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Workforce Development

A Study of Pacific Non-Regulated Workers

Phase One Executive Summary

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Contents

Foreword

Talofa lava, Malo e lelei, Kia Orana, Taloha Ni, Fakalofa Lahi Atu, Ni Sa Bula Vinaka, Kia Ora

Our Pacific people's experience of healthcare in both community and hospital settings is less than that of other New Zealanders. The role of "community health workers" or the non-regulated health workforce has developed as one of the solutions to improving this experience.

As a clinician, I have worked alongside community health workers in hospitals, clinics and the community. They have critical roles in health education and treatment compliance, family engagement and support, and in addressing determinants of health by assisting Pacific families to negotiate the health, housing and welfare sectors.

This document is part of a large study which describes the characteristics of the Pacific non-regulated health workforce and how this workforce contributes to improving our people's health outcomes. It also looks at how the effectiveness of the Pacific non-regulated workforce might be improved.

In New Zealand we are currently experiencing shortfalls in our clinical regulated workforce and this, coupled with the ability to increase cultural competency and community penetration makes our Pacific non-regulated workforce a valuable group in whom we should be investing further development and resource.

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Fa'afetai tele lava, Meitaki maata, Malo 'aupito, Fakaaue lahi lele, Fakafetai lasi, Vinaka vaka levu

Introduction

This executive summary report gives an overview of key findings from the 2007 Pacific non-regulated Health Workforce study, commissioned by the Ministry of Health (MoH) and the Health Research Council of New Zealand (HRC).

The purpose of this study is twofold. First it will expand the knowledge base on the Pacific non-regulated workforce (PNR). Secondly, the findings from this study are intended to assist the MoH and HRC with gaining a better understanding of this workforce, and to inform strategic planning and policy development. The research draws attention to the crucial role of the PNR in the delivery of health care services and in improving the health outcomes of Pacific peoples and their communities.

There is a paucity of literature and research specific to the PNR. The increasing focus within the Pacific health sector on significant building of workforce capability and capacity within all levels and areas of the sector (including health research) however, will likely see more studies emerge to explore and project future demands within a rapidly evolving demographic population.

Studies undertaken since 2000 on the non-regulated workforce in New Zealand, provide evidence which indicates that Pacific people are significantly under-represented in both the regulated and non-regulated health workforce (Acqumen Quality Solutions, 2006; Foliaki & Pearce, 2003; Ministry of Health, 2006a).

Recent literature with a specific focus on the PNR are largely drawn from ongoing work within the Pacific mental health sector (Mental Health Commission, 2001b; Ministry of Health, 2004a; Ng Shiu, 2007). Workforce issues identified as requiring attention within this sector include the need for 'for Pacific by Pacific' services and workers (Pulotu-Endemann et al, 2004); the improvement of culturally appropriate services within mainstream health organisations (Malo, 2004); benefits to mainstream services (Malo, 2004; Mental Health Commission, 2001b); and the need for improvement in mental health services in light of insufficient numbers of Pacific specific services meeting consumer demands (Pulotu-Endemann et al, 2004).

Studies conducted on the general non-regulated workforce within New Zealand provide some insights into the nature and structure of New Zealand's PNR workforce. Findings relevant to the PNR from these general population studies capture some characteristics of the PNR workforce which include: gender and age (Acqumen Quality Solutions, 2006; Brandt et al, 2004), size of the support workforce (Parsons et al, 2004), percentage of disability support workers (Parsons et al, 2004b), hours worked by disability support workers (Brandt et al, 2004), and support workers per week (Parsons et al 2004), service delivery sites (Barwick, 2000), types of services (TAS, 2006) and remuneration scales (Parsons et al 2004).

Various factors and trends have influenced the calls from within the health sector to increase and develop the Pacific workforce. These include:

- The growing disparities and inequalities of health between Pacific peoples and European New Zealanders;
- The low uptake by Pacific people in accessing GP services (Ministry of Health, 2005b), screening and preventive services, community mental health services and hospital outpatient care services (Ministry of Health & Ministry of Pacific Island Affairs, 2004b);
- The inability or non-responsiveness of mainstream services to deal with the needs of Pacific service users leading to the subsequent growth of 'culturally appropriate' services in the last ten years (Barwick, 2000);
- The lack of understanding on the importance of cultural values and practices in the efficacy of assessment, treatment and rehabilitation (Health Workforce Advisory Committee, 2002a, 2002b).

Definition of Non-Regulated Workers

National and international literature indicate that there is no universal definition of the non-regulated workforce.

In New Zealand, the following terms have been used to describe non-regulated workers: community health workers (CHW), healthcare assistants (HCA), orderlies, cultural support workers, support workers, community homecare workers, whanau ora workers, Plunket workers, mental health workers, youth workers, compulsory care coordinators, cultural assessors, care givers, care workers, care assistants, care managers, care support workers, mental health support workers, nurse assistants, care givers, nurse aides and rehabilitation assistants. Terms which are commonly used within the Pacific health sector include matua, interpreters, consumer advisers, traditional healers, community support workers, cultural advisers, family advisers, interpreters and service administrative staff (Kirk et al., 2006; Mental Health Commission, 2001, 2001b; Parsons et al., 2004; Suaalii-Sauni et al., 2007).

Acqumen Quality Solutions provides the following definition:

> ***"People who have direct personal care interaction with clients, patients or consumers within the health and disability sector and who are not subjected to regulatory requirements under health legislation. This includes all people (paid or unpaid) who interact with clients, patients or consumers within the health and disability sector, who are not subject to regulatory requirements under legislation or other means. This workforce also provides a lot of social, practical (including information, coordination, advice and cultural support) and advocacy that supports the full continuum of care." (2006: 4)***

The definition provided by Acqumen Quality Solutions (2006) was adopted for the purposes of this study.

Research Objectives

The objectives of this study are to :

1. Undertake a literature review to define and describe key aspects related to the Pacific non-regulated health workforce;
2. Undertake a survey of the Pacific non-regulated health workforce working within the Counties Manukau District Health Board (CMDHB) region to identify the composition, characteristics and constitution of this workforce;
3. Explore the aspirations of this workforce and, the current and potential paths of development for PNR health workers;
4. Identify existing barriers and enablers that influence workforce progression for current Pacific non-regulated health workers and ascertain structures necessary to assist;
5. Iinvestigate the perceptions of workers and Pacific non-regulated health staff regarding the current workforce model and assess the effectiveness of this model.

Research Methods

The information for this study was drawn from three sources:

- A comprehensive literature review;
- The Pacific Non-Regulated Workforce Survey completed by Pacific managers of Pacific non-regulated health workers; and
- In-depth interviews undertaken with Pacific non-regulated health workers and their managers.

The Survey and in-depth interviews were conducted with staff employed within the Counties Manukau District Health Board (CMDHB) region, Auckland. The workforce Survey was completed by 70 managers. Ten managers and eighteen PNR workers were interviewed.

Profile of the Workforce

The demographic profile of New Zealand's non-regulated workforce shows a workforce which is both complex in size, and unique in its regional and national roles. There is however, a serious lack of accurate and timely data on the non-regulated health workforce, which makes it difficult to ascertain recent and actual numbers in particular of all PNR health workers, where they are located, and the work that they undertake (Acqumen Quality Solutions, 2006; Health Workforce Advisory Committee, 2002b; Ministry of Health, 2007).

In 2002, there were approximately 67,000 health practitioners (i.e. doctors, nurses etc), 30,000 support workers and 10,000 alternative complementary health workers delivering health services to the New Zealand population. The non-regulated health workforce accounted for 40% of the total health workforce (Health Workforce Advisory Committee, 2002).

Findings from this study (2007) indicate that:

- PNR workers possess a wide range of competencies and undertake a variety of roles.
- Both managers and PNR workers who were interviewed highlighted the valuable contribution made by PNR workers to their clients. Pacific clients in particular benefited from services whose workers were proficient in one or more Pacific languages and who understood the cultural needs and views of the client.
- PNR health workers are located across a range of sectors and organisations, such as: rest home and residential care services for the elderly, Public Health, Disability and Mental Health services. The majority of study participants (56%) worked in the aged care sector, respite and day services.
- The remuneration for PNR health workers varied considerably across various sectors, ranging from $11 (aged care/ rest home service caregiver) to $35 per hour (primary health service counsellor).
- A significant proportion of the PNR workers in this study were of Samoan ethnicity (40%). The second largest ethnic group in this sample were Tongan PNR workers (24%), followed by: Niueans (12.1%), Fijians (7.8%) and Cook Island Maori workers (7%).
- Consistent with international literature, the PNR workforce is largely female, mature and in terms of formal education, not highly qualified. One of the key distinctions raised in the PNR survey is that the majority of the PNR were employed full-time.[1]

1. When compared to the over-all non-regulated workforce, both nationally and internationally. National research on the all inclusive non-regulated workforce and international studies on the non-regulated workforce, indicate that a large number of the non-regulated workforce work part-time

Recruitment

Currently there is a significant drive from the Ministry of Health to recruit more community health workers and health promoters into the health sector (Ministry of Health, 2006b). Problematic is the lack of information documenting recruitment and selection processes.

Pathways that lead people into the PNR workforce are varied and can be influenced by current recruitment strategies and personal networks. According to the Ministry of Health (2006) there are three main entry points into public health careers:

1. Through community experience;
2. As school leavers; and
3. Through other careers (Ministry of Health, 2006b).

Considerable efforts have been expended on attracting Pacific people into the health sector through campaigns promoting health careers, scholarships and mentoring support. The majority of PNR workers interviewed stated that they were made aware of opportunities in health through personal contacts. This may be due to the fact that the campaigns are relatively recent compared to the number of years in which many of these workers have been employed in the sector.

Findings from the in-depth interviews show that personal and opportunistic factors were identified as having influenced the PNR workers in this study to apply for and undertake PNR roles. One of the more important motivations identified by both Managers and workers was a passion and commitment to helping and working with Pacific peoples in need. Another motivation was the flexible working environment which allows PNR workers to fulfil additional familial and employment responsibilities. A study by Ramirez-Valles (2001) noted that identifying the motives of people wanting to become CHWs is useful for recruitment and retention, as this information could help to decrease turnover, and enable a tailoring of activities, tasks and responsibilities to fit the motives of potential workers.

Some of the managers interviewed indicated a need to emphasise the recruitment of young people into the non-regulated workforce; other managers indicated that the PNR needed to reflect the demographic composition of the Pacific community, such as different generational groups and the New Zealand-born population group. The 2006 national census shows that the Pacific population is youthful in comparison with the total New Zealand population, with a high proportion of children aged 0 – 14 years (37.7% of the total New Zealand Pacific cohort), and a steady increase in the numbers of those born in New Zealand. Recruiting young Pacific people is a positive strategic approach to ensuring that there is long term viability and sustainability of this workforce.

Retention

PNR workers and managers identified a number of factors that influence the retention of the PNR. These include and are not limited to: job flexibility; opportunities to make a positive difference; "feeling valued"; being part of a supportive team and opportunities for professional development and learning. Feeling 'valued' can also be reflected in financial terms. Another equally important approach to retaining PNR workers is to acknowledge and respect their contribution through the provision of appropriate support and systems (e.g. open communication, transparency, accessible developmental opportunities, a team environment and positive affirmations).

This study shows that funding has a major impact on the retention of Pacific staff. This is particularly important for NGO services which face an ongoing struggle to retain staff. NGO staff who have received ongoing training are often lured away by the prospect of better pay and opportunities offered by DHB services. There is also the perception that DHB services have a higher status and are perceived to have a greater level of prestige than NGO services (Annandale & Richard, 2006). Given the challenges faced by NGO providers in ensuring that they retain qualified staff, it is no surprise that a lot of energy and focus is directed towards succession planning. Overall, the retention of staff was noted as a fundamental barrier to the development of an organisation and was considered to result directly from a lack of funds. Managers noted the need for additional financial support to address this issue.

A further explanation for the high turnover of workers and the limited ability to recruit people into the PNR was the hidden costs for workers, due to the under-funding in contracts and low industry morale (Health Workforce Advisory Committee, 2002b). As noted by Parsons et al (2004), poor employment conditions (wage rates of above $10 per hour) attract a workforce typified by secondary earners and people receiving benefits. Current welfare benefit levels mean many workers restrict their hours of employment to ensure that they are not penalised and do not lose their benefits.

Training

In regard to the Pacific population in New Zealand, the need for increased capacity within the health workforce and training for a competent and sufficient Pacific mental health workforce is well documented (Mental Health Commission, 2001b; Ministry of Health, 2004a; Ng Shiu, 2007).

The lack of training opportunities for Pacific Community Health Workers (CHWs) has long been identified as a problem, and has to some extent been addressed through a range of courses now available from Maori and Pacific training providers. These are supported with scholarship funding. Literature suggests that workforce training is seen largely to be the responsibility of the employer with few formal links between the home, health industry, training providers and health sector standards (Health Workforce Advisory Committee, 2002b).

There are currently established training programmes for non-regulated health workers. However, a concern is that where many PNR workers may have received a certificate or training in one area, these cannot be transfered into other health courses (Health Workforce Advisory Committee, 2002b). Managers in the survey noted that while developmental pathways are considered important, it was suggested that workforce training should be initiated from an entry level foundation course and progress through to tertiary level certificates, diplomas, and degrees.

Managers emphasised the need to maintain integrity regarding processes around compliance and the development of regulatory requirements for the non-regulated workforce. This entails specifying the overall outcomes and objectives of particular qualifications and ensuring that these are premised on benefits to the workers. More recently, a formal training programme has been introduced within the New Zealand disability support workforce. This programme begins at the foundation level and builds upon existing induction and orientation training which all home-based service providers are required to undertake. This training has improved knowledge and skill sets of support workers and is important in their work with service users within the disability sector. Positive benefits from this training have been identified by providers, service users and non-regulated workers (Health Outcomes International, 2008).

Evidence within the mental health sector suggests that, since there are many Pacific health workers employed in non-regulated roles, there is a clear need for a Pacific Mental Health Workforce Development Organisation (PMHWDO) that allows for capacity building and continues to develop the strengths of this workforce. Kirk et al. (2006) explored the feasibility of such an organisation and found that, in order for PMHWDO to be effective it requires the following:

- A focus on empowering Pacific consumers and families;
- A focus on actively recruiting and retaining Pacific workers;
- A focus on effective training strategies;
- A focus on developing Pacific mental health managers and leaders;
- A relevance to current mental health practices; and
- the capability to secure sustainable core funding (Kirk et al., 2006).

It is important to note that older workers and those on atypical contracts often fare badly in terms of participation in training. Andrews et al (2006) notes that the most appropriate learning style, length of training programme and content of knowledge may differ by demographic group. While there is a high level of knowledge and expertise that currently exists within the non-regulated workforce, managers noted that theoretical and tertiary training could be challenging for some. Maintaining integrity was also linked with valuing the experience and expertise that non-regulated workers bring to their roles. Whilst regulatory requirements are noted as being potentially beneficial, it is also noted that managers are adverse to systems becoming so rigid that workers are judged only on qualifications and not on the experience and expertise that some already have.

Barriers

Findings from the in-depth interviews highlight twelve overarching barriers or challenges to workforce development. Workers noted that barriers within organisations included: broad workloads and few resources; limited funding for resources and professional development; a lack of recognition of their roles; and for some, a lack of managerial and organisational support. It was identified that the lack of access to opportunities for advanced learning and training within organisations also hindered professional development. Managers noted that limited funding impacted negatively on effectively supporting volunteer workers, supporting qualifications, retaining staff, and building workforce capacity.

There were personal barriers identified, which include a lack of confidence by workers (discussed below). It was also stated that the impact of additional familial and church-related responsibilities affected workers' ability to complete their training. Other barriers which were identified by managers include: few incentives to encourage workers to complete educational training; difficulties in achieving New Zealand registration for those with qualifications from Pacific Island nations, changing political climates, the challenges of workers completing training due to pressures placed on workers by cultural and familial commitments; and for workers who came directly from tertiary institutions, a lack of applied experience and knowledge.

The responses from this study suggest that PNR workers are not accessing academic support provided by academic tertiary institutions for a range of reasons. The often demanding roles and commitments of PNR workers warrant the need to explore new and innovative academic support strategies. A key issue raised in the study is that a lack of confidence on the part of the worker acts as a barrier to personal and organisational development. Some of the underlying reasons for a lack of confidence include: a lack of self-esteem, a fear of making mistakes, and unfamiliarity with either medical language (jargon) or in the case of migrant workers a need to improve their proficiency in the English language. It was noted by managers that workforce training should include foundation level programmes that incorporate practical elements on assertiveness skills training as well as practical work-based components.

An additional challenge to positive training and development outcomes for non-regulated health workers is the impact that difficulties with speaking English has on communication. Formal training and accreditation are delivered almost exclusively in the mainstream environment where proficiency in the English language is a prerequisite (Health Workforce Advisory Committee, 2002b; Ministry of Health, 2004a). A report by Parsons, Dixon, Brandt et al., (2004) on support workers in New Zealand, found that in the Auckland region, high numbers of workers reported English as their second language. This study by Parsons et al., noted that where English was a second language, communication between service users and support workers as well as between support workers and their service providers was compromised. It also identified that approximately one third of workers had difficulties in communicating verbally and in writing in the English language. Parsons et al (2004b) notes that (where communication is compromised), this may also have an impact on the ability of services to deliver safe health care.

The misuse or exploitation of non-regulated health workers in their current roles was also identified as a barrier to productive working relationships. In New Zealand, the Health Workforce Advisory Committee (2002a) identifies that Pacific health practitioners face institutional and, in many cases, peer-discrimination that creates inappropriate perceptions about skills and competencies and presents a barrier to career development. Also, organisations that recruit Pacific people are likely to capitalise on the cultural competency of their staff to provide additional services for Pacific service users and many neither acknowledge nor recompense these extra duties and cultural competencies (Health Workforce Advisory Committee, 2002a). A report by the Mental Health Commission (2001) found that Pacific mental health workers often feel isolated

and unsupported, and the highly technical aspects of the job can be very intimidating. It is not always evident that their background and skills are valued, and at times this has resulted in the loss of competent Pacific mental health workers from the mental health sector (Mental Health Commission, 2001).

International literature suggests that Community Health Workers may be expected to work under difficult conditions, carry out difficult tasks, sometimes work without pay, while professional health workers are not willing to do the same (Lehmann et al. (2004). Spilsbury and Meyer (2004) note examples of exploitation and misuse of Health Care Assistants (HCAs) in a hospital setting. For example, although formal policies exist that outline the work and expectations of HCAs, HCAs are directly accountable to the Registered Nurses (RNs) within the wards. Examples are provided of where HCAs have been mistreated and misused by their senior health colleagues. For example, although registered nurses may recognise the available skills, local community experience, knowledge of the organisation and available skills of the HCAs, they tended not to utilise these skills or knowledge in the hospital setting. It was also noted that registered nurses did not involve HCAs in discussions about patient care and/or discharges. There were also situations where registered nurses in hospital settings admitted to sometimes asking HCAs to do activities that were outside the accepted HCA role. In this scenario, HCA workers would often undertake additional activities that are the role of registered nurses (Spilsbury & Meyer, 2004). Findings from the PNR worker interviews identified that a few PNR workers admitted that they did at times feel mistreated by fellow health professionals in their roles.

Enablers

PNR workers identified several enablers to workforce progression that are categorised as either institutional factors (developmental pathways, one-on-one personal development planning, management support and supervision) or individual factors (networking, peer support, familial support, self motivation and confidence). Managers identified a number of enablers in place that supported workforce progression: organisational commitment to workforce progression; managerial support and encouragement; financial support provided by the Pacific Provider Development Funding (PPDF) scheme; scholarships and mentoring. These enablers encourage both PNR workers to develop, learn and up-skill, and allow organisations to develop and build competence and capacity.

An exploratory study by Hind (2000) looked at the potential role of healthcare support workers in the critical care setting and examined the attitudes of nursing staff to the development of this role. Common themes that emerged were the need for shared learning and continuing education for all staff including newly recruited support workers. In addition, training is considered an important determinant of how HCAs as well as registered nurses viewed the role of non-regulated health workers. It was noted that the RNs placed more emphasis on the qualifications and credentials of the worker (Spilsbury & Meyer, 2004).

All participants in the PNR study described their work as a place of learning and up-skilling. It was noted that workplaces provide opportunities to learn about both the theoretical underpinnings of health issues (e.g. smoking, breast screening and human biology) and new practical skills (e.g. training for equipment use: hoists and walking frames). This learning was considered empowering for participants as it enabled them to address clients' concerns and gave them confidence to approach communities to educate on health risks and health services. Participants also noted feeling empowered by the fact that their new learning could act to empower others in the community to adopt healthier lifestyles.

Implications

Profile

This study identifies that:

- A desire to be of 'service'; having opportunities 'to help'; and having a 'passion' for working with people are important to the recruitment of workers into PNR roles
- A challenge in developing the PNR workforce is the ongoing need for data that is relevant, robust and comprehensive and which will inform the development of a highly trained and skilled Pacific non-regulated workforce[2]
- Involving management and workers as part of the professional development process is both empowering and effective.

Recruitment and Retention

Pay ranges and increments for PNR workers vary across health settings. This has led to some PNR workers leaving the health workforce entirely or moving into other health services because of the enticement of higher salaries. This significantly impacts on the recruitment, retention and viability of this workforce particularly for those health organisations not offering competitive wages. This has been evident within the NGO services that cite their inability to compete with salaries by DHB and larger organisations.

Study participants noted that they were made aware of the roles which they currently hold through personal contacts. In light of the various community and church roles in which many PNR workers are involved, it would make sense that current PNR workers have key roles in engaging with and communicating recruitment needs and approaches between organisations and community.

In light of workforce shortages within the health sector and future demographic predictions, the Pacific youth population serves as a potential supply of health workers. Continual efforts and evaluations of current recruitment drives will be key to ensuring its success.

This study found that health scholarships are important to the recruitment, retention and professional development of the PNR workforce. In some work areas PNR workers are aware of and able to access scholarships. However, in other areas the availability and awareness of scholarships is minimal. There also exists a perception amongst PNR workers that scholarships are for people at tertiary level.

2 Including demographic details and role descriptions.

Training

While there are established training programmes for the non-regulated workforce, the evidence from this study suggest that there are low levels of access to, and awareness of these training opportunities within the PNR workforce.

It has been identified that there are differences in accessing training opportunities for PNR workers in mainstream organisations and PNR workers in NGO Pacific-led and aged care services. PNR workers in DHB services are not eligible to access Ministry of Health scholarships as the view is held that their professional and training needs will be met by the DHB. However, some workers have highlighted their inability to access this funding. PNR workers in non-government organisations on the other hand have been able to source financial support for studies through their organisation, through PPDF funding and through Ministry of Health scholarship funding.

It has been identified that there is a need for foundation/ base level training which integrates the skills, cultural capacities, knowledge and values that PNR workers bring to their roles into a qualification. The inclusion of assertiveness training has also been identified as a need.

The establishment of academic support services within the workplace is an innovative strategy. Such strategies could include mentoring and pastoral care. Workshops that teach basic writing skills, essays and exam preparation may further assist workers with academic skills that can help with completing their qualifications.

Barriers and Enablers

This study has highlighted the value of managerial and/ or organisational commitment to professional development and the provision of appropriate pathways to achieve this. Evidence however, strongly suggests that ongoing one-on-one personal development is being undertaken only in some organisations.

This study identifies the need for partnership and collaboration between clinical and non-regulated health staff. Central to this is the recognition of valuing worker. Further exploration of clinical and medical staff attitudes and view towards the effectiveness of the PNR workers will provide a balanced view to validate claims within this study.

This study identifies that workforce and professional development for PNR workers is centred upon relationships with management and peers. These forums play an important role in enabling the PNR workforce to network, collaborate and access peer support.

An issue which draws particular attention is the identification by workers in this study of familial, cultural and church related responsibilites as barriers and challenges to the completion or undertaking of training. The relationship between personal and employment related wellbeing is important to the overall ability for workers to be effective contributors to their families and employers, and as a consequence to Pacific communities. The challenge is to understand and address how familial, cultural and church related responsibilities can become enablers and not barriers to professional development. This question requires further exploration.

Conclusion

This study provides a snapshot of the Pacific non-regulated workforce at this point in time. It identifies areas that can be improved and highlights fields of work that are beneficial to Pacific non-regulated workers' productivity and wellbeing, and which can therefore continue to be supported and strengthened. Proactive responses to the points under the Implications section of this report will provide stakeholders with the means by which they are able to effectively develop the Pacific non-regulated workforce. The way forward is to build on existing information, whilst working towards planning for what will be required of this workforce in the short and long term future. Effective collaboration and engagement between key stakeholders such as the Ministry of Health, District Health Boards and the Pacific non-regulated workforce will be critical to ensuring the timely and adequately resourced development of this workforce.

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