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The supporters of disabled people participating in New Zealand society: The providers' profile of the disability support workforce

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Abstract

To understand one of the predominant groups supporting people with disabilities and illness, this study examined the profile of New Zealand paid caregivers, including their training needs.

Paid caregivers, also known as health-care assistants, caregivers and home-health aides, work across several long term care settings, such as residential homes, continuing-care hospitals and also private homes. Their roles include assisting with personal cares and household management. New Zealand, similar to other countries, is facing a health workforce shortage.

A three-phased design was used: Phase I, a survey of all home-based and residential care providers (N=942, response rate = 45%); Phase II, a targeted survey of training needs (n=107, response = 100%); Phase III, four focus groups and 14 interviews with 36 providers, exploring themes arising from Phases I and II.

Findings on 17,910 paid caregivers revealed a workforce predominantly female (94%), aged between 40 and 50, with 6% over the age of 60. Mean hourly pay NZ\$10.90 (Minimum wage NZ\$10.00 approx. UK£3.00 at time of study) and 24 hours per week. The national paid caregiver turnover was 29% residential care and 39% community. Most providers recognised the importance of training, but felt their paid caregivers were not adequately trained. Training was poorly attended; reasons cited were funding, family, secondary employment, staff turnover, low pay, few incentives.

The paid caregiver profile described reflects trends also observed in other countries. There is a clear policy direction in New Zealand and other countries to support disabled people at home, and yet the work force which is facilitating this vision is itself highly vulnerable. Paid caregivers have minimum pay, are female, work part-time and although it is

recognised that training is important for them, they do not attend, so consequently remain untrained.

Key words: Paid caregivers, support workers, training, nurse aides, community support, residential care.

Supporting disabled people to participate in New Zealand society: A profile of the disability support workforce

This study looked at the providers' perspective of the current paid caregivers' (support workforce) profile including their training needs. The study population included all New Zealand home-based and residential care disability support providers funded by the Ministry of Health (MoH) and/or Accident Compensation Corporation (ACC). ACC is a government insurance scheme that provides injury cover for all New Zealand citizens; in return people do not have the right to sue for personal injury, other than for exemplary damages. These providers deliver services to people of all ages and employ paid caregivers to assist with personal care and household management tasks.

The focus of ageing and disability policies is to support older people to continue to live in their own homes and to support people with functional limitations to participate as fully as possible in society. These goals are inherent in the current policies of developed countries. Similar to other Organisation for Economic Co-operation and Development (OECD) countries the New Zealand Government's Positive Ageing Strategy (Office for Senior Citizens, 2001) described freedom of choice by developing a workforce for the delivery of improved services within the community to enable ageing in place. Most older people do find it preferable to remain in their own homes (Netten, 2001, Thorson, 2000,

Pezzin et al., 1996). Many of the recent legislative steps have been to promote the rights of people with disabilities, such as the United States of America (USA) with the Americans with Disabilities Act 1990 (USA Government, 1990); the United Kingdom (UK) Disability Discrimination Act 1995 (amended 2005, UK Government, 2005); and New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2000). In addition to ageing strategies, such as ageing in place, there are disability policies orientated towards realising an inclusive society that is non-disabling and enables all people to participate. In New Zealand this overarching perspective is based on the goals set out in the New Zealand Disability Strategy (Ministry of Health, 2001), the Health of Older People's Strategies (Ministry of Health, 2002), and the New Zealand Positive Ageing Strategy (Office for Senior Citizens, 2001).

Paid caregivers are known as the linchpin of the long-term care industry and play a pivotal role in providing services, underpinned by policies focused on enabling all people to age in place, by providing community services which allow people to have choices. The choices are to remain living in the community rather than residential care and participate as fully possible in society (Ministry of Health, 2002, Diallo et al., 2003, Dalziel, 2001). Paid caregivers are known by titles such as support workers, health-care assistants, direct-care workers, home-care helpers (workers or aides), nurse aides (or assistants), formal caregivers, personal assistants and home-health aides. For the purposes of this paper the generic term paid caregiver will be used. Paid caregivers work across several settings generically known as residential care, such as rest homes, nursing homes, hostels, chronic care or rehabilitation hospitals, extended care facilities, and private homes. The paid caregiver does not include staff working in acute hospitals. They provide assistance with personal care, instrumental activities of daily living, employment, social and leisure pursuits (Clark et al., 2004). In some countries there is evidence that paid caregivers are also undertaking duties which have typically been the domain of nurses (Baldwin et al., 2003). In the USA paid caregivers

provide 70-80% of the paid long-term care workforce (Morgan and Konrad, 2008), which includes both residential care and living in their own homes, the latter preferred by most people (Pezzin et al., 1996, Thorson, 2000).

Paid caregivers' characteristics revealed a vulnerable group of minimally trained, middle-aged women, with heavy workloads often to the point of exhaustion. This workforce is poorly educated, part-time, with an average age between the mid-thirties to mid-forties (Yamada, 2002, Montgomery et al., 2005, Fleming and Taylor, 2006). They are receiving low remuneration, in many cases close to the minimum wage (Braun et al., 2005, Campbell et al., 2003). They are often single parents from minority ethnic groups (Nicholas et al., 2007) and have other commitments, such as family, or secondary employment needed to enhance their salaries (Yamada, 2002, Monahan and McCarthy, 1992). Paid caregivers provide intimate, life-supporting care, subject to many of the same pressures as health professionals, although they are not protected by a professional identity or regulations in most countries (Brannon, 2007).

A shortfall in the number of paid caregivers has become apparent in many countries and predicted for others (Nicholas et al., 2007), further increasing the need for review. The increase in the education levels of this age group means more educated women will be less willing to accept work with low wages and low benefits than their predecessors (Stone, 2008). On the other hand, there will also be less informal caregivers as the population ages and diversifies, which will ultimately lead to an increase in the need for more paid caregivers (Polivka, 2005). The consumer population's support needs are becoming more complex, such as being more dependent with their activities of daily living and personal cares (Leece, 2003). The use of home-based and residential care services is also predicted to increase as the population ages (Bhattacharya et al., 2004, Binstock et al., 1996). These factors make it relevant to examine the support provided for people with complex health and disability needs.

One of the key aspects of support is the provision of effective, appropriate services to support people to engage as fully as possible in society. Providing a good service to people with complex health and disability needs has been linked to having staff with proper training, knowledge, skills and empathy (Nicholas et al., 2007, Braun et al., 2005). These problems are major issues for the support workforce of New Zealand as well as many other countries (Fleming and Taylor, 2006, Coogle et al., 2007, Kash et al., 2006, Parsons et al., 2003). Although staff turnover varies from place to place, one USA study found as much as 70-100% staff turnover experienced in residential care, and 40-60% in the home care sector (Braun et al., 2005).

Retention studies, including a study of 72 nursing homes with 1779 paid caregivers, showed job satisfaction and labour market conditions were significant predictors of the intention to leave (Nicholas et al., 2007, Brannon, 2007). Pay was linked to retention in one study of 1,017 nursing home facilities (Kash et al., 2006), while supervision, information and professional development was found by others to influence retention (Parsons et al., 2003). Training (Sung et al., 2005), work commitment (Fleming and Taylor, 2006), relationships with service users, involvement in care planning (Banaszak-Holl and Hines, 1996), opportunities for advancement and less work overload (Brannon, 2007) were all factors found to influence good staff retention.

For this group training would seem to be the panacea for many issues highlighted by the retention and recruitment problems. Training increases paid caregiver's knowledge, skills and confidence, ultimately leading to improved patient care (McKenna et al., 2005a, Keeney et al., 2005, Schopp et al., 2007). However, there is no compulsory training for paid caregivers in New Zealand and few standardised training programmes for paid caregivers found in other countries (McKenna et al., 2004, Chang and Lam, 1997). Programmes varied primarily due to different employment requirements and topics based on the needs of

individual facilities (Drennan et al., 2004, Schopp et al., 2007, McKenna et al., 2005b). However, the need for additional topics to enhance knowledge and skills has been identified by both paid caregivers and teacher in programme evaluations (McKenna et al., 2005a, Schopp et al., 2007). Most programmes do contain theory and practice with an emphasis on learning on-the-job. While researchers suggested the balance between theory and practical experience was an area for improvement, paid caregivers and teachers' experiences only highlighted the importance of practical learning (Keeney et al., 2005, McKenna et al., 2005a). Such 'hands-on' learning is a priority in training programmes in the USA and UK. Some governments have initiated the introduction of training programmes for paid caregivers in order to improving quality of care (Baldwin, 1993, Paraprofessional Healthcare Institute, 2005). In the UK National Vocational Qualifications (NVQ) were established to standardise paid caregiver training (McKenna et al., 2004) and promote competencies and theory related to workplace settings (Francis, 1998). The USA training has set numbers of teaching hours and directly supervised hands-on experience as the way to improve the quality of paid caregivers' work (Brannon, 2007). Training is now required by law to work in certified residential and home care agencies.

The New Zealand disability support sector has had considerable changes in recent years (Ministry of Health, 2001, Ministry of Economic Development, 2003). Until recently little has been known about the quality of service delivery, training requirements and demographic profile of paid caregivers. Furthermore, there is recognition that paid caregivers are crucial to improving outcomes and supporting policy goals which have been orientated towards assisting people to continue to live and participate in the community. To enable the New Zealand workforce and sector development to proceed, a stock-take of the residential and home-based disability support workforce is essential. Few articles were found relating to

paid caregivers, which leaves gaps in our knowledge and impedes the development of strategies.

Does New Zealand have a vulnerable workforce providing sub-standard care, catering to vulnerable people with complex support needs? Are these aspects a contradiction between the value we say we place on caring for our people and what is actually happening? The objectives of this study were to investigate these questions by examining the current profile of the support workforce, including future training requirements.

Methods

A three-phased sequential study using mixed methods design was conducted in 2004. A sequential model was chosen to enable a large sample to be recruited, and to attain the depth of information required to fully illustrate the findings. The data from each phase were further explored subsequently. A quantitative design was used for the first two phases followed by a qualitative design in Phase III. Mixed method design uses data collection and analysis techniques in parallel, or in sequence, to fully describe the divergent aspects of a phenomenon (Johnson and Onwuegbuzie, 2003, Creswell, 2003, Tashakkori and Teddlie, 2003). Because social phenomena are so complex, mixing different types of methods can strengthen a study (Tashakkori and Teddlie, 2003). Phase I commenced with a self-administered survey. In Phase II a short survey was conducted with a sub-group of Phase I. This was requested by the funder following their review of the initial findings. Phase III was focus groups and interviews developed from the previous phases. Details of each phase are as follows.

Phase I

A database of 1033 service providers representing the total provider population was obtained from the MoH of which a total of 942 were eligible for inclusion. Excluded were providers who were not operating a support worker service at that time. The survey questions

were developed from the literature review and representatives of the following groups: residential, home-based, and intellectual / physical / neurological disability support providers. Content validity of the survey was established through a pilot test and reviewed by four providers. The survey was mailed to the participants with a covering letter and a stamped, addressed, return envelope. The survey covered the following topics: numbers of paid caregivers employed, gender, age, hours worked, English as a second language, pay, turnover rates, training, attendance plans and barriers, and future national training issues. Ethnicity data was collected directly from paid caregivers in a subsequent study (Parsons et al., 2004). A total of 420 providers (44.6%) responded. This response rate was considered acceptable (Moser and Kalton, 1985) and deemed to be representative of the sector. The majority of respondents were residential care providers (n=232), 119 were both residential and home-based providers, 51 were home-based providers, and the remainder did not specify service type. A range of services were offered by providers, with most offering more than one type (Table 1).

Phase II

Participants from Phase I were asked if they were willing to participate in further in-depth exploration about support workforce and training requirements; 119 agreed to participate (12% acceptance rate). Four providers were excluded because they were no longer providing services (n=107). Fifty seven providers returned this survey (53%). The survey contained questions about the training topics provided and how the providers ranked their importance. These were ranked on a five-point Likert scale from 5= very important to 1= not important.

Phase III

A purposeful sample (Patton, 2002) of 38 providers from Phase II were invited and participated in either a focus group or interview. In order to obtain a range of perspectives and representation from all provider groups, the following criteria were applied: (a) rural and

urban areas; (b) residential and home-based services; and (c) services provided to all adults with physical and/or intellectual disabilities. Twenty four service providers participated in one of four focus groups and 14 service providers were individually interviewed due to an inability to attend any of the focus groups. Questions were developed from data from Phases I and II and tested by four providers.

Ethical approval

Ethics approval was granted by The University of Auckland Human Ethics Committee and written informed consent was obtained from all participants prior to data collection.

Analysis

Quantitative data were entered into the statistical programme SPSS for Windows 14 (Green and Salkind, 2004). The data were divided and labelled into specific variables according to support service type (home based, residential based, or a mixture of the two) from which descriptive statistics, such as means and frequencies were calculated. The qualitative interviews were transcribed verbatim and entered into NVivo for analysis (Rich and Patashnick, 2002). The data gathered were analysed using a General Inductive Approach derived from Grounded Theory, as described by Thomas (2006). This was used to build categories gradually from the extensive raw text data, and condensed into summary format. A major point of Inductive theory is to avoid preconceptions for narrowing what is observed and theorised (Ezzy, 2002). The raw data were read many times then codes were developed line by line. The codes were collated and broad categories developed then themes were formed using frequently reported patterns found in the data analysis. Five transcripts were given to two senior researchers to recode and compare, and then were reviewed (Patton, 2002). The choice of a General Inductive Approach was to condense the extensive raw data into a summary format in line with the research objectives.

Results

Support workforce profile

The number of paid caregivers employed by providers varied, with some providers having a workforce in the thousands. The mean number of paid caregivers per provider (N=942) was as follows: (a) the home-based sector 97, (b) the residential care sector 18 and (c) mixed services 25. Overall the results indicated a mean of 19 paid caregivers per provider. The disability support workforce (Table 2) was dominated by women (94%), most aged over 40 years. As illustrated by one provider:

"The majority of people who seek work as paid caregivers have little formal education, many having left school in their teens and are from lower socio-economic backgrounds with English as a second language."

Poor literacy and difficulties with spoken English was a common theme identified by providers. Out of the 81 providers who answered the communication abilities question, an average of eight paid caregivers per provider had difficulty with spoken English, while an average of 12 had difficulty with written English. These problems have implications for training, as one provider illustrated:

"Workers are not easily trained because they have poor writing and reading skills and are intimidated by training."

Providers were asked to report the number of paid caregivers with recognised and adequate training. Out of the 313 providers answering this question, an average of 45% of paid caregivers per provider were adequately trained in home-based services, 57% in residential care, and 52% in mixed service provider organisations.

Working conditions

At the time of the survey the mean salary for home-based and residential paid caregivers was \$10.80 NZ and \$11.00 NZ, (just over UK£3.00 at that time) per hour respectively. Home-based workers worked a mean of 13 hours per week and residential care workers 25 hours per week, with an overall mean of 24 hours per week. Eighty two percent of home-based providers (n=51) reimbursed workers for travel costs, either by means of payment for travelling time, public transport, or use of the workers own vehicle. Providers viewed pay and working conditions as poor given the importance of the work undertaken by paid caregivers, as illustrated by a home-based provider:

“The pay is terrible for the level of responsibility they carry and the hours they work. We operate from 6.30 am to 10 pm seven days a week. They [referral agency] then asked if we would go out on Christmas morning for \$10 [per hour].”

Two thirds of providers offered a financial incentive to paid caregivers for completing training, or gaining a certificate (n=280, 67%), while 109 (26%) providers gave no incentive and 31 (7%) did not respond.

Staff turnover

Providers said staff turnover in residential care and the home based sector (29% and 39% respectively) was due to inadequate training, job stress, lack of a career pathway, and low pay:

“Workers leave because the job is stressful; they don’t make much money; they are not paid mileage and there are few opportunities to advance in the field.”

The absence of adequate pay was seen by providers as a major barrier to recruiting and retaining quality trained caregivers. Providers also suggested that despite wanting to hire people with particular skills, the inadequate supply and poor job status meant this was not feasible.

“Providers cannot attract the right types as [support work] is not perceived as a glamour job. Therefore [the industry] attracts only certain peoples with mixed priorities.”

Training provided: Topics, funding and attendance rates

Providers value training for paid caregivers, and from their perspective it is “mainly a risk management” mechanism. More specifically, providers identified training as a way to improve outcomes for clients, enhance the reliability, confidence, self-worth, and commitment of the paid caregivers to carry out their duties. The majority of providers (n=392, 93%) have a training plan in place, with 90% indicating training was mandatory, however there were no legal consequences of non attendance. Many fund training (n=322, 78%) with only a small proportion of paid caregiver training funded by government agencies (n=16, 3%) and (n=5, 1%) by employees. The importance rated by the provider and number of training topics provided varied across provider groups. Table 3 shows the number of courses taught, the importance the provider placed on those topics and the number of providers responding to that question. All topics were deemed by the providers to be at least moderately important except for training on sexuality, which was rated as not important by home-based providers. Training on health and safety topics, such as infection control, emergency, fire and safety procedures were rated as very important. Attendance rates for training sessions differed between provider groups. Of the data completed for analysis (n=360 questionnaires), home-based providers (n=43) had the lowest mean rate of attendance (40%), and residential (n=212) and mixed providers (n=105) both at a mean of 70%. Providers

believed poor attendance rates were influenced by the absence of incentives to attend. One provider commented:

“The lack of adequate funding affects the number of staff we can employ, which makes it difficult to release staff for training.”

There was also a feeling that more funding would enable providers to “make attendance compulsory.” Providers however, who did pay workers to attend found attendance rates were influenced by other commitments, such as family, or secondary employment. Home-based providers experienced this more than other provider groups because they had a higher proportion of part-time paid caregivers. Distance from work also influenced attendance, particularly for home-based workers living in rural communities.

“Staff [who] travel long distances usually have to stay overnight and funding for travel is not possible.”

Providers were asked what the barriers to providing training were: (1) lack of funding, (2) difficulty releasing staff for training, (3) lack of incentives for staff to attend, (4) difficulty finding appropriate speakers, (5) transport issues, (6) training venue issues and (7) widely dispersed clients and staff. A lack of funding was mentioned most often for all service groups. The second for all groups was the problem of releasing staff to enable them to attend the training sessions. Widely dispersed clients and staff was an issue for the home-based service providers, followed by a lack of incentives for all groups. However, despite funding constraints, the findings suggest many providers valued training and simply tried to make it work: “We do the best we can do on a shoestring” and “Our policy is to encourage education despite funds availability [lack of].”

Future training: Perspectives on a national qualification

Perspectives on future training were explored and providers were asked if they agreed with the need for national training, generic training with specialty areas, and financial remuneration for completed training. Agreement was rated on a 5 point Likert scale as 5= strongly agree to 1= strongly disagree. The mean for a national training programme was 4.6/5, generic training with speciality areas was 4.5/5, and the need for financial remuneration for completed training 4.6/5. Providers thought that paid caregivers would only be encouraged to undergo further qualifications, such as nationally recognised certificates if they could (a) earn a certificate, (b) receive a pay rise upon completion, (c) assume greater responsibility, and/or (d) sense that training was relevant. Many providers stated that some paid caregivers in the residential sector, and many more in the home-based sector, felt their position was casual or temporary and did not see the value of further training. Some providers were also reluctant to link training qualifications to pay incentives because they felt this was unaffordable.

Discussion

Findings from this and other studies are congruent with current literature (Montgomery et al., 2005, Monahan and McCarthy, 1992, Davies et al., 1999, Kiata et al., 2005, Yamada, 2002). The findings paint a picture of paid caregivers as a vulnerable group of people who are poorly paid, predominant middle aged females, employed part-time, supporting children, minimally educated and with little practical knowledge of the job. The paid caregiver in New Zealand is a person often working autonomously in the community, or in a residential facility with little supervision. They have the responsibilities of caring for and supporting another vulnerable group of people, those who are frail, have complex support needs and have illnesses or disabilities. The findings will be discussed specifically in relation to areas of concern for policy makers and funders.

Poor pay rates for paid caregivers is a well-known issue (Banaszak-Holl and Hines, 1996; Fleming and Taylor, 2006), particularly as this study found for home-based paid caregivers. After travel costs, and receiving payment only for direct client hours, many paid caregivers earned NZ\$4.80 (£1.50) per hour. This is a pertinent point, especially in light of the fact that the minimum wage at that time was NZ\$10.00. The chances of obtaining sufficient work was often low, and paid caregivers felt financial pressure to gain employment elsewhere. Lack of guaranteed hours and the absence of travel reimbursement were also reported in the Irish home care sector (Fleming and Taylor, 2006). While Montgomery et al. (2005) reported home-based and residential care paid caregivers in the United States worked a mean of 30 and 34 hours per week respectively, in New Zealand it was found only 13 and 25 hours respectively. Providers and international studies reported that many paid caregivers were over-worked because they held multiple jobs or took extra shifts, without benefits associated with full-time status (Crown et al., 1995, Yamada, 2002).

There appeared to be a heavy reliance on part-time and casual workers (people called in on an ad-hoc basis), and untrained paid caregivers, particularly among the New Zealand home-based sector. This may be due to poor training attendance rates, which for home-based providers was 30% lower than the mean for residential care and mixed provider groups. Insufficient provider funding was identified as the main barriers affecting training attendance and provision. In particular, the inability to pay workers for training attendance, associated travel costs, and the provision of financial incentives for completion were particularly significant. This problem is not unique to New Zealand; a lack of centralised education funding has been reported in the United Kingdom (Baldwin et al., 2003).

Recruitment and retention has implications both in terms of maintaining adequate staffing levels, and training. Due to retention difficulties related to low pay and poor conditions, providers in this study felt compromised and may invariably end up employing

less experienced paid caregivers. This resulted in a compounding effect of paid caregivers needing more training to achieve an adequate level of communication and skills, creating a financial burden for the provider and more financial or time cost for the worker.

Similar to other studies, this study found high staff turnover resulted in staff shortages, leading to major quality of care and safety issues for both home-based and residential providers (Aiken et al., 2002, Bowers and Becker, 1992, Johnson-Pawlson and Infeld, 1996, Morgan et al., 2002). A high staff turnover also meant the need for a financial and time investment in training new workers, only to have them leave and work elsewhere. This waste of resources often discouraged providers from implementing initial intensive training programmes. Despite this, providers in New Zealand felt some training could reduce staff turnover. However, Banaszak-Holl & Hines (1996) reported increased training did not decrease staff turnover; instead training improved job satisfaction if coupled with increased autonomy and better career opportunities. Job satisfaction was also identified by providers as a significant factor to retaining staff, with added emphasis on increased funding to provide an incentive to complete training. This has implications when considering future national training programmes.

Despite all the challenges associated with the provision of training, the majority of the providers had training programmes in place. The providers felt responsible for the quality and safety of the services provided and correlated a lack of training and staffing shortages with safety problems. Training is viewed by many providers as an important part of promoting safety awareness through skill enhancement (Morgan et al., 2002). The findings of this study provided further support for the view that training is a means to improving the quality of care (McKenna et al., 2004, Coffey, 2004). A considerable number of providers felt that paid caregivers, although extremely good at the practical task of caregiving, considered training beyond their reach. One of the main factors identified was the presence of literacy and poor

spoken English abilities, resulting in low self-confidence and an aversion to training.

Benjamin (1997) found literacy level positively correlated with job performance and English language skills a predictor of job performance.

Providers strongly agreed that a generic national training programme, with speciality areas, was needed. Findings showed home-based and residential care placed different emphasis on the importance of the training topics provided. The link between competency areas and setting is reported elsewhere (Smith, 2004), and tailoring training programmes to service provision in the future may be problematic. Experience from Ireland suggested that while a national training programme could be possible, views vary on the topic inclusion and depth (McKenna et al., 2005b). Still others have reported the need for extended areas of learning beyond what national training qualifications offer (Hewitt-Taylor, 2005), particularly around the needs of older people (Drennan et al., 2004, Maas and Buckwalter, 2006). Consensus on what needs to be taught is an ongoing challenge.

The limitations of this study were the self-selective nature of the sample in Phase II. As a result this may have impacted on the generalisability of the findings to the whole of New Zealand and the participants may not reflect the characteristics and attributes of a larger sample. The sample however, was representative of the different services within the disability support sector and the responding providers consisted of either co-ordinators or managers of large support services, or owners / providers of smaller support services. The study was written in New Zealand, which is one of the OECD countries with a high standard of living, and thus may differ from countries outside the OECD.

Future research could examine ways to improve the acceptability of training from the paid caregivers' perspective, the ways which paid caregivers could see for improving the recruitment and retention problems, a more cost effective way, in terms of time and money, of

providing home-based services; and different ways of providing services within residential care.

Conclusion

A key focus of health and social policies is to ensure people with disabilities of all ages receive appropriate and timely services to assist them to participate fully in society. However, policy makers and funders should note that the disability support service sector is experiencing difficulties with what would appear no simple solution. Solutions are required and action is necessary, otherwise disability support services may become a myth rather than a reality in the next few decades. Low pay, retention and training are intricately linked. Thus it is difficult to address one issue without considering the others. Training does offer a proven means to improve quality of care and support, though in order for training to be effectively delivered (Kovner and Harrington, 2001, Edwards, 1997) the other serious issues need to be resolved. New Zealand does have a vulnerable workforce providing erratic care to vulnerable people. The findings in this study show that there is a contradiction between our values and what is actually happening.

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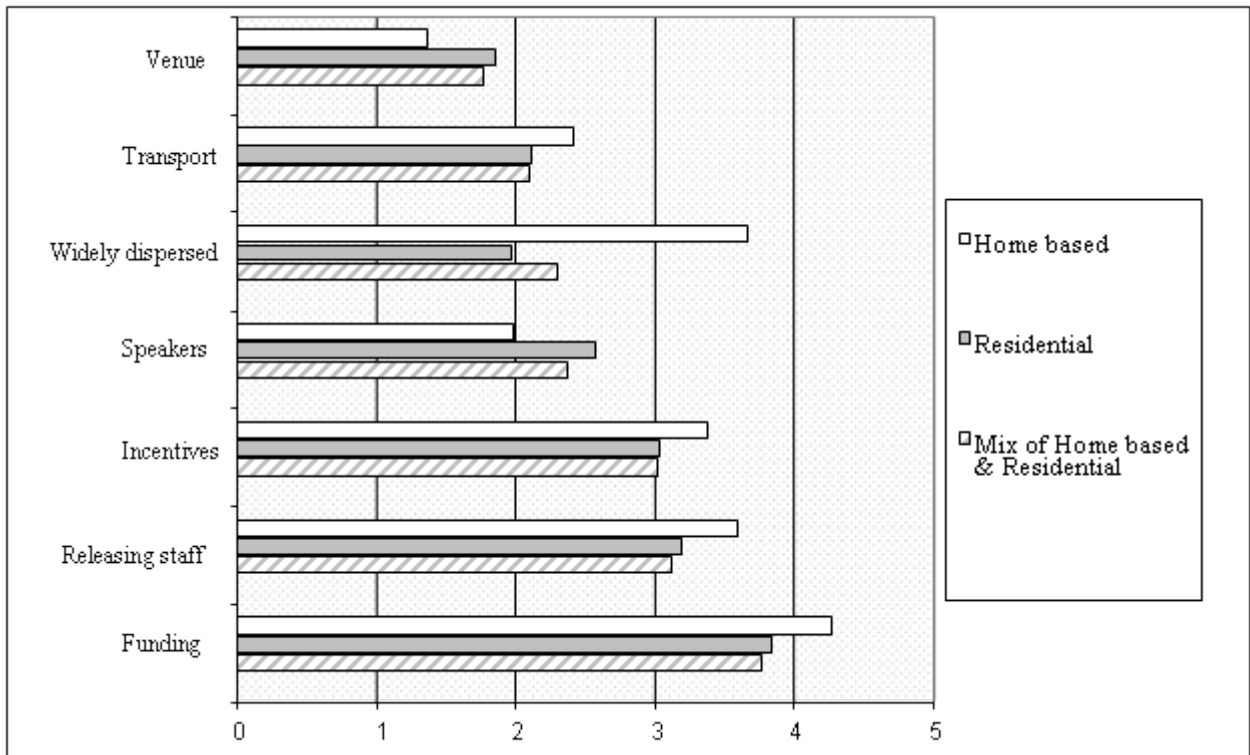


Figure 1: On scale of 1-5 (1 not important to 5 very important) what the providers perceived (mean) were the barriers to training paid caregivers, analysed by provider groups

Table 1: Services offered by providers (n=420)

Type of service	Total number of providers offering services	Providers offering one service group only
Home care for clients with life-long disability (LLD)	52 (12.4%)	2 (0.5%)
Home care for people over 65 years	77 (18.3%)	20 (4.8%)
Residential services for clients with LLD	163 (38.8%)	21 (5.0%)
Residential services for people over 65 years	252 (60.0%)	29 (6.9%)
Hospital/specialised care for people over 65 years	129 (30.7%)	9 (2.1%)
Respite/day services for clients LLD	104 (24.8%)	4 (1.0%)
Respite/day services for people over 65 years	207 (49.3%)	1 (0.2%)

Note: Due to multiple responses the percentages do not add to 100

Table 2: Age and gender profile of paid caregivers (N=17910)

Gender		Under 20	21 to 30	31 to 40	41 to 50	51 to 60	61 to 70	Over 70
Number of paid caregivers	Male	59 (0.3%)	192 (1.1%)	302 (1.7%)	249 (1.4%)	189 (1.1%)	74 (0.4%)	13 (0.1%)
	Female	483 (2.7%)	1874 (10.5%)	3994 (22.3%)	5741 (32.1%)	3702 (20.7%)	972 (5.4%)	66 (0.4%)

Table 3: Importance of training topic

Training topics	Home-based providers (n=12)			Residential care providers (n=45)			
	Taught	Importance of training topic		Training topics	Taught	Importance of training topic	
	N	Mean	No. of Responses		N	Mean	No. of Responses
Personal care	9	4.6	11	Infection control	44	5.0	40
Emergency procedures	7	4.6	9	Emergency procedures	45	5.0	42
First aid	8	4.5	11	Fire & safety	45	5.0	41
Lifting & handling	10	4.5	10	Personal care	40	4.9	37
Personal safety	11	4.5	10	Lifting & handling	44	4.9	41
Infection control	6	4.4	9	Medications	45	4.9	40
Recognising abuse	9	4.3	10	Fall prevention	41	4.8	36
Philosophy & values	10	4.3	8	Personal safety	39	4.7	38
Cultural safety	11	4.2	12	Continence	40	4.7	38
House work	6	4.1	8	Philosophy values	43	4.7	40
Fire & safety	7	4.1	9	Recognise abuse	40	4.6	40
Common disabilities	8	4.0	11	Risk management	39	4.6	35
Nutrition	9	4.0	9	Social rehab.	37	4.6	37
Medications	4	3.9	7	First aid	41	4.5	42
Fall prevention	7	3.9	7	Nutrition	36	4.5	34
Risk management	8	3.8	8	Oral hygiene	39	4.5	37
Service policies & protocols	8	3.7	9	Service policies & protocols	39	4.4	37
Continence	7	3.7	9	Common disability	39	4.3	38
Advanced personal care	4	3.6	8	Physical rehab.	32	4.1	35
Physical rehabilitation	4	3.6	8	Sexuality	36	4.0	38
Social rehabilitation	4	3.6	7	Cultural safety	40	3.8	40
Oral hygiene	5	3.5	8	Advanced personal care	27	3.7	33
Sexuality	1	2.2	6	House work	18	3.4	27

Mean (Range: 5=Very important to 1= Not important.)