFORCE DEVELOPMENT

This report was carried out by Te Pou's Disability Workforce Development (DWD) service. DWD has been contracted by the Ministry of Health to administer training grants. These include grants for Ministry of Health approved formally recognised qualifications and non-NZQA short courses, along with leadership development, and consumer leadership development grants. DWD regional facilitators engage and work in partnership with services to support access and successful completion of learning programmes and activities by the disability support workforce.

## PURPOSE

To better inform future disability support workforce development this report:

- describes disability support workforce needs and barriers identified in earlier workforce surveys
- summarises sector feedback on needs and barriers gathered by regional facilitators
- identifies key types of learning and development activities applied for in 2010 training grants
- suggests possible solutions for addressing disability support workforce needs and barriers.

This project intended to review learning needs and barriers specifically for Māori, Pacific and rural populations, but this was limited by the information currently available.<sup>6</sup>

## ORGANISATION OF THIS REPORT

This report is based on a literature review, sector feedback, and an analysis of training grant applications.

### *Literature review*

The literature review examined needs and barriers identified in previous workforce surveys and reports. The scope of the review included disability support services. Attached in Appendix A is a bibliography of relevant New Zealand workforce surveys and reports since 2000.

### *Sector feedback and grants*

Up-to-date information on needs and barriers was gathered from disability support services. Anecdotal information was gathered during sector engagement by DWD regional facilitators between June and November 2010. Careerforce was also consulted, given their role as an industry training organisation and in supporting and providing national health and disability qualifications.

The grants for formally recognised qualifications and non-NZQA short courses administered by DWD on behalf of the Ministry of Health were analysed. Results from the analysis are reported, including key types of learning and development activities applied for.

### *Summary*

Presented in the final section of this report is an overall summary of training needs based on information gathered from all sources outlined above. Organisational and individual barriers are also discussed. Suggested actions are included for addressing identified needs and barriers.

---

<sup>6</sup> The review did not specifically include the training needs of the Intellectual Disability (Compulsory Care and Rehabilitation) workforce and specialised sub-sectors (such as sensory rehabilitation), which were proposed actions in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b).

# LITERATURE REVIEW

A literature review was carried out by Te Pou as part of this report to identify training needs and barriers found in earlier disability workforce surveys. A bibliography of relevant literature is included in Appendix A. Findings from the literature review are outlined below. Workforce training is discussed first, followed by needs and barriers.

## WORKFORCE TRAINING

Disability support workers do not necessarily require any pre-entry minimum level of training to enter the disability sector (Health Workforce Advisory Committee, 2002; Health Workforce New Zealand, 2010).<sup>7 8</sup> On-the-job training is common and provided by nearly all disability support services (Ministry of Health & University of Auckland, 2004a).<sup>9</sup> The most common types include buddying and orientation training (Ministry of Health & University of Auckland, 2004a). Evidence suggests nearly all disability support workers believe opportunities to learn and train in their place of work are important (Ministry of Health & University of Auckland, 2004d).<sup>10</sup>

### MINIMUM REQUIREMENTS

The health and disability services standards (Standards New Zealand, 2008) outline requirements to support the delivery of quality services to consumers.<sup>11</sup> These include consumer rights, service governance and management, infection control, and minimising restraint.<sup>12</sup> The standards have implications for minimum workforce training requirements. Furthermore, a recommendation from the Quality and Safety project was a shift towards mandatory home-based sector standards and the compulsory training of support workers, especially those providing personal care services (Ministry of Health, 2009b).<sup>13</sup>

The best data currently available on workforce learning and development comes from the 2004 surveys of disability support services (Ministry of Health & University of Auckland, 2004a). The survey examined the types of overall and mandatory workforce training provided by services. Overall training is illustrated in Figure 1 and most frequently included first aid, lifting and handling, and fire safety. A similar pattern was found for mandatory training, which frequently occurred during orientation (Ministry of Health & University of Auckland, 2004d).<sup>14</sup> In addition, intellectual disability services specifically spent more time on disability issues and communication skills (Ministry of Health & University of Auckland, 2004d).

<sup>7</sup> Minimum standards often used in workforce recruitment include good spoken and written communication skills, relevant life and previous experiences (Ministry of Health & University of Auckland, 2004a).

<sup>8</sup> There are risks of over-professionalising this workforce. The experience in the United States of upskilling and regulating the support workforce has meant that fewer support workers are employed because the workers are now expensive to train and employ. The support role also fills a niche in the labour market, where people can enter the disability workforce relatively easily. However, there is evidence from CSSITO that workers undertaking the National Certificate in Human services are more likely to remain in the workforce and work longer hours, so any extra cost may be offset by reduced recruitment and ad hoc training costs (Health Workforce Advisory Committee, 2003).

<sup>9</sup> In total, 95 per cent of providers provided on-the-job training.

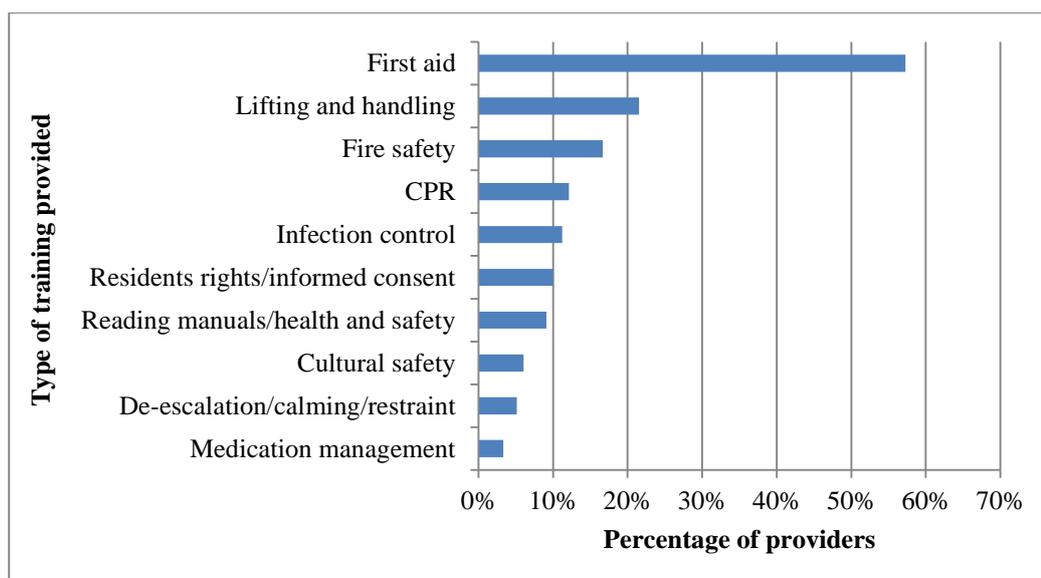
<sup>10</sup> 70 per cent of those surveyed felt it was very important and 23 per cent believed it was important.

<sup>11</sup> The standards are mandatory for services subject to the Disability Services (Safety) Act 2001. However, not all standards are relevant to all services. Providers are expected to meet standards, which vary depending on the kind of services they offer. For example, under the Health and Disability Services (Safety) Act residential disability support facilities with five or more beds are required to be certified, and must pay to be audited by designated audit agencies (Social Services Committee, 2008, p. 32).

<sup>12</sup> [http://www.moh.govt.nz/moh.nsf/pagesmh/8656/\\$File/81340-2008-nzs-readonly.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/8656/$File/81340-2008-nzs-readonly.pdf)

<sup>13</sup> To strengthen the capacity of organisations and improve service quality and safety, a proposed action in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) is ensuring enough training is available to meet the sector's needs when designing new service specifications and standards.

<sup>14</sup> Mandatory training reflected training that coordinators required their support workers to complete as a pre- or co-requisite to employment (Ministry of Health & University of Auckland, 2004b). It does not necessarily reflect training included in service specifications or service contracts.



**Figure 1.** The main types of training provided overall by 330 disability support services.

*Note.* Training specifically provided is illustrated. Source: (Ministry of Health & University of Auckland, 2004a).

### FORMALLY RECOGNISED TRAINING

Nationally recognised formal qualifications have been developed for the health and disability sector. Courses available through Careerforce are summarised in Appendix B. Underpinning these qualifications is an in-house or embedded model of training, in which the employer takes responsibility for learning and assessment (Ryan, 2009). This helps ensure training received is relevant to workers and their organisations. Currently the priority for Ministry of Health grants administered by DWD is for levels three to five training. Findings from surveys in 2004 indicate national courses and qualifications are perceived to have great value and benefit by disability support services (Ministry of Health & University of Auckland, 2004b).

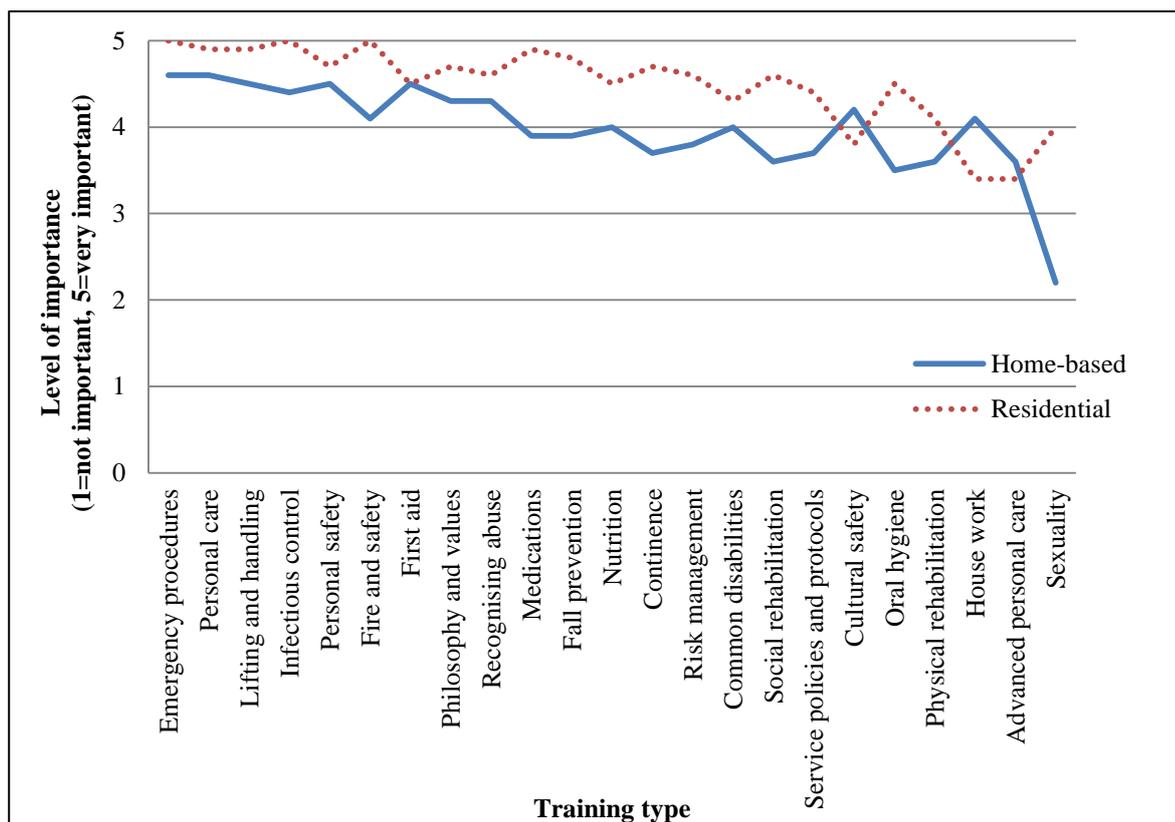
The National Certificate in Community Support Services aids the development of core skills, attitudes and knowledge required to work in disability services (see Summary section).<sup>15</sup> About one in six disability support workers are estimated to have completed relevant national certificates or diplomas. The survey of intellectual disability services, for example, found 16.5 per cent of workers had obtained a human services certificate or diploma (Higgins et al., 2009).<sup>16</sup>

<sup>15</sup> In addition, several degree courses are available with a focus on disability through academic institutions, such as Bachelor of Human Services (Disability Studies Major) at Auckland University, Bachelor of Health Science (Rehabilitation Major) at Massey University, and the Postgraduate Diploma in Arts (Disability Studies) at Massey University.

<sup>16</sup> Challenges motivating staff to undertake formal qualifications have nevertheless been reported by disability support service providers (Ministry of Health & University of Auckland, 2004b).

## TRAINING NEEDS

The type of training provided and perceived important by disability support services has been examined in earlier surveys. Findings from the 2004 disability support services survey are presented in Figure 2. In community residential support services key needs included infection control, emergency procedures, fire and safety, personal care, lifting and handling, and medications. Key needs in home and community support services included personal care, emergency procedures, first aid, lifting and handling, personal safety, and infection control. Interviews carried out with consumers in home-based settings also indicated physical safety was a key area of concern (including poor hygiene, food preparation and safety practices), and was attributed to a lack of training and understanding of what it is to be disabled (Ministry of Health & University of Auckland, 2004c).



**Figure 2.** Importance of training reported by 57 disability support service providers.

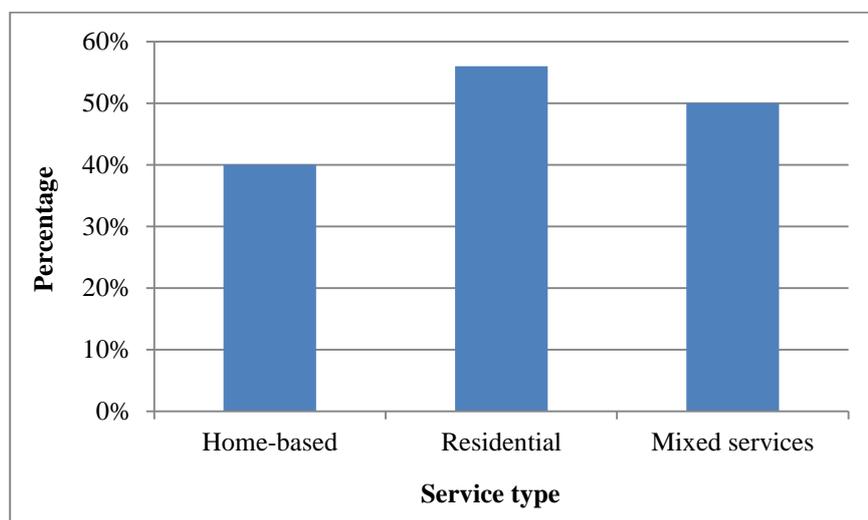
*Note.* Other types of training rated as important or very important included behaviour (such as understanding and challenging behaviour) and the rights of disabled people (such as informed consent, code of rights). Source: (Ministry of Health & University of Auckland, 2004b).

### DIFFERENT SERVICE SETTINGS

While some of the key training areas for home and residential support services identified in Figure 2 overlap, they also differ. Disability services have previously expressed concerns about “lumping together” organisations under the same umbrella and assuming they have the same needs (Ministry of Health & University of Auckland, 2004b). Home and community support services help disabled people living in the community (Ministry of Health & University of Auckland, 2004c). While most disabled people reside in their own homes, many of those with high needs live in community residential support services (Social Services Committee, 2008).<sup>17</sup> The purpose, client base, and philosophy of these services differs and consequently impacts on the knowledge and skills required of the workforce.

<sup>17</sup> The 2006 *Disability Survey* by Statistics New Zealand indicated 82 per cent of people with a disability were adults living in households, five per cent were adults living in residential facilities, and 14 per cent were children (under 15 years) living in households (Health Workforce Information Programme, 2010).

Challenges in accessing training with a home and community support focus have been highlighted in disability and non-government organisation reports (Ministry of Health, 2003; Peel, 2006). Concerns over the relevance of national certificates for home-based support services have also been raised (Health Outcomes International, 2007).<sup>18</sup> As illustrated in Figure 3, evidence suggests support workers in home-based support services are less likely to be sufficiently trained. Similarly, concerns over the quality of the workforce, especially home-based support workers, have been highlighted by consumers (Ministry of Health & University of Auckland, 2004c). Home and community support services may therefore have greater workforce learning needs and require access to different types of training.



**Figure 3.** Level of sufficient and recognised training in disability support services.

Source: (Ministry of Health & University of Auckland, 2004a).

## NEW DISABILITY MODEL

A new model of disability support services was approved by the Ministry of Health in 2010 (Ministry of Health, 2010). The model is a person-centred approach which incorporates processes of local area coordination and individualised funding. The model aims to increase the choice and control disabled people have over the support they receive and involves them extensively in decision-making (Social Services Committee, 2008). Local area coordinators assist disabled people and their family/whānau to select and access supports.<sup>19</sup> The model will impact on the information and skills required by consumers to participate in their care, as well as the workforce. Workers who understand the purposes of empowerment and self-determination will be better equipped to support disabled people (Ministry of Health & University of Auckland, 2004d). The learning and development needs which emerge from the new disability model and strategies for addressing these will require exploration.

<sup>18</sup> Such as lifting and handling, and medication (Health Outcomes International, 2007). Proposed revisions to foundation skills training include elective unit standards to provide more flexibility to meet the needs of the sector (Careerforce, n.d.).

<sup>19</sup> Following a project established in 2003. Eligibility to the scheme will open to all consumers who have been allocated Home and Community Support Services as a result of an assessment and referral by a Needs Assessment and Service Coordination (NASC) organisation. See <http://www.moh.govt.nz/moh.nsf/indexmh/disability-keyprojects-ifp>.

## DISABILITY KNOWLEDGE AND AWARENESS

The need for greater disability awareness and knowledge of specific disabilities by the workforce has been recognised in earlier reports. Submissions to the inquiry into the quality of care and service provision for disabled people proposed mandatory training standards for disability support workers (Social Services Committee, 2008).<sup>20</sup> This included the social model of disability and rehabilitation principles. Consumers who took part in the Quality and Safety project also commented on the lack of awareness of disability knowledge among support workers (Ministry of Health & University of Auckland, 2004c). Consumers have therefore called for disability awareness training among all support workers, which could be delivered and run by disabled people (Ministry of Health & University of Auckland, 2004c). The need for disability related knowledge has also been recognised by the workforce as summarised in Table 2. Ongoing training would help to keep the workforce informed of evolving intervention and support philosophies (Health Workforce Advisory Committee, 2003).

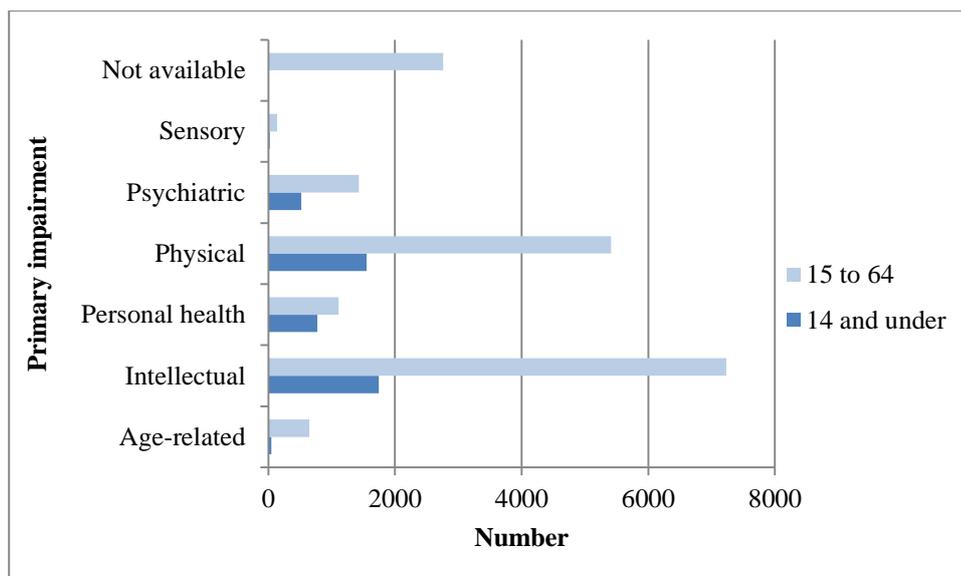
**Table 2. Training that would help Support Workers do a Better Job**

HOME-BASED COMMUNITY SUPPORT WORKERS	COMMUNITY RESIDENTIAL SUPPORT WORKERS
<ul style="list-style-type: none"> <li>• First aid</li> <li>• Manual handling*</li> <li>• Regular and current updates</li> <li>• Specialised disabilities training*</li> <li>• Psychology</li> <li>• Behavioural support</li> <li>• Personal care*</li> <li>• How to deal with difficult clients</li> <li>• Managing challenging behaviour</li> <li>• Listening skills</li> <li>• Boundary training</li> <li>• Computer training</li> <li>• Dementia training*</li> </ul>	<ul style="list-style-type: none"> <li>• Learning about common ailments and medication*</li> <li>• Communication of emotional issues with clients</li> <li>• Education of external support scenes/services*</li> <li>• CPR*</li> <li>• Wound dressing*</li> <li>• Time management</li> <li>• Mental health of older people*</li> <li>• Head injuries and rehabilitation*</li> <li>• Team work</li> <li>• Stress management</li> <li>• Diabetes*</li> <li>• Challenging behaviour</li> <li>• Nursing training</li> <li>• Caregivers course</li> </ul>
<p>Source: (Ministry of Health &amp; University of Auckland, 2004d).            * Training may be considered beneficial across both types of services.</p>	

Service users' needs impact on the knowledge and skills required by the workforce. The increased provision of home and community support has resulted in a rise in the number of disabled people with complex needs living in their homes (Ministry of Health & University of Auckland, 2004d). The primary impairments of consumers under the age of 65 receiving support are illustrated in Figure 4 (see Appendix C for impairments in the general population). Intellectual and physical disabilities were the most common *primary* impairments. Nationally recognised courses focusing on different disabilities are available through Careerforce (see Appendix B). Access to training for less prevalent and/or more complex impairments may be harder to find.<sup>21</sup>

<sup>20</sup> We have been warned that the introduction of minimum standards for the disability workforce could restrict the pool of workers at a time of significant shortage. We are concerned that in practice introducing workforce regulation may make it more difficult for providers to employ carers. Nevertheless, we consider that establishing minimum standards will ultimately improve the career opportunities of employees while providing better support for people with disabilities (Social Services Committee, 2008, p. 39)

<sup>21</sup> Feedback from consumer forums in 2009 indicated there were concerns about accessing services in some areas and assessors for people (mainly children) with autistic spectrum disorders (Ministry of Health, 2009a).



**Figure 4.** Primary impairment of consumers by age group.

*Note.* Based on data derived from the Client Claims Payment System (CCPS) driven by Needs Assessment and Service Coordination Agency (NASC) assessments. The data includes mental health residential support services, age related support services, and support services for disabled people. Data is also available for the 65+ age group. Source: (Ministry of Health & University of Auckland, 2004c).

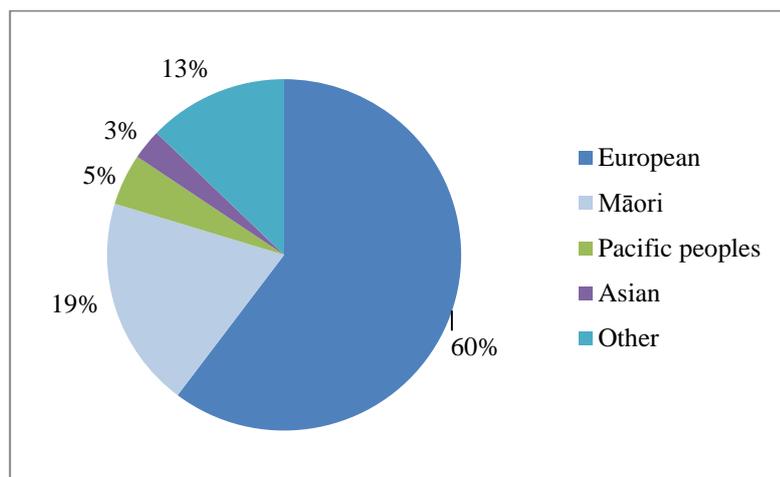
The need for skills to effectively respond to challenging behaviours has been highlighted in previous surveys. For example, training in understanding challenging behaviour was perceived as important in surveys of disability support services (Ministry of Health & University of Auckland, 2004b). Evidence suggests nearly two-thirds of workers in intellectual disability services have been verbally abused and nearly half physically abused (Higgins et al., 2009). In line with this, disability support workers have indicated that knowledge development in this area, along with behavioural support, psychology, listening and boundary skills would help them do a better job (Ministry of Health & University of Auckland, 2004d). Training which supports workforce communication, understanding of personal dynamics and boundaries, and aids self-reflection may therefore benefit the workforce.

### CONSUMER CULTURAL RESPONSIVENESS

Previous workforce surveys have highlighted the need for culturally responsive training (Ministry of Health & University of Auckland, 2004). Moreover, recent interviews with Māori consumers and caregivers found a lack of awareness by services of their cultural needs (Wiley, 2009). As pointed out by Wiley (2009), training should reflect the needs of the organisation and population it serves. The ethnic diversity of people with impairments is presented in Figures 5 and 6 based on a cut-off age of 65. These findings indicate people under the age of 65 with an impairment are more ethnically diverse.

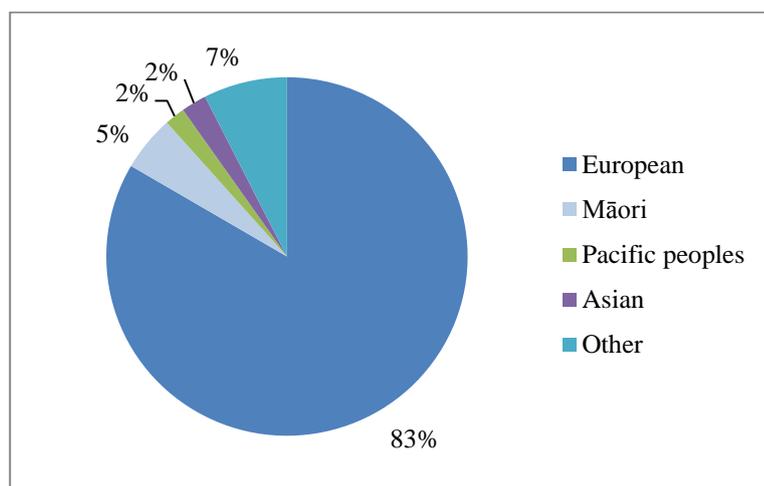
The perspectives of Māori and Pacific consumers were gathered in 2004 as part of the Quality and Safety project (Ministry of Health & University of Auckland, 2004c). There was general consensus among Māori “that all support workers and senior staff needed to undergo cultural training to better meet the needs of Māori service users” (Ministry of Health & University of Auckland, 2004c, p.67). Where workers had an understanding of cultural issues and boundaries it was perceived as particularly helpful and preferred by Māori (Ministry of Health & University of Auckland, 2004c). Similarly, fono with Pacific consumers indicated support driven by cultural needs would make a big difference and improve the quality of services to Pacific peoples (Ministry of Health & University of Auckland, 2004c). Recent feedback from Pacific disabled peoples indicates an understanding of the whole picture is important (Ministry of Health, 2009a). Communication was also identified as a key issue for Pacific consumers since English is often a second language (Ministry of Health, 2009a). In addition to Treaty of Waitangi training, there have been calls for

ongoing cultural training to occur at all levels (Ministry of Health, 2009a; Ministry of Health & University of Auckland, 2004c).



**Figure 5.** Ethnic diversity of people with disabilities aged under 65 in 2006,  $N = 440,000$ .

Source: (Statistics New Zealand, 2006).



**Figure 6.** Ethnic diversity of people with disabilities aged 65 and over in 2006,  $N = 220,300$ .

Source: (Statistics New Zealand, 2006).

Differences within ethnic cultural groups, such as Pacific peoples, also need to be taken into account. For example, there are seven main ethnic specific Pacific groups (Samoan, Cook Island Māori, Tongan, Niuean, Fijian, Tokelaean and Tuvaluan) and up to 33 overall (Statistics New Zealand, 2006). Therefore, different approaches may be required to meet the needs of consumers within specific cultural groups.

The types of services provided and preferred by consumers impacts on workforce learning and development. In hui with Māori as part of the consumer forums in 2009, there was a preference for disability support services for Māori consumers to be provided by Māori (Ministry of Health, 2009). That is, there was a strong preference for a kaupapa Māori approach.<sup>22</sup> Services for Pacific people by Pacific organisations may also be valuable.

<sup>22</sup> Although this is not always appropriate or possible (Health Workforce Advisory Committee, 2003).

## CONSUMER LEADERSHIP AND DEVELOPMENT

One of the key objectives of the *New Zealand Disability Strategy* (Ministry of Health, 2001) is to ensure the rights of disabled people. The strategy is underpinned by the social model of disability and a vision of a fully inclusive society (Disability Rights Promotion International, 2010; Stace, 2010). In line with this, an objective of the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) is to increase employment opportunities for disabled people in disability services. In a recent report on disability rights in New Zealand (Disability Rights Promotion International, 2010), social participation was found to be the single biggest issue for disabled people, and despite progress, barriers to full participation remain. It was recognised that participation was limited at times by accommodations, but more often by attitudes due a lack of understanding of the everyday realities of disabled people (Disability Rights Promotion International, 2010). The provision of training by disabled people is therefore vital to improving awareness and understanding of participation barriers. Moreover, disabled people are best placed to deliver disability awareness training.

Fostering the leadership of disabled people is another key objective included in the *New Zealand Disability Strategy* (Ministry of Health, 2001). An action included in the strategy to foster leadership is the encouragement of disabled people in decision making, service delivery, management, governance, planning and evaluation (Ministry of Health, 2001). The rationale for participation is based on consumer rights, as well as improving decision making and the quality of services (Coney, 2004). Evidence suggests that the knowledge and expertise of consumers derived from their experiences contributes to better decisions, and improvements in service quality and policies (Coney, 2004). A review on implementation of the disability strategy in 2007 reiterated the need to develop “the capacity of disabled people to contribute as employees and external experts on disability issues” (Office for Disability Issues, 2008, p.5). Disabled people and their families have also called for greater input and control over the disability supports they receive (Ministry of Health, 2009a).

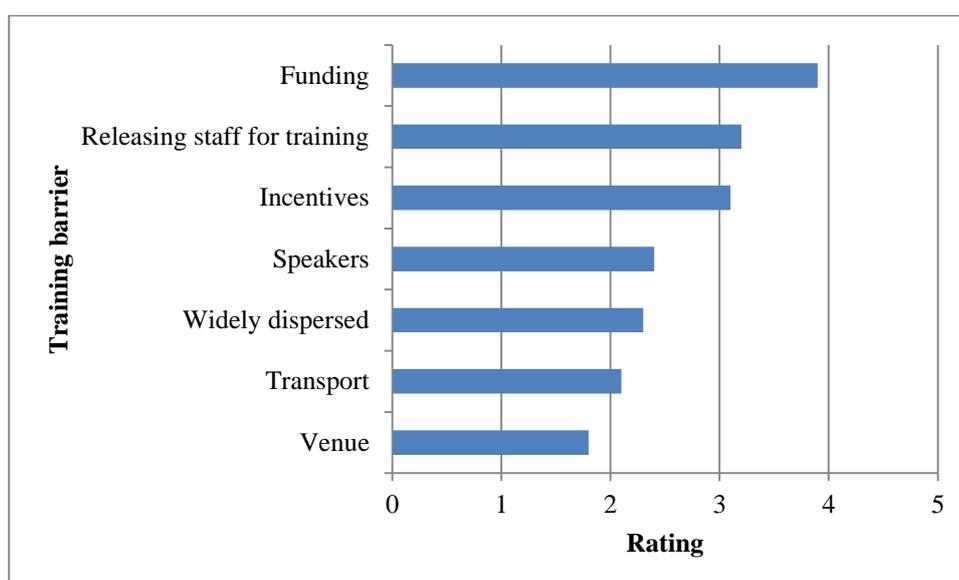
Participation in decision making by disabled people is empowering and can occur at a number of levels, ranging from merely taking part or being present, to more significant involvement and consultation (Cavet & Sloper, 2004; Franklin & Sloper, 2006). Increasing the capacity of disabled people in advocacy and decision making will promote leadership and contribute to greater independence and empowerment (Balcazar, Seekins, Fawcett, & Hopkins, 1990; Saucier, 2002). Several barriers to consumer participation have been identified including a “lack of skills, resources and confidence to access information, decision making, the technical complexity of many issues and professional/administrator scepticism and attitudes (Ministry of Health, 1995; Aotearoa Network of Psychiatric Survivors, 1996; Bowl, 1996; Bastian, 1999; Thompson et al., 2002; Consumers’ Health Forum of Australia, 2002; Commission for Health Improvement, 2004)” (Coney, 2004, p. 47). Advocacy training for and by consumers, their families, friends and non-governmental organisations can assist the development of necessary skills (Coney, 2004). Furthermore, setting up training for disabled people to better manage their own support services and resources is an action outlined in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b). To support consumer leadership, DWD administers consumer leadership development grants on behalf of the Ministry of Health.

## ORGANISATIONAL BARRIERS

Summarised in this section are the findings from previous workforce surveys examining organisational and individual barriers. Key organisational barriers include an ability to support and encourage staff training, responding to diverse workforce characteristics, and developing sustainable infrastructures. These barriers are discussed further below.

### STAFF SUPPORT AND ENCOURAGEMENT

The main barrier to workforce training identified in previous surveys was funding (see Figure 7). Funding impacts on an organisation's ability to afford training, pay staff to attend, backfill positions, cover travel costs, and provide financial incentives.<sup>23</sup> To support workforce learning and development, the Ministry of Health training grants administered by the DWD support formally recognised qualifications, short-term skills development, leadership, and consumer leadership development.



**Figure 7.** Barriers to successful training of disability support workers.

Source: (Ministry of Health & University of Auckland, 2004a).

Services located in rural areas may experience greater workforce development challenges. Earlier surveys have highlighted how course attendance in rural areas can be both costly in terms of mileage and time, and often less convenient for staff given other commitments (Ministry of Health & University of Auckland, 2004d). The challenge in training rural staff has similarly been reported for non-government organisation and mental health and addiction services (Mental Health Commission, 2010; Peel, 2006).

### RESPONDING TO DIVERSE WORKFORCE CHARACTERISTICS

The characteristics and diversity of the workforce impacts on learning needs. Preliminary findings from the Health Workforce Information Programme project (2010) indicate support workers are ethnically diverse with 18 per cent being Māori, eight per cent Pacific peoples, and seven per cent identifying as Asian. Moreover, people within ethnic cultural groups differ and are not homogenous.

<sup>23</sup> The challenge in back-filling positions has similarly been reported for non-government organisation services, particularly in smaller organisations, as well as the difficulty in being able to access affordable training (Peel, 2006).

## SUSTAINABLE INFRASTRUCTURE

Resources required to provide adequate training to support workers were examined in the 2004 survey of disability support services (Ministry of Health & University of Auckland, 2004b). Services indicated a need for better access to trainers, tutors, mentors, and information on who provided training. Community residential support services also recommended pooling resources to enable the provision of generic training sessions.

## INDIVIDUAL BARRIERS

Individual barriers identified in earlier reports include workforce confidence, skills, motivation, time and resources to undertake training.

### CONFIDENCE, SKILLS AND MOTIVATION

Disability support workers may have a low level of learning confidence and require support for literacy issues. The support workforce is characterised by a low level of education, poor literacy, and difficulties with spoken and written English (Jorgensen et al., 2009). For example, in intellectual residential services about 45 per cent of the workforce have a post-school or tertiary education (Higgins et al., 2009). While this is in line with the general population, it is lower than other health services such as non-government organisations in the mental health and addiction sector (Platform, 2007). On average, services report having eight workers with difficulties in speaking English and 12 with writing (Jorgensen et al., 2009). Literacy is also a barrier in the non-government organisation sector (Peel, 2006) and among Pacific mental health workers (Suaalii-Sauni et al., 2007).

Evidence suggests many support workers are fearful of education, believe they cannot do it, and will fail (Ministry of Health & University of Auckland, 2004b). Low confidence is associated with a low level of learning motivation (Warr & Birdi, 1998). Research also indicates older people tend to have a lower level of education, training confidence, and motivation (Warr & Birdi, 1998). About one-third of disability support and care workers are aged over 50 years and are predominately female (Health Workforce New Zealand, 2010; Jorgensen et al., 2009).<sup>24</sup> The older workforce may be more anxious about learning and view their education days as over (Davies, Slack, Laker, & Philp, 1999). Disability services may therefore find it more challenging motivating some staff with low confidence and/or limited positive previous learning experiences.

### TIME AND RESOURCES

Other time commitments may discourage workers from attending courses. The disability support workforce often includes part-time employees, single parents, and those who have other employment, home, family and community obligations (Jorgensen et al., 2009). For example, preliminary results from the Health Workforce Information Programme project (2010) indicate most of the workforce is employed on a permanent part-time basis for 21 hours per week on average. Many workers may have limited time available for additional learning or need to juggle other commitments. The review of the home-based support service training initiative found support workers typically completed their course at night and during weekends once family commitments had been addressed (Health Outcomes International, 2007).

---

<sup>24</sup> The Health Workforce Information Programme preliminary results suggest the average age of support workers is 48 years and 52 years for care workers.

The greater difficulties reported by home and community support workers in taking up learning opportunities likely contributes to the lower level of training reported for this workforce (Ameratunga, 2005; Ministry of Health & University of Auckland, 2004d). Home-based workers have frequently indicated they need to juggle client appointments and time available, making it more difficult for them to attend courses (Ministry of Health & University of Auckland, 2004d).

To overcome issues with attending lengthy courses, the Social Services Committee report (2008) highlighted the need for skills-based training. The report recommended steps be taken to establish short courses given they were not widely offered and were appropriate for the sector.

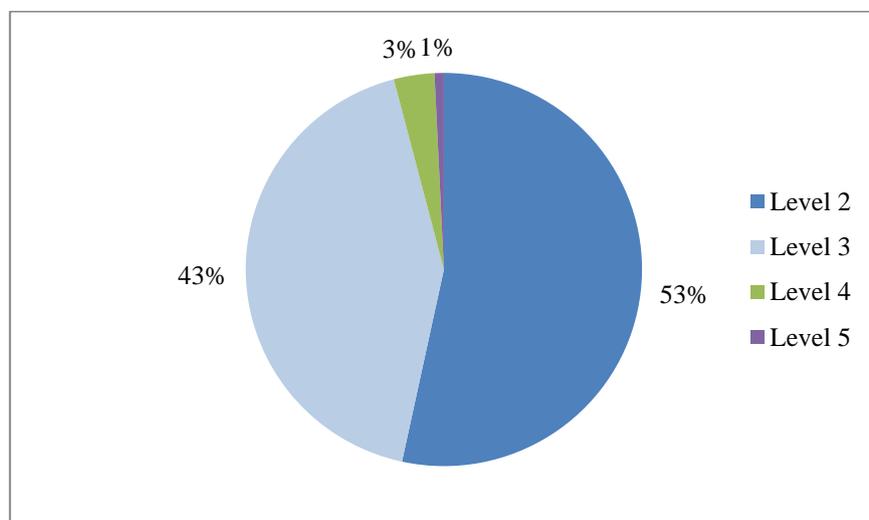
# SECTOR FEEDBACK AND GRANTS

To gain an up-to-date picture of training needs and barriers, feedback was gathered from disability support services. Anecdotal information was gathered during sector engagement by DWD regional facilitators between June and November 2010. Careerforce was also consulted, given their key role as an industry training organisation and in supporting and providing national health and disability qualifications. Applications for grants administered by DWD in 2010 were also analysed. These findings are presented below and are largely in line with previous survey findings.

## TRAINING GRANT APPLICATIONS

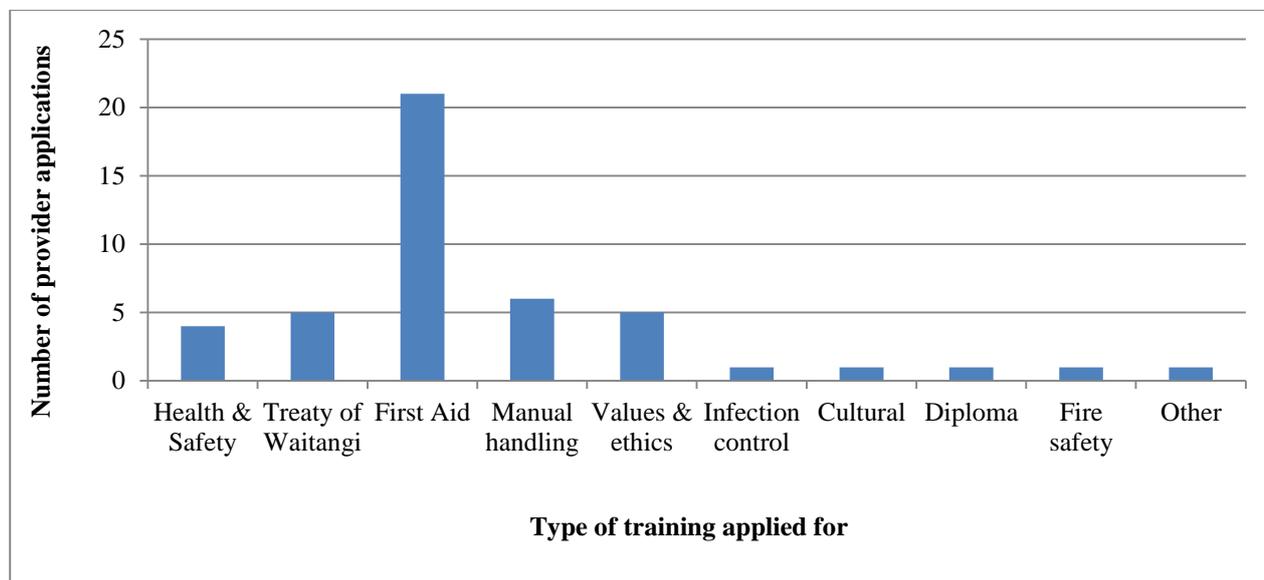
In 2010 training grants for formally recognised qualifications were available to disability support services. In addition, an open round of funding that focussed on short-term skills acquisition was offered. Applications for both grants were analysed to identify key kinds of training requested.

Grant applications were received from 65 disability services overall (including training and open round non-NZQA grant applications). Applications for formal qualifications are illustrated in Figure 8. Out of the 1842 applications received for individual workers, more than half were for level two foundational training, and 43 per cent for level three core competency training. Only a small percentage of applications received were for levels four and five training.



**Figure 8.** Training grant applications for individual workers in 2010,  $N = 1842$ .

Open round grant applications for non-NZQA courses are summarised in Figure 9. The open round grants were guided by Ministry of Health priorities and influenced applications received. On average, services applied for more than one type of course (average = 1.35).<sup>25</sup> Out of the 34 provider applications received, 21 included first aid. Other types frequently requested included manual handling, health and safety, and ethics and values. Sector feedback also reiterated the value of Ministry of Health grants for non-NZQA training, in addition to those for formal qualifications.



**Figure 9.** Open round training grant service provider applications in 2010.

*Note.* Providers could apply for more than one type of training.

<sup>25</sup> In total, 46 types of training were applied for.

## SECTOR FEEDBACK

Sector feedback gathered by DWD regional facilitators during sector engagement between June and November 2010 is summarised below. While the short time period did not allow for a comprehensive and systematic method of data collection, information reported during sector engagement is summarised and presented below. Training needs are discussed first, followed by barriers.

### DIFFERENT SERVICE SETTINGS

Sector feedback indicated a need for more training aimed at independent living as current qualifications are often more suited to community residential support services. This also includes emerging areas in the new disability model related to local area co-ordination and individualised funding.

### DISABILITY KNOWLEDGE AND AWARENESS

Feedback indicated some organisations are now starting to move into more specialised areas of disability. The need for knowledge related to particular disabilities, as well as comorbid conditions, challenging behaviour and dementia were reported, such as:

- specific disabilities, including autism spectrum disorders<sup>26</sup> and brain injury
- assistive technology
- understanding mental health issues among disabled people<sup>27 28</sup>
- behaviour support
- dementia among those working with older people.

Knowledge of dementia is an emerging need for disability support services. Many organisations are just beginning to recognise this given dementia has a younger age of onset among disabled people.<sup>29</sup>

### CONSUMER CULTURAL RESPONSIVENESS

The need for cultural training was highlighted in sector feedback in order to assist the workforce to respond effectively to consumers.

A kaupapa Māori provider also reported struggling to find relevant courses that reflect respect and incorporate tikanga or culturally appropriate models of delivery.

<sup>26</sup> Resources on autism spectrum disorder are being developed by the New Zealand Guidelines Group (<http://www.asdguideline.com>) and specialist training has been provided through the Werry Centre. See <http://www.moh.govt.nz/moh.nsf/indexmh/disability-keyprojects-asd>

<sup>27</sup> A proposed action in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) is the development of a national approach to specialist services supporting people who have co-existing disabilities (for example, a dual diagnosis of mental illness and intellectual disability) that supports both the users and providers of services to people with complex needs.

<sup>28</sup> Research suggests people with severe intellectual disabilities have an increased risk of mental illness (Bhaumik, Tyrer, McGrother, & Ganghadaran, 2008; Whitaker & Read, 2006). Common disorders among intellectual disability service users also include behaviour (20 per cent) and autistic spectrum disorders (9 per cent) (Bhaumik et al., 2008). Furthermore, challenging behaviours among people with intellectual disabilities have also been associated with psychiatric disorders, in particular affective or depressive disorders (Hemmings, Gravestock, Pickard, & Bouras, 2006).

<sup>29</sup> There is an association between disability and dementia. This partly reflects the changing age structure of the population. Among people with intellectual disabilities for example there is a higher prevalence and younger age of onset of dementia (Strydom, Hassiotis, King, & Livingston, 2009; Strydom, Livingston, King, & Hassiotis, 2007). The prevalence of dementia among older adults with intellectual disabilities is estimated to be about three times higher than those without.

## CONSUMER LEADERSHIP AND DEVELOPMENT

Feedback indicated a need for consumer self-advocacy training. Advocacy enables people to speak for themselves and has been increasingly accepted and widely available for the empowerment of disabled people in the U.K. (Chapman, 2010). Significant support may be required to aid the development of disabled people, such as people with intellectual disabilities. Sector feedback however noted that there is currently a paucity of opportunities available in this area.<sup>30 31</sup>

There is a need for more opportunities to be trained by disabled people. Leadership development will also support the greater involvement of disabled people at a governance level.

## ORGANISATIONAL BARRIERS

### *Staff support and encouragement*

Sector feedback reiterated finance as a key barrier. Where services were able to offer some paid study time, it generally did not cover all the time required, and therefore needed a personal time commitment. Rural providers may also incur additional costs associated with travel and accommodation when staff travel to attend courses.

### *Awareness and availability of learning programmes and activities*

A lack of awareness of learning programmes and activities available, and how they can be accessed, was identified as a barrier by some organisations. In addition, not all organisations used the internet to access information.

Accessing high quality courses in rural areas is often a struggle. It can be harder to find training in particular areas and/or different types of expertise. In rural areas or smaller towns, for example, finding expertise in autism spectrum disorders, and values and ethics is more difficult. The availability of assessors was also identified as a barrier, particularly in remote areas.

Training programmes and courses need to be relevant to the workforce and service delivery. However, it takes time to develop qualifications. Consequently courses often lag behind practice. For example, skills related to whānau ora practice or the new disability model incorporating local area co-ordination and individualised funding, are not yet part of qualifications. Therefore, finding programmes to develop these skills can be difficult. Furthermore, obtaining funding for this type of non-NZQA course can be a challenge. It is also difficult finding training which builds expertise in particular areas, especially for conditions which are uncommon and where there may not be a critical mass of students. Feedback also indicates a need for better access to relevant learning opportunities that are not specifically disability focused, such as working with families and younger people.<sup>32</sup> Disability services appreciate Ministry of Health training grants, but have advised they require greater flexibility to cover all their needs (such as non-NZQA grants with a broader scope).

### *Responding to diverse workforce characteristics*

Trainers need some understanding of adult learning needs and literacy issues. In addition, English may be a second language for many workers, especially in the Auckland region. Feedback from a Pacific provider also suggested that some cultural groups do not feel comfortable undertaking training with others. There

<sup>30</sup> People First is part of an international self advocacy movement led by and for people with learning/intellectual disability. See <http://www.peoplefirst.org.nz/LinkClick.aspx?fileticket=KQlpxHvQVE4%3d&tabid=55&mid=427>

<sup>31</sup> The Health and Disability Advocacy website provides information and tips on making complaints (see <http://advocacy.hdc.org.nz/self-advocacy/what-is-self-advocacy>). They have also run “speaking up” sessions for residents and staff to provide a safe environment for residents to speak up (see <http://www.hdc.org.nz/about-us/disability/events/making-it-easy-to-speak-up-national-disability-conference>)

<sup>32</sup> In 2010 a guideline was developed for supporting disabled young people and children (Child Youth and Family and the Ministry of Health., 2010). The development of an action plan focused on children and youth has been initiated by Disability Support Services. See <http://www.moh.govt.nz/moh.nsf/indexmh/disability-keyprojects-childyouthaus>

are also differences within cultural groups, such as Pacific peoples. Furthermore, sector feedback highlighted how the learning styles or preferences of different groups can vary. The classroom style of teaching, for example, may not work as well for Māori.<sup>33</sup>

### *Sustainable infrastructure*

Feedback from Careerforce highlighted the importance of developing sustainable workforce development infrastructures.<sup>34</sup> Current funding and contractual requirements may impact on an organisation's commitment to training. Where organisations are strongly focused on securing their funding, there may be a lack of medium to long-term workforce planning. An organisation may also have values that are incompatible with learning and development (such as innovation). In addition, there is currently no contractual requirement for disability support workers to attain a certain level of qualification.<sup>35</sup>

Employers also require information and support when considering workforce training. Services are often not fully aware of the type of strategies and policies they need to develop, or the resources required for successful training. Establishment of an infrastructure requires organisational commitment of both financial and human resources. Even in medium sized organisations a lot of resources are required. This can be particularly difficult for smaller organisations. Many workplaces may underestimate the level of resources required.

Infrastructure development requires access to trainers, assessors and/or verifiers to support trainees. Many organisations may not have access to formal trainers within their organisation with the requisite level of skills and knowledge. Many organisations may also experience difficulties in knowing who to contact and in accessing funds for external trainers and assessors. However, feedback indicates better outcomes are achieved in workplaces with strong infrastructures. Organisations could further explore options to work collaboratively and share resources, such as trainers and assessors, to support the development of sustainable infrastructures.

## **INDIVIDUAL BARRIERS**

### *Confidence, skills and motivation*

Sector feedback suggests the level of literacy and confidence in written work is a challenge for some staff. Many workers may have low confidence in their ability to undertake training, particularly if they have not obtained formal qualifications in the past and had a minimal level of schooling. There is also limited formal learning support currently available, such as support or study groups. In addition, some staff may not have computer access or experience.<sup>36</sup> Client records are increasingly being recorded electronically, requiring a sufficient level of computer literacy.<sup>37</sup>

Feedback from the sector indicates that it is often difficult motivating staff to undertake training, particularly older women who may have had limited learning or educational experience, as well as staff with family and other commitments, and those unlikely to receive tangible outcomes (such as a pay rise).

### *Time and resources*

While some services offer workers paid study time, a personal time commitment is often required which impacts on the ability of individual workers to undertake training.

<sup>33</sup> Among Pacific mental health workers a lack of appropriate and available mentors was identified as a training barrier (Suaalii-Sauni et al., 2007).

<sup>34</sup> A proposed action included in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) to improve the accessibility and sustainability of workforce training included ensuring suitable training infrastructure is available for smaller home and community support services (especially those for Māori, Pacific peoples, and people in rural areas).

<sup>35</sup> In contrast, there is a move in mental health and addiction towards all support workers having a level four or equivalent national certificate.

<sup>36</sup> Latest findings from (Statistics New Zealand, 2010) indicate that while 80 per cent of adults used the internet in the past 12 months, the rate is lower among older people and those with a lower level of education.

<sup>37</sup> The evaluation of the home based support service training initiative found many participants did not have sufficient confidence in their computer literacy skills or ready access to a computer (Health Outcomes International, 2007).

# SUMMARY

This section summarises training needs and barriers and suggests possible actions to improve access and overcome barriers.

## TRAINING NEEDS

Key training needs reported are summarised in Table 3. These include minimum knowledge and skills required to work in different service settings; the development of core skills through formally recognised qualifications; improved disability knowledge and awareness; cultural responsiveness to meet the needs of Māori, Pacific and consumers of other ethnic groups; and consumer leadership and development. As illustrated in Table 3, training needs in different service settings varied. Each area of training is discussed further below.

**Table 3.** *Disability Workforce Training Needs*

KEY AREAS	KEY TRAINING NEEDS	
Minimum requirements <sup>38</sup>	<ul style="list-style-type: none"> <li>• First aid</li> <li>• Lifting and handling</li> <li>• Fire safety</li> <li>• Infection control</li> </ul>	<ul style="list-style-type: none"> <li>• Informed consent</li> <li>• Health and safety</li> <li>• Values and ethics</li> <li>• Treaty of Waitangi</li> </ul>
Community residential support services	<ul style="list-style-type: none"> <li>• Emergency procedures</li> <li>• Personal care</li> <li>• Lifting and handling</li> <li>• Infection control</li> </ul>	<ul style="list-style-type: none"> <li>• Fire and safety</li> <li>• Medications</li> </ul>
Home and community support services	<ul style="list-style-type: none"> <li>• Emergency procedures</li> <li>• Personal care</li> <li>• Lifting and handling</li> <li>• Infection control</li> </ul>	<ul style="list-style-type: none"> <li>• First aid</li> <li>• Personal safety</li> <li>• Professional boundaries</li> </ul>
Formally recognised qualifications	<ul style="list-style-type: none"> <li>• National certificates and diplomas that support core skill development and knowledge required to work in specific disability areas</li> </ul>	<ul style="list-style-type: none"> <li>• Levels three to five</li> </ul>
Disability knowledge and awareness	<ul style="list-style-type: none"> <li>• Disability awareness</li> <li>• Specific disabilities, such as autism spectrum disorders and brain injury</li> <li>• Dual diagnosis disability and mental illness</li> <li>• Behaviour support</li> </ul>	<ul style="list-style-type: none"> <li>• Dementia</li> <li>• Assistive technology</li> <li>• New model of disability including local area co-ordination and individualised funding</li> <li>• Whānau ora</li> </ul>
Consumer cultural responsiveness	<ul style="list-style-type: none"> <li>• Cultural responsiveness</li> <li>• Responding to diverse ethnic groups, including Pacific peoples</li> </ul>	<ul style="list-style-type: none"> <li>• Kaupapa Māori training, that incorporates tikanga or culturally appropriate models of care</li> </ul>
Consumer development	<ul style="list-style-type: none"> <li>• Disability awareness</li> </ul>	<ul style="list-style-type: none"> <li>• Self-advocacy<sup>39</sup></li> </ul>

<sup>38</sup> Proposed revisions to foundation skills (level 2) include compulsory unit standards for demonstrating knowledge of infection control, maintaining a safe and secure environment, demonstrating knowledge of the support workers role and consumer rights. See <http://www.careerforce.org.nz/assets/files/FdnCoreSum.pdf>

<sup>39</sup> Proposed compulsory unit standards for core competencies (level 3) include recognising and describing responses to suspected abuse, applying knowledge of consumer rights, describing and supporting a self-advocacy process. See <http://www.careerforce.org.nz/assets/files/FdnCoreSum.pdf>. An advocacy qualification is also currently being developed by Careerforce. See <http://www.careerforce.org.nz/Workplace-Health-and-Disability-Training-future-qualifications.html>

## MINIMUM REQUIREMENTS

A number of key skills required by disability support workers are summarised in Table 3. Earlier surveys suggest training most frequently provided and incorporated within mandatory staff training includes first aid, lifting and handling, fire safety, infection control, informed consent, and health and safety (Ministry of Health & University of Auckland, 2004d). These learning areas were similarly reflected in non-NZQA open round grant applications, along with values and ethics, and the Treaty of Waitangi.<sup>40</sup> Some needs summarised in Table 3 are addressed by the National Certificate in Community Support Services available through Careerforce (see Table 4). However, others are not incorporated into current qualifications, such as first aid. The continued provision of grants for certificates, diplomas and non-NZQA short courses is therefore recommended.

**Table 4.** *Disability Support Services Training Needs Mapped with Level 2 and 3 Qualifications*

TRAINING NEEDS	NATIONAL CERTIFICATE IN COMMUNITY SUPPORT SERVICES (FOUNDATION SKILLS)	NATIONAL CERTIFICATE IN COMMUNITY SUPPORT SERVICES (CORE COMPETENCIES)		NATIONAL CERTIFICATE IN COMMUNITY SUPPORT SERVICES (INTELLECTUAL DISABILITY)		NATIONAL CERTIFICATE IN COMMUNITY SUPPORT SERVICES (HUMAN SERVICES)	
	LEVEL 2	LEVEL 3		LEVEL 3		LEVEL 3	
	COMPULSORY	COMPULSORY	ELECTIVE	COMPULSORY	ELECTIVE	COMPULSORY	ELECTIVE
Lifting and handling	•		•		•		
Infection control	•					•	
Health and safety	•	•					
Cultural safety		•	•		•		•
Medication	•		•		•		
Personal care			•		•		
Values and ethics		•		•		•	
Consumer rights	•	•					
Self-advocacy		•					
Challenging behaviour		•					
Disability			•	•	•	•	•
Autism spectrum disorders					•		
Intellectual disability and mental illness					•		•

## DIFFERENT SERVICE SETTINGS

The level of workforce training and types of learning required appears to differ for home and community support services, compared with community residential support services. Earlier surveys suggest home-based support workers have a lower level of training (Ministry of Health & University of Auckland, 2004a). For example, more than 55 per cent of residential support workers were reported to have a sufficient level of training compared with 40 per cent of those in home-based settings (Ministry of Health & University of Auckland, 2004a). The perceived importance of different learning areas in community home-based and residential settings also differs (Ministry of Health & University of Auckland, 2004b). For example, in community residential settings training in medications and fire and safety is perceived important, while first aid and personal safety is a key need in home and community settings (see Table 3). Furthermore, greater challenges in accessing relevant courses and programmes have been reported for home and community support services.<sup>41</sup> The prioritisation of home and community support services for non-NZQA grants may therefore be warranted.

<sup>40</sup> Although applications for open round training grants for non-NZQA training were influenced by Ministry of health priorities.

<sup>41</sup> The lower level of workforce training in home and community support settings may be attributed in part to the greater difficulties reported by workers in taking up training offered (Ameratunga, 2005; Ministry of Health & University of Auckland, 2004d). Home-based workers have frequently indicated they need to juggle client appointments and time available, making it difficult for them to attend training (Ministry of Health & University of Auckland, 2004d).

## DISABILITY KNOWLEDGE AND AWARENESS

A need for specific disability knowledge and greater disability awareness has emerged in previous surveys, sector feedback and recent consumer forums. For example, consumers have commented on the lack of disability knowledge among support workers and called for greater disability awareness (Ministry of Health & University of Auckland, 2004c). In addition, sector feedback indicated a need for skills and knowledge related to specific disabilities such as autism spectrum disorders, brain injury, and coexisting conditions (mental illness and disability). Emerging areas which are not yet part of qualifications also impact on learning needs (such as local area co-ordination and individualised funding). The identification of learning programmes and activities which help address these areas could benefit the sector.

## CONSUMER CULTURAL RESPONSIVENESS

Disabled people are ethnically diverse, especially those under the age of 65. For example, in the general population 60 per cent of disabled people are New Zealand Europeans, 19 per cent Māori, five per cent Pacific, and three per cent Asian (13 per cent other) (Statistics New Zealand, 2006). The need for increased awareness of service users' cultural needs has previously been identified (Ministry of Health & University of Auckland, 2004c; Wiley, 2009). For example, an understanding of cultural needs would reportedly make a large impact on Pacific consumers (Ministry of Health & University of Auckland, 2004c).<sup>42</sup> Sector feedback similarly indicated a need for cultural responsiveness training, and access to courses which incorporate appropriate models of service delivery (such as kaupapa Māori models of service delivery). The identification of culturally responsive and appropriate training is therefore recommended.

## CONSUMER LEADERSHIP AND DEVELOPMENT

The need for consumer leadership and development has been highlighted. A key objective in the *New Zealand Disability Strategy* (Ministry of Health, 2001) is fostering the leadership of disabled people. Disabled people are best placed to improve disability awareness and understanding of participation barriers. In addition, there is a need to develop the necessary skills, knowledge and confidence of consumers to support their participation and involvement in decision making. Advocacy training for and by consumers will empower and promote the leadership of disabled people, and contribute to better decision making, quality services, and policies. However, challenges in accessing these opportunities were noted in sector feedback due to the limited training available. Therefore the continued provision of consumer leadership development grants by the Ministry of Health is recommended, along with the identification of relevant consumer leadership development programmes and activities (such as self-advocacy) and the inclusion of disabled people in training.

---

<sup>42</sup> The Real Skills Plus Seitapu framework and the Seitapu Engaging Pasifika Training Programme have been developed to provide cultural competency training for staff across the health sector, including those working in disability (Te Pou & Le Va, 2009, 2010).

## TRAINING BARRIERS

Information on organisational and individual barriers that can hinder access and successful programme completion are summarised in Table 5.

**Table 5.** *Disability Workforce Barriers*

KEY AREAS	EXAMPLES
<i>Organisational</i>	
Staff support and encouragement	<ul style="list-style-type: none"> <li>• Funding and budgetary constraints</li> <li>• The cost and affordability of courses and programmes</li> <li>• The availability of staff and cost to back-fill positions</li> <li>• Travel expenses</li> <li>• Incentives</li> </ul>
Responding to diverse workforce characteristics	<ul style="list-style-type: none"> <li>• Literacy issues</li> <li>• Adult learning needs</li> <li>• Second time learners</li> <li>• Ethnically and culturally diverse workforce</li> <li>• Language barriers</li> <li>• English as a second language</li> <li>• Different learning styles</li> <li>• Lack of culturally relevant training</li> </ul>
Awareness of learning programmes and activities	<ul style="list-style-type: none"> <li>• Lack of awareness of learning activities and programmes available</li> <li>• No central place to find out about opportunities</li> <li>• Lack of internet access to find out about training</li> </ul>
Training availability	<ul style="list-style-type: none"> <li>• Limited access to training that is not specially disability focused</li> <li>• Availability of relevant programmes and/or expertise</li> <li>• Access to relevant learning and development activities</li> <li>• Training that builds particular areas of expertise</li> </ul>
Sustainable infrastructure <sup>43</sup>	<ul style="list-style-type: none"> <li>• Financial and HR commitment to infrastructure development</li> <li>• Current funding arrangements</li> <li>• Organisational values</li> <li>• No contractual requirements for a minimum level of workforce training</li> <li>• Underestimation of resources required for workforce training</li> <li>• Access to suitably qualified and skilled trainers, assessors and verifiers</li> <li>• Dedicated learning support (such as support and study groups)</li> </ul>
<i>Individual</i>	
Confidence, skills and motivation <sup>44</sup>	<ul style="list-style-type: none"> <li>• Lack of positive previous learning experiences (including women and older adults)</li> <li>• Literacy skills</li> <li>• Difficulties with spoken and written English</li> <li>• Fear of failure</li> <li>• Low confidence</li> <li>• Lack of computer skills</li> <li>• Lack of organisational support as a disincentive for workers</li> </ul>
Time and resources	<ul style="list-style-type: none"> <li>• Other family, employment and community commitments</li> <li>• Additional personal time required</li> <li>• Unpaid training</li> </ul>
<i>Note.</i> HR = human resources.	

<sup>43</sup> Proposed actions outlined in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) include ensuring suitable training infrastructure is available to smaller home and community support services (especially those for Māori, Pacific peoples, and people in rural areas).

<sup>44</sup> It is likely to require some increase in their general motivation to learn. Among the individual factors found to be associated with motivation, learning confidence was particularly important over an above other variables. Experience of failure or difficulty can reduce an older person's learning motivation and confidence (Warr & Birdi, 1998).

## ORGANISATIONAL BARRIERS

Organisational barriers outlined in Table 5 include:

- an ability to support and encourage staff (for example, funding and providing time off)
- awareness of learning programmes and activities available
- the availability of training (such as access to courses in local area co-ordination and individualised funding)
- responding to diverse workforce characteristics (such as literacy issues, adult learning needs, English as a second language, and preferred learning styles)
- developing sustainable infrastructures (for example, access to suitably qualified and skilled trainers and assessors, learning support, and sufficient allocation of resources).

### *Staff support and encouragement*

In 2010 DWD administered grants on behalf of the Ministry of Health to support disability workforce training. Funding remains a key barrier based on the literature review and sector feedback. Funding impacts on an organisation's ability to afford training, pay staff to attend training, backfill positions where staff are released for training, cover travel costs, and provide financial incentives for programme or course completion. The continued availability of disability workforce grants will therefore help address one of the main barriers reported.

Another related barrier was an organisation's ability to access affordable training. Sector feedback indicates that where district health boards have included disability providers in their standard training, such as infection control, this has benefitted some services. Improved access to district health board training programmes and the development of a central training directory are therefore possible solutions.<sup>45</sup>

Service providers have previously recognised the importance of financial remuneration as an incentive, especially for formally recognised qualifications (Ministry of Health & University of Auckland, 2004a). While the provision of financial incentives may aid workforce development (for example, paid study leave or pay rises) this may be challenging for many services. Other potential incentives for motivating staff identified in previous surveys include personal interest and/or client satisfaction (see Figure 10). Similarly, many support workers who took part in the home-based services training initiative indicated they did so to improve their knowledge and the way they interacted with clients (Health Outcomes International, 2007).<sup>46</sup> In addition, some disability support workers have suggested better recognition and rewards would motivate them to train (Ministry of Health & University of Auckland, 2004d).<sup>47</sup> Others have reported completing programmes or courses in the past because it was compulsory (Ministry of Health & University of Auckland, 2004d). Financial and non-financial incentives that recognise and reward learning should therefore be explored.<sup>48</sup> The continued profiling of workforce learning by Careerforce and Te Pou will help recognise training.

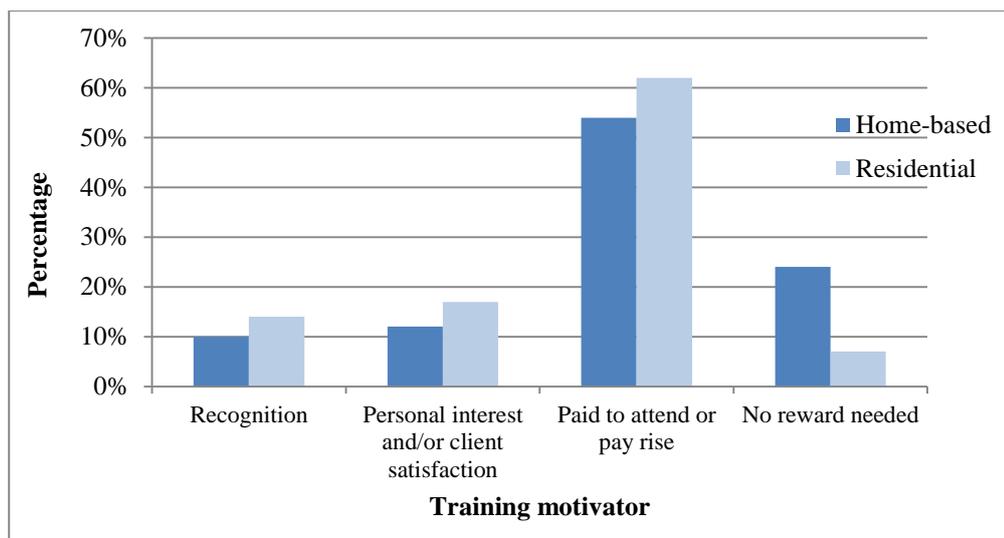
---

<sup>45</sup>A 2006 non-government organisation workforce report indicated there are limited opportunities for non-government organisation workers to participate in district health board training programmes (such as for example infection control, health and safety, restraint minimisation train the trainer) and sometimes district health board training has little relevance to non-government organisation work (Peel, 2006).

<sup>46</sup> Anticipated pay increases were a primary motivator for just over 30 per cent of participants (Health Outcomes International, 2007).

<sup>47</sup> Such as movie tickets or days off.

<sup>48</sup> The *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b) proposed actions to increase funding through provider contracts, as resources permit, to improve pay conditions with respect to equivalent health occupations and comparably sized jobs in similar sectors.



**Figure 10.** Training motivators reported by disability support workers.

Source: (Ministry of Health & University of Auckland, 2004d).

Workforce development in rural areas can be a challenge. For example, rural providers experience greater difficulties accessing training and assessors, and may incur additional expenses when staff need to travel to attend courses. While greater use of technology has been recommended in rural areas (National Disability Administrators, 2006), this requires a supporting infrastructure which is often lacking (Peel, 2006). Nevertheless, evidence suggests those services who provide on-site training perceive fewer barriers (Ministry of Health & University of Auckland, 2004a). While rural services may benefit from providing this, a special circumstances allowance is currently available for grants and may assist in paying for some travel expenses.

#### *Awareness and availability of learning programmes and activities*

The challenge in accessing high quality courses and programmes has been highlighted in earlier reports and sector feedback. It can be hard finding training in particular areas and/or different types of expertise, especially in rural areas.<sup>49</sup> This includes emerging areas related to new models such as whānau ora, local area co-ordination, and individualised funding. This highlights the potential value of a central training directory for disability support services. This is currently being explored by DWD and the Australasian Disability Professionals Association. However, thought should be given to dissemination methods as not all services use the internet to access information. In addition, the incorporation of broader and more specific areas relevant to disability should be considered within the scope of non-NZQA grants.

#### *Responding to diverse workforce characteristics*

Training needs to reflect and take into account the culture of organisations and the diverse characteristics of the workforce. To improve the accessibility of learning and development opportunities to individual workers, a number of factors need to be considered. These include literacy issues, adult learning needs, potential language barriers, learning and teaching styles, the provision of culturally appropriate training and mentoring. Fono feedback, for example, indicated the provision of programmes by Pacific educators may make it more accessible to Pacific peoples (Ministry of Health & University of Auckland, 2004c). Sector feedback has also recognised that the learning styles or preferences of different groups can vary. To increase the effectiveness of training, workforce characteristics and diversity should be considered.

<sup>49</sup> Such as autism spectrum disorders.

### *Sustainable infrastructure*

Building a skilled workforce to support disabled people requires organisational commitment, the development of a supporting infrastructure, and good leadership. Establishing an infrastructure requires commitment of both financial and human resources. Sector feedback indicates this can be particularly challenging for smaller organisations. Many organisations may experience difficulties accessing external trainers and assessors, and funding for this. To support employers in developing their learning and assessment capacity, funding was recently made available through the Careerforce Training Innovation Trust. Resources and support, including a training and completion plan guide, are also available on Careerforce's website.<sup>50 51</sup> Other suggested actions for improving workforce infrastructures include formal learning support, supporting disability support services to network and link with each other, and building local hubs to enable the sharing of resources. This may be particularly useful where established networks exist.

Leadership is critical for the implementation of workforce development strategies and plans (National Disability Administrators, 2006). Building leadership capacity is similarly recognised in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b). Support and encouragement of the workforce is required to utilise knowledge and practice new skills in service settings. Continued provision and administration of leadership grants by DWD will contribute to disability support workforce development, particularly when focused on workforce development. The Ministry of Health's funding and contractual requirements may further be used to support organisational commitment to workforce training.

Career pathways can support the identification of relevant training that can contribute to developing the workforces' potential. A Career Framework has been developed for the health workforce that covers both the clinical and non-clinical workforces and identifies career pathways for different occupations (Ashton, 2008; Ministry of Health & District Health Boards New Zealand Workforce Group, 2007). The framework aims to support career advancement and the development of transferable and generic skills in the health and disability sector. The Disability Services Consumer Consortium has endorsed this framework for the disability support workforce (Social Services Committee, 2008). There is, however, a difference of opinion in the disability sector on the direction of the disability pathway. That is, whether or not the disability pathway should be closely linked to that of the health pathway. Further discussion on the career framework is required.

---

<sup>50</sup> For supports and resources available through Careerforce see <http://www.careerforce.org.nz/Workplace-Health-and-Disability-Training-educator-supports.html>. A training and completion plan guide has also been developed to support workplaces in monitoring employee progress and is available here [http://www.careerforce.org.nz/assets/files/Training%20and%20Completion%20Plan%20Guide\(1\).pdf](http://www.careerforce.org.nz/assets/files/Training%20and%20Completion%20Plan%20Guide(1).pdf)

<sup>51</sup> <http://www.careerforce.org.nz/Workplace-Health-and-Disability-Training-innovation.html>

## INDIVIDUAL BARRIERS

Individual barriers summarised in Table 5 include:

- confidence, skills and motivation (for example, literacy issues and previous learning experiences)
- time and resources (for example, computer access and other commitments).

### *Confidence, skills and motivation*

Some support staff may be less motivated to learn given their level of confidence and literacy. Many services also report having staff with difficulties in written and spoken English. In addition, women and older people may be more anxious about learning. To support and encourage future learning, creating a sense of achievement is important (Ministry of Health & University of Auckland, 2004b). Greater formal support for learning, such as study groups could be provided. Training methods which take into account literacy issues, provide literacy support, and use more direct teaching methods have also been recommended (Ministry of Health & University of Auckland, 2004d; Peel, 2006; Suaalii-Sauni et al., 2007). Sector feedback suggests that where services have identified these issues and engaged a literacy support programme, there tends to be positive outcomes, particularly when group learning is part of the programme. Careerforce's Integrated Workplace Learning Project (IWLP) helps address literacy issues to support trainees with learning challenges they may face.<sup>52</sup> <sup>53</sup> The sharing and promotion of successful learning stories and workforce development initiatives may also benefit the sector. Profiled on DWD's website are some examples of successful workforce training stories.<sup>54</sup>

### *Time and resources*

Learning programme and course attendance often requires a personal time commitment by staff. However, many workers may have other home and community obligations. Recommended strategies for supporting workforce learning and development have included providing paid time off, flexible training times, and arranging suitable childcare (Ministry of Health & University of Auckland, 2004d). Other support workers have indicated the ability to reduce their hours worked to attend courses would be useful (Ministry of Health & University of Auckland, 2004d). Sector feedback has also suggested the provision and funding for short courses that support skill acquisition would be valuable, due to the irregular hours worked by staff. Similarly, the Social Services Committee report (2008) highlighted the need for skills-based training to overcome issues with attending lengthy courses. The continued funding of non-NZQA short courses and identification of relevant programmes is therefore recommended.

---

<sup>52</sup> The Integrated Workplace Learning Project (IWLP) by Careerforce supports health and disability workplaces to overcome some of the learning challenges their trainees may face. This includes developing a workplace training plan, establishing training teams, providing professional development, developing strategies to overcome literacy, language, numeracy and learning barriers, providing sample lesson plans, utilising national literacy assessment tool, and linking workplace resources with learning. See [http://careerforce.org.nz/assets/files/IWLP\(1\).pdf](http://careerforce.org.nz/assets/files/IWLP(1).pdf)

<sup>53</sup> Careerforce is anticipating making literacy pre-screening available for level two and three qualifications.

<sup>54</sup> See <http://www.disabilityworkforce.co.nz/page/74-grant-funding+success-stories>. Some training success stories are also published by Careerforce see <http://www.careerforce.org.nz/Workplace-Health-and-Disability-Training-workplace-success-stories.html>

## CONCLUSION

This report summarises disability support workforce training needs and barriers.

Disability support workforce training needs include:

- short courses to develop minimum knowledge and skills (such as first aid, fire safety, emergency procedures) required in different service settings (such as home and community support services)
- formally recognised qualifications to develop core generic skills and those for specialist areas
- improved disability knowledge and awareness (such as autism spectrum disorders, comorbid conditions<sup>55</sup>, behaviour support and dementia)
- cultural responsiveness to meet the needs of Māori, Pacific and consumers of other ethnic groups
- consumer leadership and development (such as self-advocacy).

Organisational training barriers include:

- an ability to support and encourage staff (for example, funding and providing time off)
- responding to diverse workforce characteristics (such as literacy issues, adult learning needs, English as a second language, and preferred learning styles)
- awareness of learning programmes and activities available
- the availability of relevant courses and programmes (such as access to training in local area co-ordination and individualised funding)
- developing a sustainable infrastructure (for example, accessing suitably qualified and skilled trainers and assessors, dedicated learning support, and sufficient allocation of resources).

Individual barriers include:

- confidence, skills and motivation (for example, literacy issues and previous learning experiences)
- time and resources (such as computer access and other commitments).

## STRENGTHS AND LIMITATIONS

A number of factors should be taken into account when interpreting these findings. Not all disability learning and development needs will be captured by this report. The most recent comprehensive survey of training needs for disability support workers was carried out in 2004. This included long-term disability and aged care providers and may not fully reflect disability support workforce needs. Nevertheless, a survey is currently underway by the New Zealand Disability Support Network which may address some current gaps. However, information is still required for specific population groups including Māori, Pacific and rural populations. In addition, information about the training needs of health professionals in specialist disability services needs to be captured.<sup>56</sup>

Sector feedback contained in this report is primarily based on the perspectives of disability support services. Information was gathered during sector engagement by regional facilitators between June and November 2010. A longer time frame would have permitted a more comprehensive and systematic method of data collection. Furthermore, the views of the disability support workforce, consumers and their family/whānau were not specifically captured. Future work would benefit from gathering these perspectives.

---

<sup>55</sup> Such as mental illness among disabled people.

<sup>56</sup> Some information was captured for health professionals in the *Disability Workforce Analysis Report* (Ministry of Health, 2003). Information is also not captured in this report about the needs of health professionals providing services disabled people within the general population.

Despite limitations, this report summarises training needs and barriers for the disability support workforce. Some practical strategies for improving access and overcoming barriers have been identified. However, sector consultation is required to identify priority areas and preferred actions.

## RECOMMENDATIONS

### *Ministry of Health grant funding*

1. Continued for formally recognised qualifications and non-NZQA short courses.
2. Continued for leadership development with a key focus on workforce development.
3. Continued for consumer leadership development.
4. Future targeting of home and community support services for non-NZQA grants.
5. Opportunities for expanding grant criteria explored by DWD with the Ministry of Health.

### *Workforce development infrastructure*

6. A central disability training directory developed collaboratively by DWD.
7. Incentives explored and successful initiatives shared with the sector by DWD and Careerforce.
8. Services supported to network and share resources by DWD and Careerforce.

### *Training delivery*

9. Disabled people included in relevant programmes and courses.
10. Programmes and courses reflect the diverse characteristics of the workforce.

### *Sector feedback*

11. Making this report available on the DWD website to gain feedback, including:
  - a. what training needs or barriers are not captured by this report?
  - b. which potential solutions offer the greatest benefit and should be prioritised?
  - c. what additional strategies would support future workforce training?

# APPENDIX A: BIBLIOGRAPHY

This bibliography contains New Zealand workforce surveys and reports relevant to disability support workforce training published since 2000.

- *2010 Health Workforce New Zealand Report* (Health Workforce Information Programme, 2010)  
Work is currently being completed by Health Workforce New Zealand scoping workforce issues for the aged-care and disability sectors.<sup>57</sup> This project aims to provide better information for training programmes to meet the needs of disabled people. Areas examined included disability workforce headcount, age, gender, length of service, and ethnicity. Preliminary results suggest support and care workers represent approximately 88 per cent of the workforce providing care and/or support services to disabled people.
- *2009 Consumer Forums* (Ministry of Health, 2009a)  
In 2009 the Disability Support Services Group within the Ministry of Health held consumer forums around New Zealand to provide disabled people, their families, whānau, aiga and carers an opportunity to say what supports and services were working for them, what is not working, and what could be done to change this. Over 550 people attended the forums, fono and hui.
- *2009 Outcome Evaluation of Objective 11 of the New Zealand Disability Strategy* (Wiley, 2009)  
In 2009 interviews were carried out with policy makers, service providers, and Māori consumers and caregivers. This work evaluated the extent to which participation of Māori people with disabilities had been promoted and achieved.
- *2009 Improving Workforce Development and Organisational Performance* (Ryan, 2009)  
In 2009 Careerforce undertook work examining the benefits of embedding workplace training in the health and disability sector. Key areas examined included organisational supports required to adopt the model and obstacles experienced.
- *2009 Up Where We Belong* (Public Service Association and the Service and Food Workers Union, 2009)  
In 2009 a report was completed by the Public Service Association and the Service and Food Workers Union on raising the status of disability support work.
- *2008 Residential Intellectual Disability Services Workforce Survey* (Higgins et al., 2009)  
A recent survey of residential intellectual disability services was carried out by the Donald Beasley Institute (Higgins et al., 2009). In total, 1267 intellectual residential support staff from nine agencies took part in the survey.<sup>58</sup> The survey provides information on workforce characteristics, training, qualifications, work history, role understanding, experiences of abuse, and job satisfaction.
- *2008 A Health Workforce Career Framework* (Ashton, 2008)  
A career framework was outlined for the health and disability sector. The framework aims to support identification of career pathways for both clinical and non-clinical workforces.

---

<sup>57</sup> Ensuring the collection of data that enables trend analysis and forecasting that can be used by Disability Support Services to inform key planning and funding decisions is also an action in the *Disability Support Services Workforce Action Plan* (Ministry of Health, 2009b).

<sup>58</sup> Approximately 21 per cent of the intellectual disability residential workforce took part in the survey.

- *2008 Social Services Committee Inquiry into the Quality of Care and Service Provision for People with Disabilities* (Social Services Committee, 2008)  
In 2008 an inquiry was carried out in response to concerns about the quality of services, training and availability of staff for disabled people. The report made recommendations related, but not limited to, models of service delivery that allow more choice for disabled people, workforce training, pay conditions, and service evaluations.
- *2007 NgOIT Workforce Survey* (Platform, 2007)  
In 2007 a workforce survey of non-government organisations providing mental health and addiction support was carried out. In total, 1833 people took part, of which over half were support workers.
- *2006 Health and Disability Sector NGO Workforce Development* (Peel, 2006)  
A report by the non-government organisation working group in 2006 examined workforce development issues for the non-government organisation health and disability sector, including disability services. Factors which could support workforce training were included.
- *2005 Auckland Pacific Disability Research Report* (Pacific Information Advocacy and Support Services (PIASS) Trust, 2005)  
In 2005 Pacific consumers, their families and aiga were interviewed as part of the Auckland Disability Research Project. The study also involved interviews with ten service providers in the Auckland region. Key themes discussed in the report include cultural competency, training, and workforce development.
- *2004 Disability Support Services Workforce Survey* (Ministry of Health & University of Auckland, 2004a, 2004b, 2004c, 2004d)  
As part of the Quality and Safety Project, surveys of the disability support workforce were undertaken in 2003/04 by the Ministry of Health and University of Auckland. The project gathered information from the disability support workforce, providers and consumers. About one-third of survey participants worked in long-term disability and two-thirds in aged-care services. As part of the project hui were carried out with Māori support workers and fono with Pacific support workers. Information about training was captured from service providers, the workforce and consumers.<sup>59</sup>
- *2003 Disability Workforce Analysis Report* (Ministry of Health, 2003)  
In 2003 a review was carried out for the Clinical Training Agency by the Ministry of Health, which looked at workforce characteristics and training issues for the specialist and non-regulated disability workforce.
- *2001 The New Zealand Health Workforce Reports* (Health Workforce Advisory Committee, 2002, 2003)  
This 2001 report provides a snapshot of the New Zealand health workforce, including the disability workforce. The report estimated there were 30,000 informal and funded support workers, reflecting about 85 per cent of the disability workforce.

---

<sup>59</sup> In total, 420 home-based and residential care providers took part (51 home-based; 232 residential care; 119 both and 114 not specified) and specific training needs were investigated in a sub-group of providers ( $n = 107$ ). Focus groups and interviews were also carried out with 36 providers to further explore issues and gain a more in-depth understanding of training needs.

# APPENDIX B: CAREERFORCE NATIONAL TRAINING

**Table 6.** *Careerforce Health and Disability Nationally Recognised Training*

LEVEL	QUALIFICATION	DESCRIPTION
2	Foundational skills	Designed as an entry-level qualification to recognise the knowledge and skills required of support workers during their induction into work in a health and disability setting.
3	Core competencies	The National Certificate in Community Support (core competencies) is designed to recognise the industry generic knowledge and skills required of support workers working in a health and disability setting.
	Human services	The National Certificate in Community Support Services (Human Services) is designed to recognise the knowledge and skills required of support workers in the delivery of human support services
	Intellectual disability	The National Certificate in Community Support Services (Intellectual Disability) is designed to recognise the knowledge and skills required in the delivery of disability support services
	Vision and hearing screening	The National Certificate in Community Support Services (Vision and Hearing Screening) qualification is designed for employees who conduct vision and hearing screening tests with children.
4	Disability information provision	The National Certificate in Community Support Services (Disability Information Provision) is designed for people already working in the health and disability sector as Disability Information Consultants or equivalent, and/or those wishing to pursue a career within the sector.
	Residential Limited Credit Programme	This group of standards for the Limited Credit Programme (LCP) supports caregivers entering the dementia residential field and represents the essential knowledge and skills for working with residents affected by dementia.
	Diversional therapy	The National Certificate in Diversional Therapy (Level 4) is designed for people working as diversional therapists (also known as activities officers) in community, residential home, or hospital setting.
5	Disability support assessment, planning & co-ordination	The National Certificate in Disability Support, Planning and Co-ordination (Level 5) is intended for people who are new to, or are working in needs assessment and service co-ordination, case management, or similar roles. On completion of this qualification, people will be equipped to work in a supervised capacity.
	Hearing Therapy	The National Diploma in Hearing Therapy is designed for people who wish to work in the field of adult aural rehabilitation.
	Human Services	The National Diploma in Human Services (Level 5) provides recognition of the level of competence, knowledge, values and skills required by those working with people with disability
	Epilepsy care	This qualification is designed for people who specialise in providing support for people with epilepsy.
	Guide Dog Training (Trainer)	People who have been awarded the National Diploma in Guide Dog Training (Trainer) (Level 5) are able to develop training programmes, assess, and train guide dogs to international standards for use within New Zealand and overseas, to provide information to the media and interest groups.
6	Epilepsy care	The National Diploma in Community Support (Epilepsy Care) (Level 6) is designed for people who specialise in providing support for people with epilepsy.
7	Guide Dog Training (Instructor)	Holders of the National Diploma in Guide Dog Training (Instructor) are able to work as a member of a team to assess vision impaired people for suitability with Guide Dogs, match and instruct those people with qualified Guide Dogs, train those people to manage the qualified Guide Dogs to national and international standards, and provide information to interest groups.

In 2009 Careerforce reviewed the Foundation Skills and Core Competencies qualifications to ensure they met the needs of the health and disability sector. It was proposed the Foundation Skills qualification comprise of four compulsory unit standards including infection control, maintaining a safe and secure environment, demonstrating knowledge of the role of a support worker, and consumer's rights. It was also recommended that elective standards be included in the revised qualification.

Some proposed revisions to the Core Competencies qualification have been proposed. It was recommended this qualification contain three compulsory unit standards including recognising indicators and describing responses to suspected abuse, consumer's rights, and describing self-advocacy. Additional compulsory units focus on knowledge of culture or culturally safe operating principles. For further details see <http://www.careerforce.org.nz/assets/files/FdnCoreSum.pdf>.

Summarised in Table 7 are qualifications currently being developed by Careerforce.

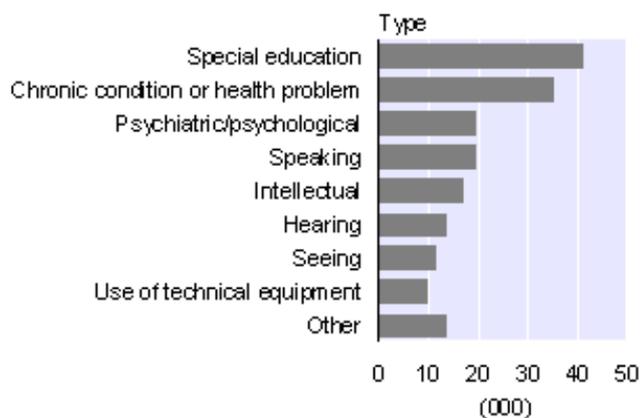
**Table 7.** *Careerforce Qualifications Currently Being Developed*

LEVEL	QUALIFICATION	DESCRIPTION
4	Brain injury support	This proposed qualification is designed to recognise the knowledge and skills required of residential or community based support workers who provide support to people after brain injury.
4/5	Senior support and team management	Development of these new qualifications resulted from sector requests for more tangible career pathways. Sector panels, originally from the Aged Care, Disability, and Home and Community Sectors, worked with Careerforce to develop the core competencies required of supervisors and team leaders. The competencies have been converted into draft unit standards and qualifications, which recent e-Consults have supported.
5	Advocacy	Aimed at advocates working under contract to the Health and Disability Commissioner's Office, as well as managers of consumer advocacy groups.

*Note.* See <http://www.careerforce.org.nz/Workplace-Health-and-Disability-Training-future-qualifications.html>

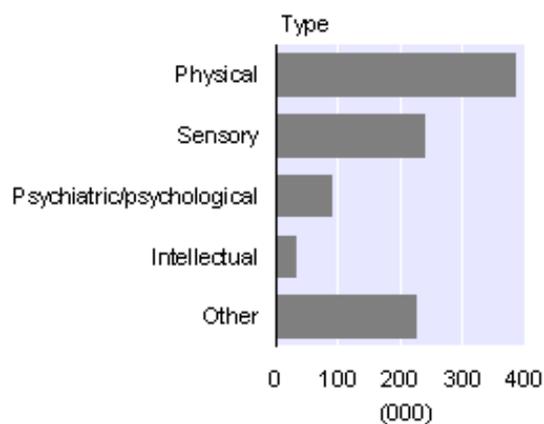
# APPENDIX C: GENERAL POPULATION DISABILITY

The 2006 Disability Survey (Statistics New Zealand, 2007) examined the prevalence of disability in the general population. Findings for children and adults are presented below in Figures 11 and 12 respectively.



**Figure 11.** Type of disability among children aged 0-14 years in 2006.

*Note.* Children could have more than one disorder. Source: (Statistics New Zealand, 2007).



**Figure 12.** Type of disability among adults aged 15 years and over in 2006.

*Note.* Adults could have more than one disorder. Source: (Statistics New Zealand, 2007).

Findings from the 2006 Disability Survey differ from the primary impairments identified among consumers (see Literature Review). This reflects in part:

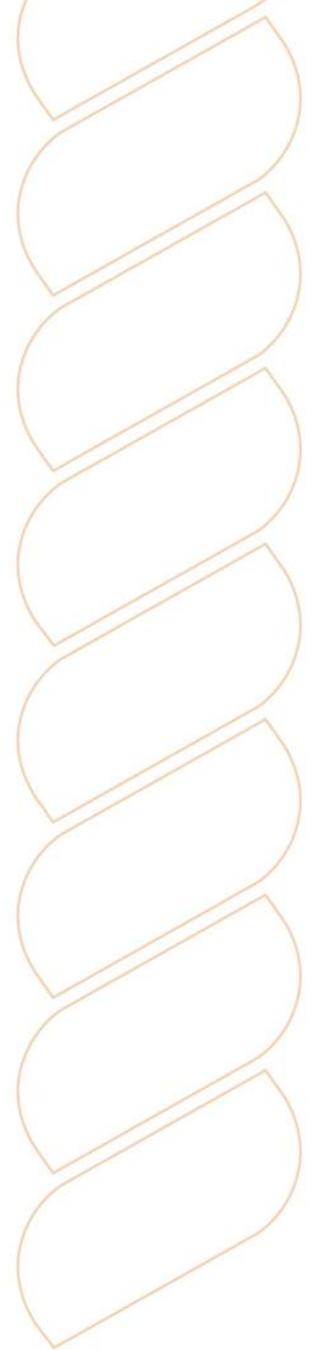
- the population groups examined (people living in the community compared with service users)
- the method used to assess impairments (all types of disability compared with a primary impairment)
- data source (self-reported disability compared with NASC assessments).

# REFERENCES

- Aguinis, H., & Kraiger, K. (2009). Benefits of training and development for individuals and teams, organizations, and society. *Annual Review of Psychology*, *60*, 451-474. Abstract retrieved from <http://www.annualreviews.org/doi/abs/410.1146/annurev.psych.1160.110707.163505?journalCode=psych>.
- Ameratunga, S. (2005). Disability counts - or does it? *Injury Prevention*, *11*(3), 129-130. Abstract retrieved from <http://injuryprevention.bmj.com/content/111/123/129.extract>.
- Ashton, T. (2008). *A health workforce career framework*. Auckland: CHSRP. Retrieved from <http://www.hpm.org/survey/nz/a11/4>
- Balcazar, F. E., Seekins, T., Fawcett, S. B., & Hopkins, B. L. (1990). Empowering people with physical disabilities through advocacy skills training. *American Journal of Community Psychology*, *18*(2), 281-296.
- Bhaumik, S., Tyrer, F. C., McGrother, C., & Ganghadaran, S. K. (2008). Psychiatric service use and psychiatric disorders in adults with intellectual disability. *Journal of Intellectual Disability Research*, *52*(11), 986-995. Abstract retrieved from [http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?\\_nfpb=true&\\_ERICExtSearch\\_SearchValue\\_980=EJ814218&ERICExtSearch\\_SearchType\\_814210=no&accno=EJ814218](http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_ERICExtSearch_SearchValue_980=EJ814218&ERICExtSearch_SearchType_814210=no&accno=EJ814218).
- Careerforce. (n.d.). *Summary of results for proposed revisions to foundation skills (level 2) and core competencies (level 3)*. Retrieved from <http://www.careerforce.org.nz/assets/files/FdnCoreSum.pdf>.
- Cavet, J., & Sloper, P. (2004). Participation of disabled children in individual decisions about their lives and in public decisions about service development. *Children & Society*, *18*(4), 278-290. Abstract retrieved from <http://onlinelibrary.wiley.com/doi/210.1002/chi.1803/abstract>.
- Chapman, M. (2010). Seeking and establishing the views of disabled children and young people: A literature review. *Social Work Now*, November 2010, 9-18. Retrieved from <http://www.practicecentre.cyf.govt.nz/whats-new/social-work-now/news/index.html>.
- Child Youth and Family and the Ministry of Health. (2010). *Roles and Responsibilities for Supporting Children and Young People with Disabilities under the Children, Young Persons, and Their Families Act 1989*. Wellington: Ministry of Health. Retrieved from [http://www.moh.govt.nz/moh.nsf/pagesmh/9078/\\$File/roles-child-youth-disability-mar10.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/9078/$File/roles-child-youth-disability-mar10.pdf).
- Coney, S. (2004). *Effective consumer voice and participation for New Zealand: A systematic review of the evidence*. Wellington: New Zealand Guidelines Group. Retrieved from [http://www.nzgg.org.nz/guidelines/0086/050511\\_Consumer\\_Report.pdf](http://www.nzgg.org.nz/guidelines/0086/050511_Consumer_Report.pdf).
- Davies, S., Slack, R., Laker, S., & Philp, I. (1999). The educational preparation of staff in nursing homes: Relationship with resident autonomy. *Journal of Advanced Nursing*, *29*(1), 208-217. Abstract retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10064301>.
- Disability Rights Promotion International. (2010). *Disability Rights in Aotearoa New Zealand 2010*: Disability Rights Promotion International. Retrieved from [http://www.hrc.co.nz/hrc\\_new/hrc/cms/files/documents/08-Dec-2010\\_13-17-27\\_DisabilityRightsinNZ2010.pdf](http://www.hrc.co.nz/hrc_new/hrc/cms/files/documents/08-Dec-2010_13-17-27_DisabilityRightsinNZ2010.pdf).
- Franklin, A., & Sloper, P. (2006). Participation of disabled children and young people in decision making within social services departments: A survey of current and recent activities in England. *British Journal of Social Work*, *36*(5), 723-741. Retrieved from <http://bjsw.oxfordjournals.org/content/736/725/723.full.pdf+html>.
- Health Outcomes International. (2007). *Evaluation of the home based support service (HBSS) training initiative*. St Peters South Australia: Health Outcomes International. Retrieved from <http://www.moh.govt.nz/moh.nsf/indexmh/evaluation-of-hbss-training-initiative>.
- Health Workforce Advisory Committee. (2002). *The New Zealand Health Workforce: A Stocktake of Issues and Capacity 2001*. Wellington: Ministry of Health.
- Health Workforce Advisory Committee. (2003). *The New Zealand Health Workforce: Framing Future Directions - Analysis of Submissions and Draft Recommendations to the Minister of Health*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz/moh.nsf/pagesmh/5754?Open>.

- Health Workforce Information Programme. (2010). *Disability Workforce Information Project*. Wellington: Health Workforce Information Programme.
- Health Workforce New Zealand. (2010). *Annual Plan: 2010-2011*. Wellington: Ministry of Health. Retrieved from <http://www.nzdoctor.co.nz/media/186724/annual-plan-2010-2011.pdf>.
- Hemmings, C. P., Gravestock, S., Pickard, M., & Bouras, N. (2006). Psychiatric symptoms and problem behaviours in people with intellectual disabilities. *Journal of Intellectual Disability Research*, 50(4), 269-276. Abstract retrieved from [http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?\\_nfpb=true&\\_ERICExtSearch\\_SearchValue\\_260=EJ732953&ERICExtSearch\\_SearchType\\_732950=no&accno=EJ732953](http://www.eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_ERICExtSearch_SearchValue_260=EJ732953&ERICExtSearch_SearchType_732950=no&accno=EJ732953).
- Higgins, N., Evans-Turner, T., Milner, P., Mirfin-Veitch, B., Gates, S., & Collins, A. (2009). *Working in residential intellectual disability services, what is it like? Combined agency data*. Dunedin: Donald Beasley Institute. Retrieved from [http://www.donaldbeasley.org.nz/research\\_prj4.htm](http://www.donaldbeasley.org.nz/research_prj4.htm).
- Jorgensen, D., Parsons, M., Reid, M. G., Weidenbohm, K., Parsons, J., & Jacobs, S. (2009). The providers' profile of the disability support workforce in New Zealand. *Health & Social Care in the Community*, 17(4), 396-405. Abstract retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/19220491>.
- Mental Health Commission. (2010). *Future Workforce Development Needs*. Wellington: Mental Health Commission. Retrieved from <http://www.mhc.govt.nz>.
- Ministry of Health. (2001). *New Zealand Disability Strategy*. Wellington: Ministry of Health. Retrieved from <http://www.odi.govt.nz/nzds/>
- Ministry of Health. (2003). *Disability workforce analysis report*. Wellington: Ministry of Health. Retrieved from <http://www.moh.govt.nz/moh.nsf/pagesmh/2374>.
- Ministry of Health. (2009a). *Consumer Forums 2009: Summary report*. Wellington: Ministry of Health. Retrieved from [http://www.moh.govt.nz/moh.nsf/pagesmh/5244/\\$File/forums-summary-09+Final.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/5244/$File/forums-summary-09+Final.pdf).
- Ministry of Health. (2009b). *Disability Support Services Workforce Action Plan*. Wellington: Ministry of Health.
- Ministry of Health. (2010). *Disability Support Services: Introducing the New Model for supporting disabled people*. Wellington: Ministry of Health. Retrieved from [http://www.moh.govt.nz/moh.nsf/pagesmh/10082/\\$File/new-model-presentation-17dec.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/10082/$File/new-model-presentation-17dec.pdf).
- Ministry of Health & District Health Boards New Zealand Workforce Group. (2007). *A Career Framework for the Health Workforce in New Zealand*. Wellington: Ministry of Health & DHBNZ. Retrieved from <http://www.dhbnz.org.nz/Site/Current-Issues/Career-Framework-for-HW-in-NZ.aspx>
- Ministry of Health & University of Auckland. (2004a). *Disability support services in New Zealand: Part I, service provider survey*. Auckland: University of Auckland. Retrieved from <http://www.moh.govt.nz/moh.nsf/pagesmh/3696>.
- Ministry of Health & University of Auckland. (2004b). *Disability support services in New Zealand: Part II, provider survey*. Auckland: University of Auckland. Retrieved from <http://www.moh.govt.nz/moh.nsf/pagesmh/3696>.
- Ministry of Health & University of Auckland. (2004c). *Disability support services in New Zealand: The service user survey*. Auckland: University of Auckland. Retrieved from [http://www.moh.govt.nz/moh.nsf/0/69A15ED7BE0F32FCCC256F6C000836FC/\\$File/serviceusersurvey.pdf](http://www.moh.govt.nz/moh.nsf/0/69A15ED7BE0F32FCCC256F6C000836FC/$File/serviceusersurvey.pdf).
- Ministry of Health & University of Auckland. (2004d). *Disability support services in New Zealand: The workforce survey - final report*. Auckland: University of Auckland. Retrieved from <http://www.moh.govt.nz/moh.nsf/pagesmh/3696>.
- National Disability Administrators. (2006). *Investigation into disability workforce capacity issues: Research report*. Australia: National Disability Administrators. Retrieved from <http://www.nda.gov.au/cproot/504/1830/DisabilityWorkforceCapacityResearchReport.pdf>.
- Office for Disability Issues. (2008). *New Zealand Disability Strategy Implementation Review 2001-2007*. Wellington: Litmus. Retrieved from <http://www.odi.govt.nz>.
- Pacific Information Advocacy and Support Services (PIASS) Trust. (2005). *The Auckland Pacific Disability Research Report*. Auckland.

- Peel, K. (2006). *Health and Disability Sector NGO Workforce Development*. Wellington: Health by Design. Retrieved from [http://www.ngo.health.govt.nz/moh.nsf/pagescm/7523/\\$File/ngo-workforce-development-160606.pdf](http://www.ngo.health.govt.nz/moh.nsf/pagescm/7523/$File/ngo-workforce-development-160606.pdf).
- Platform. (2007). *Ngait 2007 Workforce Survey*. Wellington Platform. Retrieved from <http://www.platform.org.nz/file/Documents/NgOIT-2007-wout-b-ground.pdf>.
- Public Service Association and the Service and Food Workers Union. (2009). *Up where we belong: Raising the status of disability support work*. Wellington: PSA & SFWU. Retrieved from [http://www.psa.org.nz/Libraries/Health\\_pics\\_and\\_docs/Up\\_Where\\_We\\_Belong\\_Resource\\_Aug09.sflb.ashx](http://www.psa.org.nz/Libraries/Health_pics_and_docs/Up_Where_We_Belong_Resource_Aug09.sflb.ashx).
- Ryan, R. (2009). *Improving Workforce Development and Organisational Performance - Benefits gained by embedding workplace based training in the New Zealand health and disability sector*. Wellington: Heathrose Research. Retrieved from <http://www.careerforce.org.nz/assets/files/Summary%20of%20research.pdf>.
- Saucier, P. (2002). *Promoting a national vision for people with disabilities*. Wellington: Ministry of Health. Retrieved from [http://www.moh.govt.nz/moh.nsf/pagesmh/6127/\\$File/paul-saucier.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/6127/$File/paul-saucier.pdf).
- Social Services Committee. (2008). *Inquiry into the quality of care and service provision for people with disabilities*. Wellington: Social Services Committee. Retrieved from [http://www.parliament.nz/NR/rdonlyres/06259D2F-780B-40A0-9170-005C8C046E72/93089/DBSCH\\_SCR\\_4194\\_6219.pdf](http://www.parliament.nz/NR/rdonlyres/06259D2F-780B-40A0-9170-005C8C046E72/93089/DBSCH_SCR_4194_6219.pdf).
- Stace, H. (2010). Social justice, the social model and disability policy in Aotearoa New Zealand. *Social Work Now, November 2010*, 19-24. Retrieved from <http://www.practicecentre.cyf.govt.nz/whats-new/social-work-now/news/index.html>.
- Standards New Zealand. (2008). *Health and Disability Services (General) Standard: 8134.0:2008*. Wellington: Standards NZ. Retrieved from [http://www.moh.govt.nz/moh.nsf/pagesmh/8656/\\$File/81340-2008-nzs-readonly.pdf](http://www.moh.govt.nz/moh.nsf/pagesmh/8656/$File/81340-2008-nzs-readonly.pdf).
- Statistics New Zealand. (2006). *2006 Disability Survey. Ethnic diversity of people with disabilities aged 65 and over in New Zealand*. Wellington.
- Statistics New Zealand. (2007). *2006 Disability Survey*. Wellington: Statistics New Zealand. Retrieved from [http://www.stats.govt.nz/browse\\_for\\_stats/health/disabilities/DisabilitySurvey2006\\_HOTP06/Commentary.aspx](http://www.stats.govt.nz/browse_for_stats/health/disabilities/DisabilitySurvey2006_HOTP06/Commentary.aspx).
- Statistics New Zealand. (2010). *Household use of information and communication technology: 2009*. Wellington: Statistics NZ. Retrieved from <http://www.stats.govt.nz>.
- Strydom, A., Hassiotis, A., King, M., & Livingston, G. (2009). The relationship of dementia prevalence in older adults with intellectual disability (ID) to age and severity of ID. *Psychological Medicine*, 39(01), 13-21. Abstract retrieved from <http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=2939012>.
- Strydom, A., Livingston, G., King, M., & Hassiotis, A. (2007). Prevalence of dementia in intellectual disability using different diagnostic criteria. *The British Journal of Psychiatry*, 191(2), 150-157. Retrieved from <http://bjp.repsych.org/cgi/reprint/191/152/150>.
- Suaalii-Sauni, T., Mariner, K., Lui, D., Siasoi, J., Wheeler, A., Warren, H., et al. (2007). *Pacific mental health workforce: Training needs analysis research report*. Auckland: Te Pou. Retrieved from [http://www.tepou.co.nz/file/PDF/publications/Microsoft\\_Word\\_Copy\\_of\\_Training\\_Needs\\_Report\\_Final\\_Website.pdf](http://www.tepou.co.nz/file/PDF/publications/Microsoft_Word_Copy_of_Training_Needs_Report_Final_Website.pdf).
- Te Pou, & Le Va. (2010). *Real skills plus Seitapu: Training programme*. Auckland: Te Pou.
- Warr, P., & Birdi, K. (1998). Employee age and voluntary development activity. *International Journal of Training and Development*, 2(3), 190-204. Abstract retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/1468-2419.00047/abstract>.
- Whitaker, S., & Read, S. (2006). The prevalence of psychiatric disorders among people with intellectual disabilities: An analysis of the literature. *Journal of Applied Research in Intellectual Disabilities*, 19(4), 330-345. Abstract retrieved from <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3148.2006.00293.x/abstract>.
- Wiley, A. (2009). At a cultural crossroads: Lessons on culture and policy from the New Zealand Disability Strategy. *Disability & Rehabilitation*, 31(14), 1205-1214. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/19802934?dopt=Abstract>.



#### AUCKLAND

Level 2, 8 Nugent Street (B), Grafton  
PO Box 108-244, Symonds Street  
Auckland 1150, NEW ZEALAND  
T +64 (9) 373 2125 F +64 (9) 373 2127

#### HAMILTON

Kakariki House, 293 Grey Street, Hamilton East  
PO Box 219, Waikato Mail Centre  
Hamilton 3240, NEW ZEALAND  
T +64 (7) 857 1202 F +64 (7) 857 1297

#### WELLINGTON

Level 3, 147 Tory Street  
PO Box 6169, Marion Square  
Wellington 6141, NEW ZEALAND  
T +64 (4) 237 6424 F +64 (4) 238 2016

#### CHRISTCHURCH

Level 4, 104 Victoria Street, Christchurch 8013  
PO Box 22105, High Street,  
Christchurch 8142, NEW ZEALAND  
T +64 (3) 371 0317 F +64 (3) 379 7354