



# Identifying, Preventing, and Responding to Abuse against Disabled People: Literature Review

Prepared by: Origin Research Charitable Trust

Prepared for: Child Matters

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## Introduction

“Disability is part of the human condition. Almost everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning. Most extended families have a disabled member, and many non-disabled people take responsibility for supporting and caring for their relatives and friends with disabilities” (Hague et al., 2008, as cited in WHO, 2011).

The New Zealand Disability Survey identified that, in 2013, 24 per cent of New Zealand’s population were identified as disabled, with this figure likely to rise as a result of our aging population (Statistics NZ, 2013). The World Health Organisation (WHO) and the United Nations Conventions on the Rights of Persons with Disabilities (UNCRPD) define disabilities in three ways: as an impairment, as having limitations in activity, and as experiencing restrictions on participation (Office of the High Commissioner for Human Rights [OHCHR], 2017b, as cited in Hickey & Wilson, 2017).

In the past decade, worldwide recognition of the rights of disabled people has increased significantly. In 2008, the United Nations Convention on the Rights of Persons with Disabilities came into force, reinforcing the understanding of disability as a human rights issue and development priority. In 2011, The World Health Organisation and the World Bank Group jointly produced the World Report on Disability with the purpose of providing evidence for policies and programmes designed to improve the lives of disabled people.

Locally, in 2014, the New Zealand Government put in motion the New Zealand Disability Action Plan 2014-2018. A key aspect of this plan is to “ensure personal safety” by “promoting systems and practices to protect disabled children and adults in all settings” (Office of Disability Issues, 2015, p. 13). With this, the plan acknowledges that disabled people should be educated on personal safety; in particular what abuse is, their rights not to be abused, and support in speaking up about abuse. What is not included in the plan, however, is any initiative to respond to identified abuse; particularly, there is no provision regarding upskilling providers in either the disability or domestic violence sectors to ensure safe and accessible pathways are available to those who disclose abuse. With this, there is a recognised need for education and training within this sector, with a specific focus on practice development for identifying, preventing, and reporting abuse.

The purpose of this report is therefore to provide evidence which supports the establishment of the training programme. This includes a review of the history and context of the treatment of disabled people in New Zealand, with a focus on how contributing factors have arisen and allowed to flourish within New Zealand. Particular attention, for this section, is given to the deinstitutionalisation of disabled people in New Zealand, the shift from a medical model to a social model of care, and the cultural considerations for Māori. This is followed by a section which looks at the prevalence and disclosure of abuse amongst disabled people; while it is recognised that there is a universal lack of quantitative data regarding abuse of disabled people, this section seeks to synthesise the wealth of qualitative information which demonstrates the extent of the problem in New Zealand.

With limited statistics available regarding the prevalence of abuse, section three will thus focus on why disabled people are more vulnerable to abuse i.e. what factors present within the person places a person at greater risk of abuse. From here, the following section aims to review the factors present which perpetuate the cycle of abuse within the disability sector with a specific focus on the workforce risks present which appear to maintain the status quo regarding the

treatment of disabled people in care. Therefore, when looking at abuse prevention for disabled people, and considering the above risks present, the next section looks at summarising the key aspects of training and support available in New Zealand and identifying the needs and gaps present in this space. Finally, the concluding section looks at barriers to disclosure and referral, and briefly discusses how improvements to this system have been made in Australia.

For the purposes of this work we will use the definition of abuse outlined in the *Ministry of Health report: The Prevention and Management of Abuse: Guide for services funded by Disability Support Services*. That is:

To abuse someone is to harm or hurt them in some way or violate their human or civil rights. Abuse can take many forms, including but not limited to:

- physical abuse – a wilful act carried out to cause pain or injury to disabled people
- sexual abuse – forcing someone to take part in sexual activity against their will or with consent gained through coercion
- verbal abuse – using disrespectful, derogatory or demeaning language either about or in conversation with disabled people; this language presents disabled people as less important, child-like, or inferior to others
- emotional abuse – including making verbal threats against, harassing or intimidating a person. Emotional abuse can occur when disabled people are not able to make independent decisions and determine their own identity. It can also occur through restricting a person’s social, intellectual, and emotional growth or wellbeing
- financial abuse – wrongfully using another person’s assets, income, benefit or New Zealand Superannuation or using force or coercion to prevent a person from using their own assets
- neglect and poor practice – not providing the essentials for life such as adequate nutrition, medication and other health requirements, adequate heating and fresh air. It may involve not meeting disability needs, or not providing necessary equipment or support
- restrictive practices – restraining or isolating someone for reasons other than medical necessity or to prevent immediate self-harm (Ministry of Health, 2016a).

Additionally, it is important to acknowledge that there are many terms to describe disabled people. This includes ‘people with a disability’, ‘people with impairments’, and ‘people experiencing disability’, amongst others. For the purposes of this report, the term disabled people will be used. This term was adopted in the *NZ Disability Strategy*, following wide consultation with disabled people (Dalziel, 2001) and aligns with the social model of disability, locating the problem in a society that disables impaired individuals.

## History/ Context

“...if we are to learn from the past then a new kind of vigilance is needed. If we don’t listen to the voices of the affected and learn today, tomorrow we will be haunted by the ghosts of yesterday, it may be each of us that ends our days excluded, voiceless, abused, out of sight, out of mind. (Mirfin-Veitch & Conder, 2017).”

Before looking at the treatment of disabled people in today’s society, it is important to acknowledge the significant shift in perceptions and treatment towards disabled people in New Zealand over time. These factors remain present as issues to be recognised and addressed when moving forward with elevating human rights as a priority area for disabled people.

Probably the most monumental societal shift can be attributed to the deinstitutionalisation of disabled people and how this has impacted communities and those who care for disabled people. In 2006, the last residents of the Kimberley Centre were relocated into the community, spelling the end of an era of large-scale residential institutions for intellectually disabled people in New Zealand. The establishment of Templeton Farm School in 1929 was the first institution of its sort, in response to legislation introduced in 1928 which allowed certain institutions to be set aside for the care and training of “mentally deficient” children. Following this, the construction of Ngawhetu in Nelson catered for younger intellectually disabled people, while the Kimberley Centre (formerly Levin Farm Mental Deficiency Colony) and Mangere Hospital became specialist institutions for intellectually disabled people. In New Zealand, as in many other parts of the world, the period of 1940s through to 1970s saw an increase in intellectually disabled people living in institutions. Thomson describes the focus of institutions as “to meet the basic demands of life, shelter people with an intellectual disability from the demands of society, and relieve society, particularly families, from the burden of dealing with people with an intellectual disability” (Thomson, 1995, as cited in Milner, Gates, Mirfin-Veitch, & Stewart, 2008, p. 2). Conversely, Robert Martin, an intellectually disabled disability rights activist and member of the UNCRPD, states “I’ve spoken to people all over New Zealand who lived in Kimberley and places like it. In fact, all over the world people have told me their stories and they are all the same: institutions are places of abuse” (McRae, 2014, p. 34).

Poor living conditions, such as those mentioned by Martin, became one of the key driving factors towards deinstitutionalisation. Deinstitutionalisation, “the movement of people from institutions to community based care” (Milner et al., 2008, p. 2) gathered momentum worldwide in the 1980s. In line with international trends “the New Zealand government announced in 1985 that it was adopting a policy of community living for people living in long stay institutional care” (Milner et al., 2008, p. 3). With this, in 1994, Mangere became the first institution to close, followed by Templeton Centre in 1999, and Braemar in 2004. The Kimberley Centre was the last institute of its kind to exist in New Zealand and closed its doors in 2006.

“They hurt. And the children hurt, too. And when, years later, everything changed, when the child came back into the community, sometimes 20,30, or 40 years on, it was a tremendous shock” (Alison Campbell, in McRae, 2014, p. 118).

Deinstitutionalisation, while an overall positive change in society’s approach to the treatment of disabled people, brought with it its own set of challenges and concerns. The report by the Donald Beasley Institute (2008) ‘*An examination of the outcome of the resettlement of residents from the Kimberley Centre*’ looks at the effects of deinstitutionalisation on disabled people, their families, and staff through interviews with these groups before and after resettlement. While, for the most part, vast improvements and positive outcomes were noted for resettled intellectually disabled people and their families, there has been “considerable variation in some areas considered important to the life quality of people who depend on disability services for support” (Milner et al., 2008, p. 3). With this, the report mentions that community-based services have often failed to deliver expected outcomes in terms of social relationships and community inclusion, personal choice, and valued social roles. For families, concerns revolve around long term security of funding for their families, with families often reporting that they do not believe funding will be on-going and long term. Additionally, at the forefront of concerns amongst families of resettled intellectually disabled people is having well trained and experienced staff to care for their family member. These concerns have been present for these families since the announcement of the planned closure, with many families mentioning they felt ill prepared and concerned about safety, security and staffing quality (Milner et al., 2008). Interestingly, even amongst those who favoured and had positive experiences with deinstitutionalisation, families frequently reported feeling

concerned about the ability of the community-based service system to recruit and retain staff with appropriate values and skills.

Inherent in institutionalisation is the concept that disabled people were out of sight and out of mind; deinstitutionalisation thus meant that disabled people were coming into a society with low levels of disability awareness and a social construct of disabled people as “devalued, low status, and not deserving of full societal involvement and support” (Hager, 2017, p. 58). Michael Roguski’s report *The Hidden Abuse of Disabled People Residing in the Community* (2013) reflects on some of the elements discussed by disabled people which indicates social oppression and negative attitudes and behaviours towards disabled people. Disability-focused humour, socially-endorsed alienation, social exclusion, and justification of rough treatment are some of the behaviours mentioned by Roguski (p.31) that demonstrate that while disabled people are no longer removed from society by way of institutionalisation, society is still relatively unaccepting of disabled people. The term ‘ableism’ has been coined by disability activists to describe “... discrimination against people with disabilities, including the expression of hate for people with disabilities, denial of accessibility, rejection of disabled applicants for housing and jobs, (and) institutionalised discrimination in the form of benefit systems designed to keep people with disabilities in poverty” (Feminists with disabilities for a way forward (n.d.) as cited in Hager, 2017, p. 63). Further to this, the discrimination and stigma experienced by disabled people results in verbal and physical abuse, denial of rights, segregation, and denial of appropriate health care (WHO, 2011). The consequences of this are a disabled person living in fear, withdrawal, isolation, reduced economic/ social participation, and ultimately low self-esteem.

The way in which society impacts on the overall well-being of a disabled person is emphasised through a shift from the medical model of disability to the social model of disability; this highlights the way in which society can impair or restrict an individual. The traditional medical model focused primarily on the person’s impairment and reflects the notion of the medical response to fix or heal so that the person can function ‘normally’ (Crow, 1996, as cited in Hager, 2017, p. 46). A key criticism of the medical model is thus that it ‘abnormalises’ disabled people and posits their role in society to one of being a problem that needs to be solved. This restricts disabled people in their rights, ability to make choices, control their own lives, and develop their own potential (Nikora, 2004, as cited in Hager, 2017). The social model of disability, on the other hand, emphasises that impairments occur because of societal barriers, that people are “disabled by a society that fails to be accessible to the range and needs present in the population” (Hager, 2017, p. 48). With this, people are disabled by the aforementioned attitudes and behaviours that disabled people encounter, the way society is organised and built, and the social structures that underpin society. This is further endorsed through the *New Zealand Disability Strategy* (2001) which states:

“Disability is not something individuals have. What individuals have are impairments. They may be physical, sensory, neurological, psychiatric, intellectual, or other impairments. Disability is the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have” (Dalziel, 2001).

However, further to the social and medical models of disability is consideration regarding how this looks for Māori. Indeed, Māori experience a higher prevalence of disability (33%) than other ethnic groups (24%) (Statistics NZ, 2013) and, despite this, Māori have less access to health and disability services (Hickey & Wilson, 2017). Criticisms of the aforementioned models include that they are not conducive to the values of community, whanau, and collectivism present in Māori culture, with the added recognition that many services are not set up to serve minority populations such as Māori. To this, Hickey and Wilson (2017) identify that the model Whanau Haua considers the more holistic Māori concepts of health, interdependence, and whanau. Whanau

Haua, the wind that propels whanau with members who have a disability, differs from the traditional definition of family, and widens this to encompass community and those with common purposes and experiences. Whanau Haua thus manage disability as part of their daily life, rather than it being central to an individual's identity. With this, Whanau Haua is similar to the social model of disability, but with the added cultural dimension of whanau working together to restore balance (Hickey & Wilson, 2017).

Fundamental to all of the aforementioned changes in the societal landscape was a move towards recognising disability as a human rights issue. In particular, the recognition that disabled people are subject to extraordinary violations of dignity through the lived realities of social exclusion, maltreatment, and abuse. What is known about the prevalence of abuse is discussed in the following section.

## Recognition of the Prevalence of Abuse Amongst Disabled People

When looking at the prevalence of abuse amongst disabled people, it is clear that it is a vast and difficult problem to quantify reliably. Extensively, it is noted that insufficient data, varying definitions of disability, methodological weaknesses, and limitations in the types of disability and violence addressed through existing studies means that there is a lack of robust data which can accurately convey the levels of abuse experienced by disabled people. As a result, as stated by Thiara et al (2012) "the first thing the research literature tells us is that there is not very much of it in any country" (as cited in Hager, 2017, p. 4)

Regardless of a lack of robust evidence, there are international studies which help, in some way, to indicate the extent of abuse experienced by disabled people. However, it is interesting to note that these studies predominantly focus on particular groups felt to be 'at risk'. These groups typically appear to be elderly people, people with learning disabilities, and, to some extent, disabled women (Calderbank, 2000). However, a piece of research was carried out in Canada by the Roeher Institute, which looked at the abuse of all disabled adults. The research found that disabled people are more likely than others to be subjected to acts of violence and abuse that are prescribed by criminal and civil acts (Rioux, Crawford, Ticoll, & Bach, 1997).

Baladerian, Coleman, and Stream (2013) conducted the 2012 *Survey on Abuse of People with Disabilities*, stated to be the first national survey of its kind in America. The preface to the report states "our findings were at the same time shocking and validating...the extent of abuse is epidemic, and the inadequate response of our community agencies is disturbing" (Baladerian, Coleman, & Stream, 2013, p. ii). The survey reached 7,289 responses, with respondents living in all 50 states across America. Respondents mostly had a direct connection with the disability experience, with 20.2% of respondents having a disability themselves or having an immediate family member with a disability (47.4%). Over 70% of disabled people in the survey stated they had been victims of abuse, with 63% of immediate family members reporting that their family member had experienced abuse. The survey also looked at abuse by different disability types, with those with mental health conditions reporting the highest levels of experience with abuse (74.8%). This was followed by 67.1% of those with a speech disability reporting they had been victims of abuse, 66.5% of those with autism, 62.5% of those with an intellectual disability, and 55.2% of those with a mobility disability. Another key finding from this study was the frequency of abuse experienced by disabled people, with more than 90% of disabled people who had been victims of abuse mentioning they had experienced abuse on multiple occasions (Baladerian et al., 2013).

The high levels of recurring abuse experienced amongst intellectually disabled people is further emphasised in a study by McCarthy and Thompson (1997) which found that sexual abuse of

intellectually disabled people was a frequent occurrence. Of the intellectually disabled people surveyed, 26% of women and 11% of men had been sexually abused once, 17% of women and 24% of men had been sexually abused several times, and 22% of women and 24% of men had experienced sexual abuse continuously over the years (Bruder & Kroese, 2005).

Studies have been conducted which explore the prevalence of abuse amongst disabled women. Nosek et al., quantitatively surveyed 504 disabled women. Of the 504 disabled women, 36% stated they had experienced some form of abuse (Nosek, Foley, Hughes, & Howland, 2001). Additional literature reports international prevalence rates ranging up to 90% for disabled women, stating that disabled women are between 3 and 4 times at a greater risk of sexual abuse than non-disabled women (Hager, 2017). This was further evidenced in Sobsey's (2001) study which identified that women with a developmental disability were much more likely than non-disabled women to experience sexual abuse. Sobsey analysed that almost half (46.6%) of the 100 disabled females in his database were sexually assaulted more than 10 times (Sobsey, 2001, as cited in Thornberry & Olson, 2005). Further to this, it was noted that women with a learning disability are at an even greater risk of abuse than women with a physical disability (Hager, 2017).

As discussed, reliable prevalence data regarding abuse of disabled people is very limited; it is even more limited when looking specifically at New Zealand literature of this sort. As an example, in New Zealand, national domestic violence studies to date have not included questions about disability or sought to be inclusive of disabled people. Deborah Hager, as part of her PhD entitled *Not inherently vulnerable: An examination of paradigms, attitudes and systems that enable the abuse of dis/abled women*, reviews some of the New Zealand literature available regarding the prevalence of abuse amongst disabled women and identifies that the closest measure for levels of violence against disabled women is the disability survey that asked about experiences of crime, with 11% of the disabled women surveyed mentioning they had been victims of any crime (Hager, 2017, p. 30). This evidence is restricted however to the fact that the question was confined to only the last 12 months, and there is no indication of whether it is physical, sexual, emotional or other violence. Interestingly, Hager also mentions two prevalence studies carried out in New Zealand institutes over 30 years ago whereby the results were never published due to almost all participants disclosing abuse therefore anonymity could no longer be guaranteed due to that level of disclosure (Hager, 2017).

An evaluation of the *Keeping Ourselves Safe* programme across 252 intermediate schools in New Zealand identified children with severe learning problems to be at the greatest risk of all forms of abuse (Briggs, 2006). In particular sexual abuse was mentioned, with 81% of girls in special education groups reporting sexual offence (compared to 4% for those not in special education classes). In all cases students had been shown pornography to desensitise them and normalise deviant sex with a number of disclosures made following their participation in the programme *Keeping Ourselves Safe*. It was also noted that, further increasing the risk, children with learning disabilities were less likely to be having conversations with their parents about personal safety issues (Briggs, 2006).

In the absence of quantitative data, we cannot ignore the extensive qualitative data that is available. With this, Roguski's (2013) report is a key piece of New Zealand literature which goes some way in providing qualitative evidence regarding the levels of abuse of disabled people in New Zealand. This research was conducted in 2013 with the purpose of understanding the nature of abuse and identifying the societal, and structural barriers that assist in the continuation of abuse or prevent disabled people from voicing abuse. Forty-four individuals participated in the research through individual, small group, and focus group interviews. The research highlighted that the prevalence is wide-reaching, occurring in residential services for physically, mentally, and intellectually disabled people, in general residential nursing services, and institutional

settings such as hospitals. Perpetrators were also wide-reaching, including health and welfare professionals, educators, care-givers, landlords, partners, friends, family, and in community settings. Roguski identified physical, sexual, emotional, and financial abuse as forms of abuse against disabled people. Further to this, Roguski also discusses a form of abuse he terms silencing, which refers to disabled people being pressured to refrain from reporting abuse, or having their complaints ignored (Roguski, 2013).

In addition, an important piece of literature which emphasises the stories of the abused is Mirfin-Veitch and Conder's (2017) report for the New Zealand Human Rights Commission to find out what is known about abuse of people with learning and other disabilities in State care. Many of the examples of abuse that are contained within this report are disabled people's stories, told and reported in their own voice. Through these stories, the report identifies that neglect was common, with nobody to comfort them, nothing to do, no family contact or relationship, no basic care and attention for injuries, being cold, and being made to work from a young age. Neglect appeared to feature more frequently across life stories than any other form of abuse:

"I use a fold-up cane to get me around these days, but when I was at Mangere Hospital, I didn't have anything to help me... I had to hold onto someone's arm to move around. If there was no one to hold onto, I'd have to wait" (Mirfin-Veitch & Conder, 2017, p. 11).

"There were people who couldn't move, and they would just stay where they had been left in the morning after breakfast. Most of these people were non-verbal and were trapped until someone got around to attending to them" (Mirfin-Veitch & Conder, 2017, p. 25).

Emotional abuse was noted through disabled people talking about being scared a lot, manifesting in a lack of trust, difficulty to make their own decisions, and long-lasting trauma.

"I was made to kneel on the wood pile, for two hours or more. It hurt so much..." (Mirfin-Veitch & Conder, 2017, p. 13).

"I was never loved as a child. Me and all those other kids... Even today I find it hard to show affection to other people. I don't trust easily." (Mirfin-Veitch & Conder, 2017, p. 12).

Being physically restrained, locked up, and being physically abused were also mentioned by participants in the study. Sexual abuse was perpetrated by staff as well as others living within the institutions.

"...He lectured me about all the trouble I had caused in my life and then he put his hands down my pants and touched me. I didn't know what was happening. All I knew was that I was bad and the man touching me was there to take care of me and must be allowed to do what he was doing" (Mirfin-Veitch & Conder, 2017, p. 14).

"I got belted up in Carrington Hospital by a patient. She kicked me in the leg until it bled. She took great big hunks of my leg... it took a long time to heal. I got belted up by her and she wouldn't leave me alone. I also used to get doped up in Carrington Hospital" (Mirfin-Veitch & Conder, 2017, p. 22).

Considering the above, it is inarguable to suggest that abuse is not prevalent against disabled people. Further to this, what is clear from various comparison studies, is that disabled people are at a much higher risk of experiencing abuse than non-disabled people. One such example of this is a comparison study conducted by Brownridge (2006) (as cited in Roguski, 2013) which highlighted that disabled women have a higher risk of experiencing violence than non-disabled women. The survey of 7,027 women (disabled and non-disabled) showed that disabled women were 1.4 to 1.9

times more likely to experience the threat of assault or to be physically abused than non-disabled women. Additionally, disabled women were 3 times more likely to have experienced sexual assault or a threat of sexual assault. This was further iterated by a comparison study by Martin, Ray, Stores-Alvarez, Kupper, Marocco, and Dickens (2006) which, using a similar methodology to the aforementioned research, identified that disabled women had more than 4 times the odds of experiencing sexual abuse, than non-disabled women (Martin et al., 2006).

Comparison studies such as these provide evidence to understanding how disabled people are incredibly vulnerable to abuse. These vulnerabilities are discussed in the following section.

## Vulnerabilities of disabled people

“because they’re so, really a more vulnerable group in the population and abuse is a great chooser of vulnerability” (Participant in Hager’s study, Hager, 2017, p.207).

There are various meanings of the word vulnerable within literature. In the first instance, *The Oxford Dictionary* provides two definitions: one definition focuses on someone or something being “exposed to the possibility of being attacked or harmed, either emotionally or physically” while the alternative definition focuses on the weakness inherent “(of a person) in need of special care, support, or protection because of age, disability, or risk of abuse or neglect” (Oxford Dictionary). Of particular relevance, the New Zealand Crimes Act (1961) defines a vulnerable adult as “a person unable, by reason of detention, age, sickness, mental impairment, or any other cause, to withdraw himself or herself from the care or charge of another person” (New Zealand Government, 1961).

Blum et al (2002) describes vulnerability as an interactive process between the social contexts in which a person lives and a set of underlying factors that, when present, place a person at risk of negative outcomes (as cited in Bruder & Kroese, 2005). Hager (2017) talked to participants in her research from across domestic violence and disability sectors and queried why vulnerability might exist amongst disabled people:

“Depending on the disability and on the person, it’s not quite so easy for them to walk away, or to seek help, because their own disability might get in the way of that. If someone’s living in a modified house, their partner’s being abusive, they can’t easily be the one to leave; the rest of us can pack a bag and off we go; they can’t because they need that living environment... Someone with an intellectual disability, it’s so, so easy to brainwash them, to control them, without them actually knowing how to deal with it, how to get out of it; and sometimes recognising what’s going on” (Hager, 2017, p. 201).

Andrew and Veronen (1993) cited 8 reasons for increased vulnerabilities: increased dependency, denial of human rights resulting in perceptions of powerlessness, less risk of discovery as perceived by the perpetrator, difficulty in being believed, less education about appropriate and inappropriate sexuality, social isolation and increased risk of manipulation, physical helplessness and vulnerability in public places, and “ values and attitudes within the field of disabilities toward mainstreaming and integration without consideration for each individual’s capacity for self-protection” (as cited in Nosek et al., 2001, p. 178).

Literature suggests that disabled people are at the highest risk of all forms of abuse because they are devalued by society in general. As mentioned, institutionalisation and subsequent deinstitutionalisation led to a society with low levels of disability awareness and a social construct of disabled people as devalued, low status, and not deserving of full societal involvement and

support. Parents were made to feel “embarrassed, ashamed, and guilty” about having disabled children (Kirkpatrick, 2003, as cited in Thornberry & Olson, 2005, p. 3) which in turn set up cultural stereotypes of disabled people as dangerous, sick, dependent, or useless.

“If we all stopped treating people with disabilities like helpless vulnerable people, not only would they begin to feel differently about themselves, then others would as well” (as cited in Thornberry & Olson, 2005, p. 13).

The experiences of stigma and discrimination results in low-self worth for disabled individuals, therefore they are more likely to have an increased tolerance to abuse or that they have no other choice. This was evidenced in Hassouneh-Phillips and McNeff’s (2005) study which found that high degrees of impairment are associated with lower body self esteem in physically disabled women, this in turn allows negative perceptions of themselves and “increases a women’s vulnerability to getting into and staying in abusive relationships over time” (Hassouneh-Phillips & McNeff, 2005, p. 228).

Additionally, this creates the external perception that abuse is thus inevitable, as highlighted in this quote from a participant in Hager’s (2017) study: “I heard an MOH official, and this was in relation to violence in facilities... and she used the words ‘it’s inevitable’, which I corrected to unacceptability...” (Hager, 2017, p. 207). Hager points out concerns that due to this perception of inevitability, that processes developed will not be robust and address causation as ‘it’s just going to happen anyway’.

The discrimination and stigma arising from stereotypes frequently results in disabled people experiencing physical and verbal abuse, denial of rights, segregation, and lack of accommodation (WHO, 2011). Intersectionality “addresses multiple discriminations and helps us to understand how different sets of identities impact on access to rights and opportunities” (AWID, 2007, as cited in Hager, 2017, p. 59). Hager’s report specifically focuses on disabled women, and, as such, discusses intersectionality in regard to placing the female gender at the centre, but recognising that lives are diverse and that racism, sexuality, socio-economic status, class, caste, skin colour, and religion combine to affect women’s social positions and societal experiences. With this, Frowley et al., (2005) observe that those seeking to understand violence against disabled women should also have knowledge of gender, disability, and other factors of diversity including living remotely or being indigenous (Hager, 2017, p. 61). Intersecting oppressions, cultural identities, communication barriers, lack of trust in the system and lack of access to culturally appropriate services are issues identified by Lightfoot & Williams (2009) in their study of disabled people of colour; in this study, disabled participants elaborated on feelings of being “exhausted” trying to define the discrimination they were experiencing as “racism, sexism, or some combination of all three” (as cited in Hager, 2017, p. 61). Due to fighting a number of stigmatisations, disabled people with additional intersectional elements become increasingly marginalised and discounted. Stigma and discrimination such as these lead not only to an increased risk of abuse, but also to disabled people’s testimonies being increasingly given less credence, making it hard to report abuse.

Another factor that is highlighted as increasing disabled people’s risk of abuse is difficulty in communicating the abuse. This factor increases vulnerability, particularly amongst those who are non-verbal, deaf, or have language impairments. Verdugo et al., (1997) (as cited in Thornberry & Olson, 2005) found that 75% of their research participants who had been abused had language problems (37% did not speak at all) and that the more severe the speech problem was, the greater the prevalence of abuse. Hager (2017) discusses that, particularly in the deaf community, that there may not be explicit language appropriate to describe the abuse that they are experiencing:

“If I explain to you... I would be explaining very differently than I explain to a woman from my community I understand the translation gets mixed up... financial abuse I can’t translate” (Hager, 2017, p. 135)

Additionally, barriers to understanding and recognising abuse also increase a disabled person’s susceptibility to being abused. This is particularly relevant for those with learning disabilities. Briggs (2006) discusses the likelihood that children with disabilities are targeted because they are less likely than others to recognise abuse as wrong, know their rights and report abuse, and be regarded as competent witnesses for court proceedings.

Abuse stems largely from the power/ control relationship between a carer and an individual, with many disabled people completely reliant on care and assistance, therefore feeling disempowered by their status; “disabled people often face disempowering situations where they are reliant on other people’s assistance- they mainly live in a world which consists of ‘wait a minute’ and so their lives go by ignored, constantly abused by those with power who exert control.” (McFarlane, 1995, as cited in Calderbank, 2000, p. 86). Shakespeare (1996) argues that the issue of power stems from the medical model devaluing disabled people in the eyes of non-disabled people (as cited in Calderbank, 2000). Power and control are the basic tools of the abuser; to break this cycle takes courage and the support of others. For disabled people, the opportunity to talk to someone may be scarce or, as aforementioned, communication impairments may prevent this, and gaining support may also be much more limited (Calderbank, 2000). Nosek et al., (2001) identifies that physical impairments make self-defence and escape more difficult; thus abuse is easier to perpetrate against a woman whose disability affects her strength and co-ordination. Additionally, Roguski identifies that, for a disabled person, they may become so accustomed to ill treatment that abusive behaviours are accepted as normal or not worthy of reporting.

Dependence on others might decrease assertiveness and foster the sense that one must comply with the wishes of the caregiver. A study by Sobsey and Doe (1991) (as cited in Thornberry & Olson, 2005) linked dependence and low self-esteem to “internalised devaluation” leading to dependent individuals to believe they are somehow responsible for the abuse. The role of carers is theorised as another factor which devalues disabled people, with current focus on policies and practices sympathising with the carer, making disabled people increasingly vulnerable to abuse. Further to this, the term ‘carer’ has been highlighted by disabled people as reinforcing the ‘helper-helped’ relationship which lies at the heart of dependency and reliance; the notion of replacing the word carer with that of personal assistant has been floated by some disabled groups (Calderbank, 2000).

To summarise vulnerability and abuse within disabled people, Hager (2017) states “the construction of vulnerable brings with it an expectation that abuse will occur and that those who are vulnerable will be preyed upon... as a society we know that vulnerable people will be abused, we create the conditions that enable the abuse to occur” (p.212). Indeed, it appears that the cycle of abuse is perpetuated by a society that does not appear to address the conditions by which abuse is allowed to occur. The following section discusses some of the elements present, particularly in the workforce which enables the abuse of disabled people.

## Perpetuating the cycle of abuse

Taking into consideration the history of the perception and treatment of disabled people, a recognition that there is a significant amount of abuse occurring in the disability sector, and the personal vulnerabilities present, we can begin to see that “society fosters the abuse of disabled people” (Brown, 1998, as cited in Calderbank, 2000, p. 525). Brown (1998) describes seven negative assumptions made by society about disabled people:

1. Disability is bad, inferior, or devalued
2. Disability means without ability, dignity, pride or dreams
3. Incompetent to provide for and direct their own lives
4. Vulnerability is a fault, a symptom that something is wrong with a person
5. It is acceptable to exclude them from decisions in or affecting their lives
6. Non-disabled people always know what is best for disabled people
7. Individual personal value is measured by net material worth, not personal existence (as cited in Calderbank, 2000, p. 525)

These assumptions are largely exacerbated by the medical model of disability, which devalues disabled people in the eyes of non-disabled people, making them vulnerable to abuse (Calderbank, 2000, p. 526).

Further fostering the cycle of abuse for disabled people is the lack of recognition regarding the devalued role of carers. The devalued role of carers alongside a medical model of disability is heightened through an under-resourced and ill-equipped workforce, creating workforce pressures, often culminating in perpetuating the cycle of abuse. Literature suggests that carers are under immense pressure, which leads to the deterioration of a relationship and increases the risk of abuse occurring. As mentioned, disabled people are particularly vulnerable due to the reliance on carers, this is heightened through “carers hav[ing] access to personal space, homes, and bodies making disabled people at special risk with a painful lack of means of escape” (Hendey & Pascall, 1998, as cited in Calderbank, 2000, p. 531).

The causal factors behind this immense pressure is discussed in a number of studies. Part 1 of the *Disability Service Provider* study (Ministry of Health, 2004a) identified that the workforce is dominated largely by female workers over the age of 40, with a large number of 70+ year olds reported to be working. While this data was gathered in 2004, a survey of New Zealand Disability Support Network members completed in 2015 (Te Pou o te Whakaaro Nui & NZDSN, 2016) found similar workforce trends to those in the 2004 Ministry of Health studies. Te Pou noted that, demographically, the support network population was made up of an aging, predominantly female, workforce. Further to this, reported language difficulties suggested that the workforce largely comprised of those whereby English is their second language (Ministry of Health, 2004a).

Additionally, there was also low Māori and Pasifika representation in leadership roles (Te Pou o te Whakaaro Nui & NZDSN, 2016) contributing to a lower level of cultural consideration. A study conducted by Ratima, Durie, Allan, Morrison, Gillies, and Waldon (1995) (as cited in Nikora, Karapu, Hickey, & Te Awekotuku, 2004) identified a number of cultural barriers for Māori disabled people in accessing quality, culturally appropriate, care. These included few Māori staff in services, dominance of non-Māori staff, lack of provider awareness of Māori perspectives, inadequate cultural appropriateness, and an underlying unfriendliness to Māori on the part of service providers.

The Disability Service Provider Study indicated a number of challenging workforce conditions. Uncertainty in working hours was one issue that was identified; the number of hours worked in a week varied greatly, with a median of 13 hours per week for home-based support workers and a median of 25 hours a week for residential support workers. This, combined with a high proportion of casual workers leads to poor formation of relationships between service users and providers. (Ministry of Health, 2004a). This high proportion of casual workers furthers the risk of abuse with these employees often opportunistic in nature, with theft of food or money a common problem reported (Ministry of Health, 2004b). With further regards to working hours, Higgins et al., (2009) in their report *Working in residential intellectual disability services, what is it like? Combined agency data* identified that the number of hours which staff worked typically exceeded the number of hours that they were contracted to, suggesting that staff are working longer shifts. Further to this

Higgins et al., (2009) reported that more than 47% of staff described working for longer than 20 hours in a row in a continuous shift, with 24% reporting working more than 40 hours continuously.

It was also noted that workers were on a low pay, with a figure of \$10.80 considered the most representative figure for support workers (Ministry of Health, 2004b). This is illustrated in Part 2 of the *Disability Service Provider Survey* (2004) which states “the support workers saw very little in the way of career advancement opportunities and left the sector in large numbers. The high staff turnover appeared to be due to the low rate of remuneration, inappropriate and inadequate training, the stress of the job, and the lack of career path” (Ministry of Health, 2004b, p. 3). These issues are highlighted as determining factors towards high staff turnover, a lack of suitable applicants available, and therefore an under resourced sector experiencing immense pressure.

This immense pressure is translated into service users’ perceptions of support services, as identified in *The Service User Survey*, conducted by the Ministry of Health and the University of Auckland which states “the residing impression by the service users, in relation to current service delivery, was it was inadequate and made them feel devalued” (Ministry of Health, 2004a, p. 7). Services users mentioned a lack of respect by support workers, a lack of involvement in decision making, and no consideration of cultural differences (Ministry of Health, 2004a). Furthermore, the Ministry of Health report identifies that supervision is lacking within these settings, with supervision viewed as ‘checking up on bad behaviour’ and often hard to administer in home settings, or rural/isolated settings (Ministry of Health, 2004a).

This is further discussed in Roguski’s report (2013) which identifies services in Gisborne/ Tairāwhiti as reflecting: low levels of professionalism, such as lack of professional standards demonstrated by managers of residential and home-based services; a lack of appropriately trained staff, which compromised the safety of the service user; and, questionable hiring practices. Roguski mentions that services were criticised for not carrying out checks on criminal history or previous employment (Roguski, 2013), however, this should be considered in light of the staffing issues previously discussed potentially contributing to a lack of suitable applicants. These applicants are often unable to even carry out basic domestic services, such as simple cooking or cleaning tasks, with caring for complex health-needs completely out of their skill-set (Ministry of Health, 2004b).

Roguski (2013) identifies that there were concerns raised about the failure of many services to place their clients’ safety as paramount, and that multiple examples were given of processes which re-victimised the disabled person. In order to address these workforce issues, the Kaiāwhina Workforce Plan was implemented in 2016; the vision of this plan is to have a workforce that adds value to the health and wellbeing of New Zealanders by being competent, adaptable and an integral part of the service provision; a central element of this is the provision of training (Ministry of Health & Careerforce, 2019). This is discussed in further detail in the following section.

## Training

In order to review the current training in New Zealand it is first necessary to discuss the definition of support and training for the purposes of this report. To this, support and training have been defined by the location of delivery and the type of qualification gained. This is an adaption of the definition used in the studies conducted by the Ministry of Health (Ministry of Health, 2004a, 2004b, 2004c, 2004d) which identified three general sources of training: mandatory training, optional in-service training, and ‘extra’ out-service training. Additionally, information and resources are available to support training within the sector. These training sources are further discussed in the following paragraphs.

Mandatory training was considered to be “the training that coordinators required their support workers to complete as a pre or co- requisite of employment” (Ministry of Health, 2004b, p. 12). Training such as this is generally completed in-house or on the job. Numerous mandatory training requirements were identified, referring predominantly to three key areas:

- **Standard workplace orientation:** policies and procedures, health and safety, and first aid;
- **Working with people with a disability:** correct lifting techniques, back care, food hygiene for meal preparation, first aid for specific treatments;
- **Person centred training:** e.g., some focus on disability awareness, human rights, basic communication skills, Treaty of Waitangi, cultural sensitivity.

The Ministry of Health reports identify that, often, elements one and two take priority, with person centred training taking second place. With this, staff reported a very heavy health focus and very little cultural focus.

It is interesting to observe that the above training requirements do not specifically mention prevention of abuse as a key element of training. This, however, appears to be different to the *Ministry of Health’s Guide for Prevention and Management of Abuse* (2016) whereby mandatory training falls within the required parameters for receiving funding support from Disability Support Services (DSS). To this, to receive such funding, it is recommended that training and supervision practices focus on:

- respectful approaches and self-reflective practice. Support staff need the opportunity through supervision to reflect on how they support disabled people and identify any learning opportunities;
- developing coping strategies to deal with challenging behaviours and developing effective behaviour support practices, including when restraint protocols are in place;
- understanding codes of conduct and the requirement for a more professional approach to support work;
- understanding the way people communicate and engaging with them to find out how they want to be supported;
- understanding the UNCRPD and how to put it into practice in the workplace;
- understanding what abuse is, and how to report, manage and prevent it;
- ensuring that staff are not working too many hours or working in isolation.
- working in ways that are consistent with the Let’s Get Real: Real skills for people working in disability (Ministry of Health, 2016a).

These guidelines are based on the *NZ Disability Strategy* and the *UNCRPD* 2006, however the application of these principles is left up to the provider.

Optional in-service training, or non-mandatory training, on the other hand, is offered over and above mandatory training. This form of training is often funded by the service provider and can range from talks conducted by specialists to internal training sessions taught by coordinators themselves (Ministry of Health, 2004b). These trainings appear to be focused largely on the ‘working with a person with a disability’ point, as mentioned earlier, and related to an extension of specific skills, thus quite specific and targeted training. The studies conducted by the Ministry of Health purported positive attitudes towards training from management and coordinators with regards to recognising that it improves the outcomes for service-users (Ministry of Health, 2004a). With the majority of this training funded by service providers, the implementation of this training mostly took the form of on the job training and considered to be “basically risk management” (Ministry of Health, 2004b) rather than an extension of skills or best practice.

Specific barriers to non-mandatory training were identified as:

- A lack of interest amongst staff, which was often attributed to a lack of academic ability and a general lack of readiness to be trained (i.e. poor literacy and low self-confidence in their ability to learn new skills).
- A lack of reimbursement when training also meant that staff often missed out on income (loss of a shift) and may have to travel, adding an expense to the training. There is often no pay increase or change in remuneration to motivate an increase in upskilling.
- The noted high staff turnover within the sector contributes to a difficulty in justifying the expense of training just to have people leave, especially when training resources often came directly from a profit margin.
- The sector is under resourced, which means time off to train creates difficulty and cost in both replacement of the staff member in training and also an inability to find a suitable person to replace that staff member's workload.
- The mode of delivery often didn't suit training; staff were reported to work inconsistent hours and/or travel to work, so an onsite training session may not suit their work setting. Consequently, training was largely completed in house and via buddy system.
- Personal circumstances of staff mean that they are unable to attend this type of training (home responsibilities most commonly cited) (Ministry of Health, 2004b).

Consequently, when looking at the levels of adequate training the Ministry of Health study estimated that only around 4.5% of the provider population were adequately trained (Ministry of Health, 2004a).

A further study on workforce barriers to training was completed in 2011 by Te Pou. This study was a continuation of the 2004 studies and reinforced the organisational and individual barriers represented above. However, the Te Pou study also identified a lack of awareness of the types of training available and a lack of suitable training available. This was considered to be a significant barrier to workforce upskilling (Te Pou o Te Whakaaro Nui, 2011).

In terms of out-service training, this can be categorised into formal and non-formal training. Formal training, for the purposes of this report is defined as nationally recognised certificates and diplomas that require core skill development and knowledge required to work in specific disability areas (Te Pou o Te Whakaaro Nui, 2011). With regards to formal training, there is very little information regarding the qualifications that are taken up amongst staff in the disability sector (Ministry of Health, 2013), however it was estimated that on average, 53% of support workers and 88% of co-ordinators (many co-ordinators were registered nurses) had recognised and adequate training to complete their job (Ministry of Health, 2004a). It was also noted within this report that qualification levels varied amongst service type, with those working in a residential care setting more likely to hold a recognised qualification of some sort (Ministry of Health, 2004a).

Amongst support workers generally, it seems that most qualifications are non-university qualifications and these are typically qualifications that have a recognised standard as defined by the New Zealand Qualifications Authority (Ministry of Health, 2004b). With this, the 2015 survey of New Zealand Disability Support network members (Te Pou o te Whakaaro Nui & NZDSN, 2016) found that 73% of support workers had some form of Health and Disability qualification; 53% with a Level 2 qualification, 41% a Level 3 qualification, and 6% Level 4 or higher.

When looking at the NZQA qualifications available within the sector, the type of qualifications appear to have changed over time; these were previously included in National Certificates in Health, Disability and Aged Support, National Certificate in Community Support Services, Certificate in Educational Support (Disability Studies) and a Diploma in Disability and Community

Support. Currently, the primary training organisation offering formal NZQA qualifications relating to the disability sector is Careerforce (previously CSSITO, Community Support Services Industry Training Organisation). Careerforce is an accredited Industry Training Organisation for the health, wellbeing, social and community sectors and is the government appointed body responsible for setting skill standards, developing and facilitating the achievement of NZQA recognised qualifications for the given sectors. The purpose of Careerforce is outlined to be to support “workplace-based training, enabling employees to achieve nationally recognised qualifications and deliver superior outcomes across the wellbeing sector” (Careerforce, 2019). Careerforce’s focus is wide-reaching and spans multiple sectors such as aged care, cleaning, disability support, healthcare services, home and community support, mental health services and addiction support, social services, urban pest management and youth work. However, when looking specifically at courses that relate to disability support, Careerforce lists a total of 33 courses, ranging from level 1 (New Zealand certificate) to level 7 (apprentice level). The purpose of the courses varies considerably, e.g., pest management, business management, health and wellbeing, dental assistance, brain injury rehabilitation etc. A full list is included in Appendix 1.

On review of the content, it appears there is a significant amount of content overlap between the courses. The disability-specific content identifies 15 applicable qualifications, mostly relating to health and wellbeing strands, however these also include elements of management roles and specialist skills. These courses are listed below:

- New Zealand Certificate in Skills for Living for Supported Learners (Level 1) with an optional strand in Skills for Working
- New Zealand Certificate in Health and Wellbeing (Level 2)
- New Zealand Certificate in Health and Wellbeing (Level 3) Health Assistance Strand
- New Zealand Certificate in Health and Wellbeing (Level 3) Orderly Services Strand
- New Zealand Certificate in Health and Wellbeing (Level 3) Support Work Strand
- New Zealand Certificate in Business (Level 3)
- New Zealand Certificate in Health and Wellbeing (Level 4) Advanced Support
- Apprenticeship in Health and Wellbeing (Level 4) Social and Community Services, Community Facilitation Strand
- New Zealand Certificate in Business (Level 4) First Line Management
- Apprenticeship in Health and Wellbeing (Level 4) Rehabilitation Assistance, Brain Injury Rehabilitation Support Strand
- New Zealand Diploma in Health and Wellbeing (Level 5) Applied Practice
- New Zealand Diploma in Business (Level 5) Leadership & Management
- New Zealand Diploma in Hearing Therapy (Level 6)
- New Zealand Diploma in Business (Level 6) Leadership & Management
- New Zealand Diploma in Vision Habilitation/Rehabilitation (Level 7)

Most of the above qualifications are delivered online, directly by Careerforce, through the online learning platform MyPath. However, while Careerforce is the government appointed body with the responsibility for the design/shape of these qualifications, they are not the only provider to offer these qualifications. Qualifications such as these can also be sourced through polytechnics, such as the New Zealand Diploma in Health and Wellbeing (Level 5) Applied Practice, which is also taught by AGI Education, Eastern Institute of Technology, Kauri Academy (NZ) International Ltd, and Southern Institute of Technology.

Additionally, Careerforce also works with other non-tertiary providers to deliver specialist qualifications in the disability sector. These include qualifications such as the Diploma for Hearing Therapy, taught by Life Unlimited and the New Zealand Diploma in Vision Habilitation/Rehabilitation (Level 7), delivered by the Blind Foundation.

The course content for the aforementioned qualifications is based around the focus on working with disabled people with complex needs. Of note, is that all level 1 – 3 disability support courses include a component of abuse identification and response; these courses are a precursor for further training in level 4 and above. When looking at this component, it appears the entry level certificate starts with recognising risk and maintaining a secure environment, further expanding to observing and responding to vulnerability and abuse (levels 2 and 3).

In March 2019 Careerforce added a component to the New Zealand Diploma in Health and Wellbeing (Level 5) Applied Practice, based on the Family Violence Sexual Violence and Violence within Whanau: Workforce Capability Framework. The framework was developed in 2017 with the purpose of giving “... the workforce a common understanding of family violence and sexual violence, enabling the workforce to provide a consistent, effective and integrated response to victims, perpetrators, their families and whanau” (Ministry of Social Development, 2017). At the time of writing, this element was in the product design stage, with Careerforce taking responsibility for the development of the resources for component. This component will include scenario-based learning and an assessment handbook, delivered via the MyPath platform. It does not appear that this content has been applied to any other course offered at this stage.

Outside of the Careerforce offering there are other formal qualifications/trainings that are relevant for those working in the disability sector. The New Zealand based employment and training website careers.govt.nz outlined 64 qualifications that related to careers within the disability sector. These include:

- 6 x Certificate level 1 – 3
- 8 x Certificate level 4
- 8 x Diploma
- 18 x Bachelors Degree
- 7 x Graduate Certificate/Diplomas
- 10 x Honours and Post Graduate Certificate/Diploma
- 3 x Masters Degrees

These courses include training offered by Universities, Polytechnics, and also NZQA accredited training organisations; this search included the Careerforce offerings.

A distinct gap in terms of a focus on Māori health and disabilities was noted, therefore one outcome of the NZQA mandatory review of the Health and Disabilities, Social Services and Whanau Ora Qualifications in December 2015 was the listing of 11 mātauranga Māori qualifications on the New Zealand Qualifications Framework (NZQF) (list included in Appendix 2). The qualifications focus on Kaupapa Māori principles in health and incorporate these approaches to working collaboratively with whanua, hapu, and iwi. With these qualifications formally listed as NZQA, they are thus able to be offered by tertiary providers.

Outside of formal training, is non-formal training. In this space, the most dominant provider of non-formal training is Te Pou o te Whakaaro Nui (Te Pou). Te Pou identifies themselves as a national centre of evidence-based workforce development for mental health, addiction and disability sectors in New Zealand. It should be noted that some of the offerings provided by Te Pou may fall within the aforementioned non-mandatory training, with a focus on workforce education. The content provided by Te Pou varies from supporting those who are disabled and in the workforce to education, information, and advocacy. Key pieces of work by Te Pou that relate to the prevention of abuse and the upholding of human rights are outlined below.

*Kai Noho Rangatira Ai Tatou* is a unique education programme developed by Te Pou and the Disabled Persons’ Assembly that puts human rights for disabled people and the Disability

Convention into a New Zealand context. The programme is based on the UNCRPD and is designed for disability support services and disabled people, however, the programme content can be used by anyone to uphold and promote human rights and holds the dignity and mana of the disabled person at the forefront of any interaction. Designed and delivered by disabled people, the programme focuses on educating and upskilling people in relation to disabled peoples' human rights. A 2-day workshop, the programme seeks to introduce and apply the Disability Convention, and places this into a New Zealand context, with the inclusion of the Treaty of Waitangi and cultural considerations of Māori. The 2-day workshop comprises of 3 models and 10 sections with a focus on practical application and increasing knowledge. A link to the programme outline is included in Appendix 3.

*Let's Get Real: Disability* is a framework that outlines the essential attitudes, values, skills and knowledge needed by anyone working in the disability sector (the attitudes, values, skills, and knowledge included in this framework are provided in Appendix 4). This framework takes a disabled person approach; it was built from the *Let's Get Real* framework for mental health and addiction and was modified in consultation with disabled people's organisations and disability support services.

Importantly, it is informed by the Treaty of Waitangi and the Human Rights Act 1993 and aligns with the UNCRPD and *Enabling Good Lives* initiative. The framework helps organisations to meet relevant New Zealand standards, Ministry of Health audit requirements, and action points of the *Putting People First* plan. However, although it is workplace focussed it produces resources for two main audiences; disabled people and their family/whanau and those who are working in disability support services. Disabled people and their family/whanau can use this framework when selecting a service, employing staff, talking about training needs, etc. Designed to enhance or complement existing organisational structures, organisations who work in disability can use the framework for similar outcomes, but can also use it to recognise and benchmark, the required values, attitudes and skills internally.

A summary of the resources and tools that are part of *Let's Get Real: Disability* are outlined below. Most have downloadable templates in word or pdf format, and all have accessible/easy to read versions, with many acting as resources that can be added to existing organisational systems and processes.

### **Tools**

- Human resources tool: helps organisations align their HR policies with the Let's Get Real framework
- Workforce planning tool and service planning tool: helps organisations understand, plan, implement and review the needs of their workforce with regards to the Let's Get real framework.
- Assessment tool: Assesses skills against the seven 'real' skills
- Real Skills: online assessment tool: helps organisations identify areas that their workforce may need to develop to better align with the *Let's Get Real* framework.

### **Resources and Guides**

- *Let's Get Real: Disability*: a framework: the primary resource that outlines the attitudes, knowledge and skills required to work in the disability sector.
- Guide for Leaders and Managers: A summary of the framework and a guide to support those who will implement the framework
- Guides to coaching, change management and project management: This set of resources helps those who are in the aforementioned roles (coaching, change and/or project management) to imbed the Let's get real: disability framework.

It should be noted that there have been some changes to the New Zealand landscape with regards to resources about violence prevention which are specifically intended for disabled people. One such example is the *Domestic Violence and Disabled People* resource produced for disabled people and their carers as part of the *Are You Ok?* campaign. This booklet outlines what family violence and abuse looks like and includes a self-check quiz for readers to understand if they are being abused along with contact numbers for support services should the person wish to make a disclosure of abuse. The following section discusses how disclosure and reporting of abuse works within the New Zealand setting.

## Barriers to disclosure, referral and reporting

It is important to discuss that through the implementation of training regarding abuse of disabled people, the incidence of reporting may subsequently increase with significant barriers in place to reporting abuse. Furthermore, personal and systemic barriers to disclosure mean that for many disabled people, the prevalence of abuse may continue to go unspoken. For the purposes of this report, disclosure is considered to be when a person (a disabled person or their carer) speaks up about abuse whereby reporting is when disclosure is made about an incident of abuse and this is reported to authorities.

Personal barriers are evident for both the disabled person and the carer when disclosing abuse. For the disabled person, Roguski (2013) discusses the fear of outcomes associated with disclosure, such as a loss of service, change in provider, or institutionalisation. Further to this, individuals can become conditioned to not report abuse from previous past negative experiences resulting from past complaints or being ignored or disbelieved by a third party (Roguski, 2013). The embarrassment and associated shame of having to report abuse is mentioned by multiple sources (Curry et al., 2011; Hague et al., 2008; Saxton et al., 2001; Saxton et al., 2006, as cited in Roguski, 2013), as is the increased level of violence and harassment toward a disabled person upon their abuse disclosure (Hague et al., 2008, as cited in Roguski, 2013).

For a carer, the *'Worker's Guide to Safe-guarding People Living with Disability from Abuse'* resource prepared by the Australasian Disability Professionals (2013) indicates that concerns that may prevent a carer from taking action include: the feeling of 'ownership' of an individual i.e. a long term carer may think that they know what's best for that person; the fear that they may be 'managed out' of supporting a person they are concerned about, or that nothing will happen anyway; anxiety about the working relationship becoming uncomfortable; and concern that, in taking action, the disabled person may become more depressed and/or isolated (Australasian Disability Professionals, 2013).

There are also a number of systemic barriers in place which may prevent disclosure from occurring. Hague et al., (2008, as cited in Roguski, 2013) identified that assistance from a support agency is a key facilitator in escaping abuse, however, Van Eden's report, *Putting People First*, identifies that there is no advocate or support person to assist a disabled person to speak out (Van Eden, 2013). With this, within Oranga Tamariki, there are social workers who advocate for vulnerable children; however, this does not appear to exist within the current system for vulnerable adults.

There also appears to be a lack of safe and accessible pathways; evidence suggests that having the certainty that disclosing abuse will ensure safety assists in facilitating disclosure (Curry et al., 2011, as cited in Roguski, 2013). However, there appears to be no such certainty, with the perpetrator (often the caregiver) continuing to provide care even after disclosure has been made (Van Eden, 2013). Further to this, there is a lack of accessible services designed to be able to safely remove a disabled person from the abuse situation. This is particularly notable through very few New Zealand refuge premises (such as Women's Refuge) being fully accessible; many of them

are not accessible at all for blind women, women in wheelchairs, those requiring other aids for mobility or communication, nor for women with learning disabilities. Services such as these do not have staff with the necessary skills to care for people with complex needs, no policies for working with disabled people, and no agreements with outside agencies (Hager, 2017). Without safe and accessible pathways present, there is no certainty that disclosing abuse will result in the safety of the disabled person.

Further to this, Van Eden's (2013) report recommends that there needs to be independent investigations undertaken of providers when significant complaints are laid. The current process involves the contacting of the provider to find out what has happened, with the provider conducting an internal investigation and reports back. This is supported by Saxton et al., (2006, as cited in Roguski, 2013) who identifies that there is a power imbalance between disabled services agencies and disabled people which does not support the disclosure of abuse. Van Eden (2013) identifies that "as long as there is a benefit to covering up abusive or neglectful behaviour, and as long as there is an advantage to those involved to collude and find against the case put forward, these behaviours will continue" (p.14) and thus suggests that the only way to obtain an accurate account of what has occurred is an independent and rigorous investigation of the incident.

There also appears to be an inability, through legislation, to prosecute perpetrators who are abusing disabled people. With this, current legislation lacks clarity around the protection of disabled people. One such example of this is identified in Hager (2017) whereby she discusses that the *Domestic Violence Act (1995)* excludes the employee/ employer relationship, effectively making it difficult to prosecute carers and support people who are intimately involved in a disabled person's life. Further to this, other legislative barriers include the *Crimes Act (Crimes Amendment Act, 2011)* which includes vulnerable adults within its legislative structure, however it is difficult to gather the evidence required for prosecution within this legislation, and requires significant impairment to be considered vulnerable (Van Eden, 2013). The *Protection of Personal Property and Rights Act (1988)* is also problematic as it lacks the criteria to guide enquiries into the suitability of the welfare guardian charged with meeting the needs of the disabled person and there is no specific requirement placed on the welfare guardian to actually account for the positive welfare of the person (Roguski, 2013).

One further piece of legislation that is currently under review is the absence of hate crime legislation. Although this is included in legislation overseas, current New Zealand legislation does not define acts of abuse as hate crimes. As such the public harassment or attack on a disabled person is not identified as a crime itself, thus there is not option for the protection or prosecution of disabled people who are subjected to this type of public abuse (Joint NGO Submission, 2014).

In addition to this, Van Eden (2013) points out a lack of understanding, skills, and empathy apparent amongst the police force. This is in relation to the difficulty of police to communicate with disabled people, which extends to a difficulty in collecting evidence required to prosecute. Supporting evidence for this was also noted within Roguski's report which identifies that "the ability of the police to prosecute an alleged perpetrator was restricted by difficulties associated with obtaining evidence that would be considered sufficient to meet the necessary evidential thresholds" (Roguski, 2013, p. x). It is important to note, however, that some investment has been made in improving police responses in this setting. The *Safeguarding Adults from Abuse (SAFA)* pilot, conducted between the Waitematā Police and the Waitematā DHB aimed to improve victim safety by preventing and reducing family harm and other forms of abuse, harm and neglect experienced by vulnerable adults (Appleton-Dyer & Soupen, 2017). This pilot appears to recognise that the police are the number one place that vulnerable adults will come to if they are being abused and seeks to provide a referral pathway and inter-agency response team for police working with vulnerable adults. Hager (2017) comments on this initiative and discusses that the

evaluation of this project identified that “carers, both paid and unpaid, abuse disabled people and that Police did not have the knowledge and skills to follow up and prosecute and/or refer abused people to support services until the interventions provided by the project provided training and resources to police. This initiative has not been continued, despite achieving very good outcomes for the 40 people supported over the 6 months of the pilot” (p.33).

When looking at the reporting system, this system came under scrutiny in the *Putting People First* report (Van Eden, 2013) which reviewed disability support services’ performance and quality management processes for services purchased by the government. A significant part of the report identified how poor performance management of government-awarded contracts contributes to reports being minimised. With this, it was discussed that provider contracts were set up to protect the Ministry, the provider, and the safety of the disabled person. However, the report identified that the timeliness of the reporting was often too slow and that decisions about reporting were based on whether the critical incident was going to result in media or political attention, rather than the severity of the incident or risk. The report also identified that there was a lack of clarity around the definition of significant risk, issues and critical incidents allowing for misinterpretation and the potential for under reporting. Furthermore, the report identified that the performance monitor reports (reports sent to local contract relationship manager regarding a provider’s performance) lacked reporting consistency, contained no useful data, were not delivered in a timely fashion, and were thus described as “strikingly ineffective” (Van Eden, 2013, p. 20).

Van Eden (2013) also suggested that independent certification audits were lacking, with these audits excluding those with fewer than 4 people, and that there was little attempt to assess the quality of a disabled person’s life when completing an audit. Roguski’s (2013) report also found a similar level of poor auditing. Roguski mentions that participants unanimously agreed that residential and home-based provision of care services are insufficiently monitored, and this contributes to the maintenance of a disabled person’s vulnerability to abuse. Lack of monitoring was identified in regard to quality of service provided, the individual client and family/ whanau satisfaction, and presence of abuse. It was regarded that no government agency was adequately auditing or overseeing complaints made by clients of home based or residential services. Additionally, there appears to be no monitoring provision for disabled people residing in their own homes, who are not in receipt of paid service provision. As such, disabled people who are home-based are in an extremely vulnerable position, with incidences of abuse likely to go unidentified.

Van Eden (2013) also identified that the Ministry of Health’s own internal process for resolving issues or complaints was lacking clarity around how to deal with a complaint. If a complaint was brought to the Ministry, there seemed to be no clear process by which a response should be given, e.g., no clear definitions of risk, no escalation points, no system to capture issues and findings in a single place, and no guidelines around what actions to take. The report concluded that the level of subjectivity was too high with decisions made by inexperienced staff members. There also seemed to be a lack of action taken when service facilities were consistently, and knowingly, underperforming. Furthermore, the report was critical when looking at the cross department sharing suggesting that data from different agencies could identify abuse disclosures and reporting earlier.

The Ministry of Health took these findings and determined an action plan. This was last reported on in August 2016 by which stage 96% of the actions were completed or ongoing in terms of improving the performance management (Ministry of Health, 2016b). However, in light of the previously discussed issues with regards to the prevalence of abuse and the perpetuation of the cycle abuse within the New Zealand setting, it is clear there are still issues present which need to be addressed before training can be implemented in a system with a supported and sustained

framework. One such example of how training can function within a framework such as this, is the support for disability services in Australia. Disability support services in Australia are funded via the National Disability Insurance Scheme (NDIS). This scheme aims to provide targeted support, better co-ordination, and better access to services for disabled people.

As part of this development, the Australian Commonwealth Government established the National Disability Insurance Scheme (NDIS) (Commonwealth of Australia). The NDIS Quality and Safeguards Commission is a new independent agency established to improve the quality and safety of NDIS supports and services. This agency is purposed with regulating the NDIS market, providing national consistency, promoting safety and quality services, resolving problems, and identifying areas for improvement. Under the NDIS Commission, the requirements for NDIS providers will be nationally consistent, proportionate to the size and scale of organisations and breaches, and responsive to an expanding market.

Requirements include:

- **A national provider registration system;**
- **NDIS Practice Standards;**
- **An NDIS Code of Conduct:** The NDIS Code of Conduct requires workers and providers delivering NDIS supports to:
  - act with respect for individual rights to freedom of expression, self-determination, and decision-making in accordance with relevant laws and conventions;
  - respect the privacy of people with disability;
  - provide supports and services in a safe and competent manner with care and skill;
  - act with integrity, honesty, and transparency;
  - promptly take steps to raise and act on concerns about matters that might have an impact on the quality and safety of supports provided to people with disability;
  - take all reasonable steps to prevent and respond to all forms of violence, exploitation, neglect, and abuse of people with disability;
  - take all reasonable steps to prevent and respond to sexual misconduct.
- **A national worker screening system:** The responsibility for providing a safe environment for people with disability rests with employers. Worker screening is a way to check that the people who are working or wish to work with the NDIS don't present an unacceptable risk to people with disability. It provides employers with an important tool for their recruitment, selection and screening processes, and in the ongoing review of the suitability of their workers. As a part of the National Disability Insurance Scheme Quality and Safeguarding Framework, the Commonwealth, most states and territories will implement nationally consistent worker screening arrangements from 1 July 2019. Worker screening is only one of a range of strategies that providers need to put in place to identify and minimise risk of harm to people with disability. Providers are also responsible for promoting positive organisational cultures that do not tolerate abuse, neglect or exploitation, ensuring quality recruitment, selection and screening, and maintaining a focus on education and training for your workers.
- **A new complaints management and resolution system:** Registered NDIS providers are required to have complaints management arrangements in place and support people with disability to understand how to make a complaint to the provider and to the NDIS Commissioner.
- **New incident management requirements, including reportable incidents:** A full list of these requirements can be accessed at: <https://www.ndiscommission.gov.au/providers/reportable-incidents>
- **New behaviour support requirements, to reduce and eliminate restrictive practices.** Behaviour support is about creating individualised strategies for people with disability that are responsive to the person's needs, in a way that reduces the occurrence and impact of behaviours of concern and minimises the use of restrictive practices. The

new arrangements for behaviour support under the NDIS Commission focus on person-centred interventions to address the underlying causes of behaviours of concern or challenging behaviours, while safeguarding the dignity and quality of life of people with disability who require specialist behaviour support. This approach includes undertaking a functional behavioural assessment, then developing an NDIS behaviour support plan containing evidence-based, proactive strategies that meet the specific needs of the participant (Commonwealth of Australia).

The above strategy appears to acknowledge and attempt to counteract many of the workplace issues, disclosure and reporting issues, and quality of care issues that are mentioned throughout this report. While this is not specific to designing and implementing a training programme, it is important to consider the issues that are included throughout this report in light of providing effective training and support within the history and context of the New Zealand setting.

# Discussion

This literature review examined the history and context of the treatment of disabled people in New Zealand, the prevalence of abuse and why disabled people are more vulnerable to abuse, factors present which perpetuate the cycle of abuse, and reviewed the key training and support available in New Zealand. The purpose of this literature review was to inform and guide the development of a training programme in recognition of the need for education and training within the disability sector, with a specific focus on identifying, preventing, and reporting abuse.

It is clear that abuse of disabled people is a significant issue, not just in New Zealand, but worldwide. While there is a wide recognition that it is a vast and difficult problem to quantify reliably, what we do know through the quantitative studies that have been conducted, is almost all reports have identified that abuse against disabled people is at “epidemic” proportions (Baladerian, Coleman, & Stream, 2013, p. ii). Furthermore, there is significant qualitative information both internationally and nationally that highlights the extent of the abuse and mistreatment suffered by disabled people. Upon writing this review, it is observed that while this is an issue that is acknowledged within ministry reports, this does not appear to be shifting societal misperceptions and miseducation enough to ensure that this culture of abuse ceases. Thus, when considering that the purpose of this review is to inform and guide the development of a training and education programme, it is imperative to understand what aspects need to be considered in order to educate, train, and ultimately address the issue of the prevalence of abuse against disabled people in New Zealand.

Through reviewing the context and history of the treatment of disabled people in New Zealand and by focusing on the vulnerabilities of disabled people, it was apparent that even through a shift to the deinstitutionalisation of disabled people, society continues to perpetuate the construct of disabled people as “devalued, low status, and not deserving of full societal involvement and support” (Hager, 2017, p.58). Disabled people continue to face significant discrimination, stigma, denial of rights, and segregation which continues to result in an increased level of abuse and mistreatment. This social construct appears to be deep-seated and one which has its roots firmly still in the period of institutionalisation. It appears that, as a collective society, we are yet to completely take the leap to fully accept de-institutionalisation and welcome disabled people as equal members of our society. Inherent in this, and of particular importance when considering education and training, is that there appears to be a lack of acknowledgement or appreciation of the basic human rights of disabled people in New Zealand. Before we can even begin to address how to recognise and respond to abuse, we need to first cement the concept that disabled people should uphold the same rights as all members of society. With this, when considering an education model, it could be argued that any training or education in the disability sector should be premised by a full and complete understanding of the human rights that each disabled person deserves.

Further to the above, it is important to acknowledge and understand the workforce components within which any training or education programme will exist. Significant issues with regards to a stressed, under-paid, under-resourced, and generally de-valued workforce are acknowledged and hypothesised as causative factors which perpetuate the cycle of abuse. Further to this, it is identified that this workforce is a particularly transient workforce, contributing to a lack of connection with the job, weakened perception of this as a viable career choice, and thus often limited relationships with the provider or those they are caring for. These workforce conditions, combined with societal assumptions of disabled people as inferior or incompetent, are exacerbated by the medical model of disability and play into the power imbalance which is

so often connected with the cycle of abuse. Service users mention a lack of respect by support workers, a lack of involvement in decision making, and no consideration of cultural differences (Ministry of Health, 2004a) which mirrors the observation made that current training delivered to service providers focuses predominantly on health training, rather than people or cultural centric training, thus continuing the lack of attention to basic human rights of disabled people.

Considering the aforementioned workforce issues, when developing training or education in the sector, it is important to also consider the key barriers to training which are contributing to the level of adequately trained staff being so low. These can be summarised as a lack of interest, a lack of appropriate reimbursement, high staff turnover contributing to a lack of justification of the expense of training, a lack of time available to do the training given the under-resourcing of the sector, and the mode of delivery being unable to suit. Thus, the creation of any training or education programme needs to first consider these barriers and how they can be overcome through the delivery of such a programme.

When looking further at training within the sector, it is interesting to note that within mandatory training, no training requirements mention prevention of abuse as a key element of training. This appears to contradict the *Ministry of Health Guide for Prevention and Management of Abuse* (2016) whereby mandatory training regarding abuse falls within the required parameters for receiving funding support from Disability Support Services. However, of concern, is the fact that the application of these principles is completely left up to the provider. Primary research with those in carer roles could seek to uncover the level to which providers actually adhere to the training guidelines regarding prevention and management of abuse, particularly when it is taken into account that around only 4.5% of the provider population were deemed “adequately trained” by a Ministry of Health report (2004a).

It is important to note that the delivery of effective training and education focusing on recognising and reporting abuse may result in an increased incidence of reporting. While this is a positive change that is needed, there are still significant barriers in place to reporting abuse and ensuring that there is a significant shift in the way disabled people are treated in New Zealand. This report, and subsequent discussion, focuses on the implementation of training and education, thus these barriers will be summarised here, rather than elaborated upon. The key barrier to reporting and shifting the status quo is the lack of an independent agency to investigate complaints; the current situation supports the power imbalance between disabled services and disabled people, and does not support the disclosure of abuse. Further to this legislative barriers impede the prosecution of perpetrators and there is a notable lack of support services available tailored to assist disabled people who are trying to escape from abuse. If there is to be an effective training and education programme in place that will raise the incidence of reporting, we need the legislative, process, and service infrastructure to be able to support this, before we see any real shift in the “epidemic” problem that is the abuse of disabled people in our country.

# Reference List

- Appleton-Dyer, D. S., & Soupen, A. (2017). *Rapid Review of the Waitematā Safeguarding Adults from Abuse (SAFA) Pilot*. Retrieved from Auckland, New Zealand:
- Australasian Disability Professionals. (2013). *A Worker's Guide to Safe-guarding People Living with Disability from Abuse* Retrieved from South Australia
- Baladerian, N., Coleman, T., & Stream, J. (2013). Abuse of people with disabilities: Victims and their families speak out.
- Briggs, F. (2006). Safety issues in the lives of children with learning disabilities / by Freda Briggs. In.
- Bruder, C., & Kroese, B. S. (2005). The efficacy of interventions designed to prevent and protect people with intellectual disabilities from sexual abuse: a review of the literature. *The Journal of Adult Protection*, 7(2), 13-27. doi:<http://dx.doi.org/10.1108/14668203200500009>
- Calderbank, R. (2000). Abuse and Disabled People: Vulnerability or social indifference? *Disability & Society*, 15(3), 521-534. doi:10.1080/713661966
- Careerforce. (2019). Careerforce: Qualifications for Life. Skills for Good. Retrieved from <https://www.careerforce.org.nz/>
- Commonwealth of Australia. NDIS Quality and Safeguards Commission. Retrieved from <https://www.ndiscommission.gov.au/>
- Dalziel, L. (2001). *The New Zealand disability strategy: Making a world of difference: Whakanui oranga*. Wellington: Ministry of Health.
- Hager, D. M. (2017). *Not inherently vulnerable: An examination of paradigms, attitudes and systems that enable the abuse of dis/abled women*. (Doctor of Philosophy in Health Science), University of Auckland, Auckland.
- Hassouneh-Phillips, D., & McNeff, E. (2005). "I Thought I was Less Worthy": Low Sexual and Body Esteem and Increased Vulnerability to Intimate Partner Abuse in Women with Physical Disabilities. *A Journal Devoted to the Psychological and Medical Aspects of Sexuality in Rehabilitation and Community Settings*, 23(4), 227-240. doi:10.1007/s11195-005-8930-3
- Hickey, H., & Wilson, D. (2017). Whānau hauā: Reframing disability from an Indigenous perspective. *Mai Journal*, 6(1), 82-94.
- Joint NGO Submission. (2014). Abuse of Disabled People in New Zealand. In.
- Martin, S. L., Ray, N., Sotres-Alvarez, D., Kupper, L. L., Moracco, K. E., Dickens, P. A., . . . Gizlice, Z. (2006). Physical and sexual assault of women with disabilities. *Violence against women*, 12(9), 823-837.
- McRae, J. (2014). *Becoming a Person: The biography of Robert Martin*. In. Nelson: Craig Potton Publishing.
- Milner, P., Gates, S., Mirfin-Veitch, B., & Stewart, C. (2008). An examination of the outcome of the resettlement of residents from the Kimberley Centre. *Dunedin: Donald Beasley Centre*.
- Ministry of Health. (2004a). *Disability Support services in New Zealand: Part 1, Service Provider Survey*. Wellington
- Ministry of Health. (2004b). *Disability Support Services in New Zealand: Part 2, Provider Survey*. Wellington
- Ministry of Health. (2004c). *Disability Support Services in New Zealand: The Service User Survey*. Wellington
- Ministry of Health. (2004d). *Disability Support Services in New Zealand: The Workforce Survey*. Wellington
- Ministry of Health. (2013). Innovative Methods of Providing Health Services for People with Intellectual Disability: A review of the literature. In. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2016a). *The Prevention and Management of Abuse: Guide for services funded by Disability Support Services*. Wellington

- Ministry of Health (Producer). (2016b). Putting People First: Quality Review. Retrieved from <https://www.health.govt.nz/our-work/disability-services/disability-projects/putting-people-first-quality-review>
- Ministry of Health, & Careerforce. (2019). *Kaiawhina: Workforce Action Plan: 5-Year Actions 2015-2020; Toward the 20-Year Vision*. New Zealand
- Ministry of Social Development. (2017). Family Violence, Sexual Violence and Violence within Whanau: Workforce Capability Framework. In. Wellington, New Zealand: Ministry of Social Development.
- Mirfin-Veitch, B., & Conder, J. (2017). "Institutions are Places of Abuse": The Experiences of Disabled Children and Adults in State Care. Dunedin: Donald Beasley Institute.
- Crimes Act. ss2(1), (1961).
- Nikora, L. W., Karapu, R., Hickey, H., & Te Awekotuku, N. (2004). *Disabled Māori and disability support options*. Retrieved from Hamilton: <https://hdl.handle.net/10289/460>
- Nosek, M., Foley, C., Hughes, R., & Howland, C. (2001). Vulnerabilities for Abuse Among Women with Disabilities. *A Journal Devoted to the Psychological and Medical Aspects of Sexuality in Rehabilitation and Community Settings*, 19(3), 177-189. doi:10.1023/a:1013152530758
- Office of Disability Issues. (2015). The Disability Action Plan 2014-2018. In. Wellington, New Zealand.
- Oxford Dictionary. Vulnerable. Retrieved from <https://en.oxforddictionaries.com/definition/vulnerable>
- Rioux, M., Crawford, C., Ticoll, M., & Bach, M. (1997). Uncovering the shape of violence: A research methodology rooted in the experience of people with disabilities. *Doing disability research*, 190-206.
- Roguski, M. (2013). *The hidden abuse of disabled people residing in the community: An exploratory study*. Retrieved from Gisborne, New Zealand:
- Statistics NZ. (2013). *Disability Survey*. Wellington Retrieved from [http://www.stats.govt.nz/browse\\_for\\_stats/health/disabilities/disabilitysurvey\\_HOTP2013/Tables.aspx](http://www.stats.govt.nz/browse_for_stats/health/disabilities/disabilitysurvey_HOTP2013/Tables.aspx)
- Te Pou o Te Whakaaro Nui. (2011). Disability Support Services: Workforce Training Needs and Barriers. In. Auckland, New Zealand.
- Te Pou o te Whakaaro Nui, & NZDSN. (2016). The New Zealand disability support workforce: 2015 survey of NZDSN member organisations: A summary report. In. Auckland: Te Pou o te Whakaaro Nui.
- Thornberry, C., & Olson, K. (2005). The Abuse of Individuals with Developmental Disabilities. *Developmental Disabilities Bulletin*, 33, 1-19.
- Van Eden, K. (2013). *Putting people first: A review of Disability Support Services performance and quality management processes for purchased provider services*. Retrieved from Wellington, New Zealand:
- WHO. (2011). World report on disability. In. Geneva, Switzerland: World Health Organisation.

# Appendices

## Appendix 1: Careerforce Qualifications related to disability support.

[https://www.careerforce.org.nz/our\\_sectors/disability-support/](https://www.careerforce.org.nz/our_sectors/disability-support/)

Level	Course	Description	Related sectors
1	New Zealand Certificate in Skills for Living for Supported Learners (Level 1) with an optional strand in Skills for Working	This programme is ideal for learners who require specialised support who want to improve their self-management skills to gain employment or further their studies.	DISABILITY SUPPORT ONLY
2	New Zealand Certificate in Health and Wellbeing (Level 2)	This is an ideal induction programme to develop entry-level skills and knowledge required for entry into careers in the health and wellbeing sectors.	AGED CARE DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT SOCIAL SERVICES
2	New Zealand Certificate in Cleaning (Level 2)	This programme is designed for cleaners in commercial, residential, health and domestic situations. It aims to encourage safe work practices, and develop skills related to cleaning effectively and efficiently.	AGED CARE CLEANING HEALTHCARE SERVICES
3	New Zealand Certificate in Health and Wellbeing (Level 3) Health Assistance Strand	This programme aims to develop the skills and knowledge required to provide care under the direction and delegation of a health professional in an aged residential, acute, primary and rehabilitative care context.	AGED CARE DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT
3	New Zealand Certificate in Health and Wellbeing (Level 3) Dental Assistance	This programme develops the skills and knowledge needed to support dentists with quality patient care and the running of a dental practice.	HEALTHCARE SERVICES
3	New Zealand Certificate in Health and Wellbeing (Level 3) Orderly Services Strand	This programme aims to develop the skills and knowledge required to support a healthcare facility through the provision of orderly services.	AGED CARE DISABILITY SUPPORT HEALTHCARE SERVICES

3	New Zealand Certificate in Health and Wellbeing (Level 3) Newborn Hearing Screening Strand	This programme aims to develop the skills and knowledge required for the hearing screening of babies.	HEALTHCARE SERVICES
3	New Zealand Certificate in Health and Wellbeing (Level 3) Vision and Hearing Screening Strand	This programme aims to develop the skills and knowledge required to undertake the vision and hearing screening of children.	HEALTHCARE SERVICES
3	New Zealand Certificate in Health and Wellbeing (Level 3) Support Work Strand	This programme aims to develop the skills and knowledge required to support and empower people in home and community settings.	AGED CARE DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT MENTAL HEALTH & ADDICTION SUPPORT
3	New Zealand Certificate in Health and Wellbeing (Level 3) Whānau, Kin and Foster Care Strand	This programme aims to develop the skills and knowledge required to support children and young people who cannot live with their own parents.	HEALTHCARE SERVICES SOCIAL SERVICES
3	New Zealand Certificate in Youth Work (Level 3)	This programme aims to develop the entry-level skills and knowledge required to work safely and effectively with young people.	SOCIAL SERVICES YOUTH WORK
3	New Zealand Certificate in Cleaning (Level 3)	This qualification is for experienced cleaners who want to gain general skills and knowledge to deliver, guide and promote safe and high-quality cleaning services.	AGED CARE CLEANING HEALTHCARE SERVICES
3	New Zealand Certificate in Cleaning (Level 3) Specialist Cleaning Strand	This qualification is for experienced cleaners wishing to gain specialist skills and knowledge in areas of cleaning including: carpet and textiles, contagion and specialised infection control, hard floor surfaces, food production and high risk environments	AGED CARE CLEANING HEALTHCARE SERVICES
3	New Zealand Certificate in Cleaning (Level 3) Supervision Strand	This qualification is for experienced cleaners who want to gain the skills and knowledge to lead a team of cleaners.	AGED CARE CLEANING HEALTHCARE SERVICES

3	New Zealand Certificate in Business (Level 3)	This programme is for business and administration staff working in social, health and hygiene sectors who wish to expand their knowledge and skills within their role.	AGED CARE CLEANING DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT MENTAL HEALTH & ADDICTION SUPPORT SOCIAL SERVICE SURBAN PEST MANAGEMENT YOUTH WORK
3	New Zealand Certificate in Pest Operations (Level 3) Urban Pest Control	This qualification will recognise the skills and knowledge of individuals who carry out pest control in built environments.	URBAN PEST MANAGEMENT
3	New Zealand Certificate in Health and Wellbeing (Health Assistance) for hospitals and the health sector	The aim of this programme is to develop and recognise the skills of healthcare assistants to provide person-centred support to patients.	AGED CARE HEALTHCARE SERVICES
4	New Zealand Certificate in Health and Wellbeing (Level 4) Advanced Support	This qualification is for senior support workers employed in residential and home and community roles who support people with complex needs and/or requiring advanced dementia care or palliative care.	AGED CARE DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT
4	Apprenticeship in Health & Wellbeing (Level 4) Social and Community Services, Mental Health & Addiction Support Strand	Apprentices will develop and demonstrate the skills needed to work alongside people, family and whānau to support autonomy by fostering hope, support recovery and build resilience.	HEALTHCARE SERVICES MENTAL HEALTH & ADDICTION SUPPORT
4	Apprenticeship in Health and Wellbeing (Level 4) Social and Community Services, Community Facilitation Strand	Apprentices will develop and demonstrate the skills needed to work alongside people, family and whānau to support autonomy to identify goals, address barriers and achieve aspirations.	AGED CARE DISABILITY SUPPORT HOME & COMMUNITY SUPPORT SOCIAL SERVICES YOUTH WORK
4	Apprenticeship in Health and Wellbeing (Level 4) Social and Community Services, Community Health Work strand	This Level 4 strand enables apprentices to develop the skills they need to work alongside people, family and whānau to support their self-management of health and wellbeing.	AGED CARE HOME & COMMUNITY SUPPORT SOCIAL SERVICES

4	New Zealand Certificate in Youth Work (Level 4)	The purpose of this qualification is to provide the youth work sector with people who are equipped with the broad operational and theoretical knowledge to work with youth.	SOCIAL SERVICES YOUTH WORK
4	New Zealand Certificate in Business (Level 4) First Line Management	This business programme is for experienced first line managers working in social, health, aged care, disability, community, cleaning and urban pest management sectors.	AGED CARE CLEANING DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT MENTAL HEALTH & ADDICTION SUPPORT SOCIAL SERVICES URBAN PEST MANAGEMENT YOUTH WORK
4	Apprenticeship in Health and Wellbeing (Level 4) Social and Community Services, Social Services Strand	Apprentices will develop and demonstrate the skills needed to work alongside people, family and whānau to support autonomy by using tools and strategies to reduce vulnerability and build resilience.	SOCIAL SERVICES
4	Apprenticeship in Health and Wellbeing (Level 4) Primary Care Practice Assistance	This Apprenticeship in Primary Care Practice Assistance gives your staff the training they need to undertake clinical and administrative tasks in a primary care practice.	HEALTHCARE SERVICES
4	Apprenticeship in Health and Wellbeing (Level 4) Rehabilitation Assistance, Brain Injury Rehabilitation Support Strand	This Apprenticeship in Brain Injury Rehabilitation Support gives your staff the training they need to support the rehabilitation of a person after a brain injury.	DISABILITY SUPPORT HEALTHCARE SERVICES
4	Apprenticeship in Health and Wellbeing (Social and Community Services) Community Facilitation strand specialising in Youth Work	The Youth Work Apprenticeship programme provides youth workers with a broad understanding of the wider social context in which they work in and provide them with youth work specific skills and knowledge.	YOUTH WORK
4	Apprenticeship in Health and Wellbeing (Social and Community Services) Community Facilitation strand specialising in Diversional Therapy	On completion, Diversional Therapists will meet the qualification and competency requirement to become registered with the New Zealand Society of Diversional Therapists.	AGED CARE

5	New Zealand Diploma in Health and Wellbeing (Level 5) Applied Practice	The diploma is designed to qualify advanced support workers who work closely and collaboratively to support people and whānau with complex needs.	DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT MENTAL HEALTH & ADDICTION SUPPORT SOCIAL SERVICES YOUTH WORK
5	New Zealand Diploma in Business (Level 5) Leadership & Management	Operational managers and team leaders will develop the skills and knowledge required to contribute to the achievement of an organisation's operational objectives.	AGED CARE CLEANING DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT MENTAL HEALTH & ADDICTION SUPPORT SOCIAL SERVICES URBAN PEST MANAGEMENT YOUTH WORK
6	New Zealand Diploma in Hearing Therapy (Level 6)	This qualification is designed to provide the hearing therapy workforce with skills and knowledge in the application of aural rehabilitation practice.	DISABILITY SUPPORT HEALTHCARE SERVICES
6	New Zealand Diploma in Business (Level 6) Leadership & Management	Strategic leaders and managers within the health, wellbeing and cleaning sectors will develop the skills and knowledge required to contribute to the achievement of an organisation's strategic objectives.	AGED CARE CLEANING DISABILITY SUPPORT HEALTHCARE SERVICES HOME & COMMUNITY SUPPORT MENTAL HEALTH & ADDICTION SUPPORT SOCIAL SERVICES URBAN PEST MANAGEMENT YOUTH WORK
6	New Zealand Diploma in Youth Work (Level 6)	This qualification is designed for people who are entering the youth development sector as youth workers while also providing a credential that recognises the skills, knowledge and competencies of those already employed in the industry.	SOCIAL SERVICES YOUTH WORK
7	New Zealand Diploma in Vision Habilitation/ Rehabilitation (Level 7)	The programme in orientation and mobility provides the vision habilitation/rehabilitation sector with a specialised workforce focused on the application of technical knowledge and skills in clinical and community settings.	DISABILITY SUPPORT HEALTHCARE SERVICES

## Appendix 2: 11 mātauranga Māori qualifications were listed on the New Zealand Qualifications Framework (NZQF)

- New Zealand Certificate in Kaupapa Māori Public Health (Level 4) [Ref: 2870]
- New Zealand Certificate in Kaupapa Māori Public Health (Level 5) [Ref: 2871]
- New Zealand Diploma in Kaupapa Māori Public Health (Level 6) [Ref: 2872]
- Te Tuapapa Hei Whai i te Ao Marama (Kaupae 4) [Ref: 2880]
- Te Pou Tautoko i te Ora (Kaupae 4) [Ref: 2875]
- Te Pou Tautoko i te Ora (Kaupae 5) [Ref: 2876]
- New Zealand Certificate in Tiaki Kuia, Koroua (Level 3) [Ref: 2873]
- New Zealand Certificate in Tiaki Kuia, Koroua (Level 4) [Ref: 2874]
- New Zealand Certificate in Whānau Ora (Level 3) [Ref: 2877]
- New Zealand Certificate in Whānau Ora (Level 4) [Ref: 2878]
- New Zealand Diploma in Whānau Ora (Level 5) [Ref: 2879]

## Appendix 3: Kia Noho Rangatira Ai Tātou

<https://www.tepou.co.nz/disability-workforce/kia-noho-rangatira-ai-tatou/184>

## Appendix 4: Let's get real: Disability Skills, Values and Attitudes

### Skills

- Working with Māori
- Working with families and whānau
- Working with communities
- Challenging stigma and discrimination
- Upholding law, policy and practice
- Maintaining professional and personal development

### Values

- Human rights
- Respect
- Service
- Communities
- Relationships

### Attitudes

- Compassionate, caring, sensitive, understanding
- Enabling, encouraging, accepting, supportive
- Genuine, warm, friendly, fun
- Honest, fair, sincere, trustworthy
- Non-judgemental, non-discriminatory, uncritical
- Open-minded, culturally aware, self-aware, innovative, creative, positive risk-takers
- Optimistic, positive, enthusiastic, inspiring,
- Patient, tolerant, flexible, accommodating
- Professional, accountable, reliable, responsible
- Resilient, emotionally strong, able to bounce back in the face of challenges
- Understanding, perceptive, considerate, responsive

