



MONASH University
Medicine, Nursing and Health Sciences

Centre for Developmental Disability Health Victoria
- Better Health, Better Lives -

Partnerships in healthcare:
crossing the cultural divide between disability support workers and health professionals

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Introductions

Dr Jane Tracy
General Practitioner,

Centre for Developmental Disability Health Victoria



Academic unit
Monash University Faculty of Medicine, Nursing & Health Sciences
University of Melbourne. Faculty of Medicine, Dentistry & Health Sciences

Mission: To improve health outcomes for adults with developmental disability by developing the capacity of generic health service systems to better meet their needs.

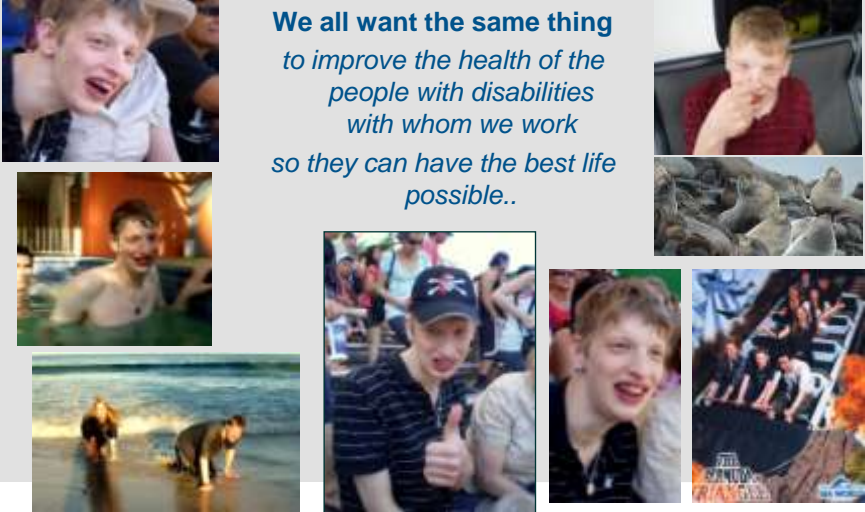

Funding: Disability Services, Dept of Human Services, Vic.

Activities: Educational, Research, Clinical, Advocacy.

For more information:
www.cddh.monash.org

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We all want the same thing
*to improve the health of the
people with disabilities
with whom we work
so they can have the best life
possible..*

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**Although those of us from the
disability and health sectors are
travelling in the same direction –**



***to improve the health of people with
disabilities –***

**we often encounter language and
cultural barriers that impair our ability
to work together!**

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Too often we see what we expect to see
– or what we want to see –
and forget that there is more than one way to see the world.

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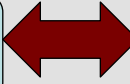
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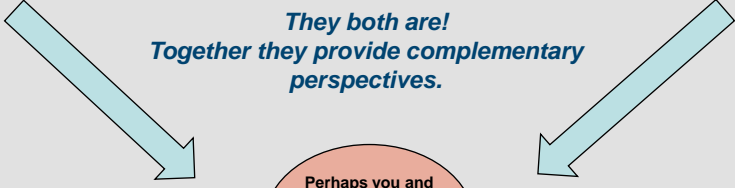
Social model or medical model - which is right?

Social model – focuses on
•Context & environment
•Strengths and abilities



Medical model - focuses on
•Individual
•Illness and pathology

They both are!
Together they provide complementary perspectives.



Perhaps you and your neighbour look at the same picture and see different things?
ASK!

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The more perspectives we can see and share – the better we understand.

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Language – jargon
We all use it – often without thinking.

*Let me share a (fictional!) story with the attendees at this **ASSID DSW** conference:*

*The house staff were under pressure. John's sister had requested **OPAs** involvement as she felt her concerns about his health were not being addressed. John has a severe **ID**, is in an **EMR DAS** house and had not had a **GSP/IPP/ISP** for several years. **OPA** requested that one be developed immediately, along with a review of John's **Health Plan**. The **ISP** identified a number of issues including **chemical restraint** requiring a report on **RIDS**. The **client** had behaviours of concern and the **OSP** required a **BSP** and medication review. The **ALM** supported to **House Sup** and **DHS DSW key worker** to complete the appropriate forms and arrangements.*

What's good about jargon and acronyms?



- Shortcut in communication
- Efficient
- Quick
- Takes up less room

- Reinforces sense of being an insider, part of the team, one of the family, one of the in-group

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The **GP** was under pressure. The patient was new to the practice, had a recent admission to **A & E** with no **D/C** summary provided and had now come to the appointment with by a **carer** who seemed to have little understanding of the **medical complexity** of the issues. The patient had not been seen for over a year, there were multiple **CDM** issues and the **DSM** diagnosis was unclear. An **AHA** using either **MBS 718** or **719** was required to develop a **GPMP** and engage appropriate **AH** professionals under **TCA**s. The **PN** was away sick and investigations including **FBE, LFT, TSH, SBG** and **RFT**s were required. The carer presented a multipage form (**CHAP**) in hardcopy and was insisting the **LMO** complete it despite this being quite incompatible with **MD**. The appointment was during the Monday morning rush.

What's bad about jargon and acronyms?

- *Confusing*
- *Impairs communication*
- *Disempowering*
- *Disenfranchising*

• *Reinforces sense of being outsider, not part of the team, not one of the family, not one of the in-group*

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And its not just differences in language...

- **Different** areas of expertise, knowledge, training, experience.
- **Different** practice guidelines, standards and other key document
- **Different** mechanisms for monitoring, peer support, professional development
- **Different** work pressures, expectations, management and responsibility structures.
- **Different** systems of pay, in service training priorities,
- **Different** peak and professional bodies

We come from such different places
We speak such different languages
...no wonder we misunderstand & even clash at times



We need to learn to work together effectively

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It can be hard to get good collaborative practice off the ground....

But if we keep trying we'll get there together!

See Jake Atway menu for some ideas to improve communication

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In the end, we have the **same objectives** to care for the patient/client ...the **PERSON** - even if we look like very different beasts!

So lets,

- **Communicate** with to each other clearly (plain english, no jargon!)
- **Ask** when we don't understand
- **Learn** about and be sensitive to the context within which the disability/health worker is operating
- **Respect** each other's perspectives and areas of knowledge

• And **work together** to ensure the **best health** outcomes for the people we work with and for.



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