



dental health  
services victoria

## Disability Awareness Guide

June 2007

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### **Acknowledgements**

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### **Consultation**

DHSV is grateful for advice and contributions received from: Carers Vic, ParaQuad Victoria, Mental Illness Fellowship Victoria, Human Rights and Equal Opportunity Commission (HREOC), Brainlink, Alzheimers Victoria and DHSV's Community Advisory Committee.

Websites consulted include:

Disability Rights Victoria - [www.advocacyhouse.org.au](http://www.advocacyhouse.org.au); Human Rights and Equal Opportunity Commission - [www.hreoc.gov.au](http://www.hreoc.gov.au); Mental Illness Fellowship Victoria - [www.mifellowship.org.au](http://www.mifellowship.org.au); Office of the Public Advocate - <http://www.publicadvocate.vic.gov.au>; ParaQuad Victoria - [www.paraquad.asn.au](http://www.paraquad.asn.au); Queensland State Government Disability Services - [www.disability.qld.gov.au/publications](http://www.disability.qld.gov.au/publications); Vision Australia - [www.visionaustralia.org.au](http://www.visionaustralia.org.au); Brainlink – [www.brainlink.org.au](http://www.brainlink.org.au)

<b>Contents</b>	<b>Page</b>
Answers to Frequently Asked Questions	3
Introduction	4
Disability in the Australian community	5
Types of disability	5
Interacting with people with disabilities	6
The words we use	7
Blindness and vision impairments	9
Hearing impairments	11
Physical impairments	13
Intellectual disabilities	16
Acquired Brain Injury	18
Dementia	19
Psychiatric disabilities	20
Invisible disabilities and medical conditions	23
Working with carers	24
Legislation	25
Related DHSV materials	26

## **Answers to Frequently Asked Questions about Disability Access**

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*Please note: the answers given here relate to the Royal Dental Hospital of Melbourne. Staff working at other locations are encouraged to find out the answers to these common questions for their particular clinics.*

**Q: Where is an accessible toilet?**

A: There are accessible toilets on levels Ground, 1, 2, 4, 5 and 6.

**Q: Where are the accessible car parking spaces for people with a disability?**

A: There are 3 accessible car parking spaces for people with a disability off Lynch Street (enter from Cardigan Street) which are available to DHSV visitors between 6am and 6pm Monday to Friday.

There are 2 more accessible car parks on the Melbourne University side of Swanston Street, just north of Grattan Street.

The City of Melbourne offers disabled drivers/passengers **daily permits** which provide all-day parking at any meter for the cost of the initial parking meter fee. Patients should ring 9658 9658 for more information.

**Q: Where is an information counter that has an accessible writing desk?**

A: All patient reception counters on all levels are at seated (wheelchair) height.

**Q: Do you have information about your services in a range of formats such as electronic, large print or Braille?**

A: If you would like service information provided in a preferred format, please request this from our Corporate Communication Unit, tel: 9341 1200.

**Q: Where can I call a taxi?**

A: There is a direct dial taxi phone (freecall) on the Ground floor.

There is a TTY public phone on the Ground floor.

**Q: What do I do in the event of an emergency?**

A: In the event of an emergency, please notify our staff that you need assistance. A staff member will ensure you are in a safe location and will stay with you throughout any evacuation.

More information is available in the Emergency Evacuation brochure which is available at the Ground floor counter.

## Introduction

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DHSV recognises that oral health is fundamental to a person's overall wellbeing and quality of life, and that people living with a disability expect and are entitled to the same level of public dental care as the wider community.

The *Disability Discrimination Act 1992* makes it unlawful to discriminate against people on the basis that they have, or may have, a disability. In addition to meeting the requirements of the law, DHSV recognises that it has an underlying professional obligation to ensure that its services are as accessible as possible to people with disabilities, their carers and families.

Working to meet the needs of our consumers with disabilities requires that we have some basic knowledge about the different types of disabilities consumers may live with, and about how to work with people with disabilities. This guide has been compiled to improve our understanding of the needs of people with disabilities and consequently to increase our confidence to provide appropriate care to consumers with disabilities.

It is expected that all DHSV staff will familiarise themselves with the information in the guide. Given that 20 percent of the Australian population has a disability, the information will also be useful to DHSV staff outside and beyond their working lives.

Our increased capacity to deliver professional and empathetic care to people with disabilities will not only benefit our consumers, it will also enable us as an organisation and individuals to feel a sense of satisfaction and confidence in the level of service we provide to people with disabilities.

## **1. Disability in the Australian community**

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In Australia, 20% of the Australian population (1 in 5 people) have a reported disability (Australian Bureau of Statistics, 2003). Disability is defined as any limitation, restriction or impairment which has lasted or is likely to last for at least six months which restricts everyday activities.

In addition to the 1 in 5 Australians who have a disability, there are the many family members, friends, carers and colleagues of people with disabilities who are also affected by poor services and inadequate access to services.

Statistics show that the likelihood of having a disability increases with age. Approximately 84% of the Australian population aged 85 years or older experiences a disability.

As a provider of specialist dental services to people with disabilities or complex medical conditions, a significant proportion of DHSV's consumers have a disability or impairment. In addition, as a provider of services to pension card holders, DHSV also provides care to a large proportion of older Victorians.

## **2. Types of disabilities**

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The definition of 'disability' under the *Disability Discrimination Act* includes the following types of disabilities:

- Physical
- Intellectual
- Psychiatric
- Sensory (includes vision and hearing disabilities)
- Neurological (this includes acquired brain injuries)
- Learning difficulties
- Physical disfigurement
- The presence in the body of disease causing organisms (this includes people living with HIV/AIDS).

*From Commonwealth Disability Discrimination Act (1992).*

### **3. Interacting with people with disabilities**

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Often it is being unsure about what to say or do that prevents people from interacting with people with disabilities. In most cases, common courtesy and sensitivity to the client's needs – the necessary ingredients of all good customer service – are all that is required.

#### **Tips for interacting with people with disabilities:**

- Think of the person first and the disability second. Sensitive use of language can reinforce the 'person first' attitude. For instance, refer to 'people with disabilities' rather than 'disabled people'.
- Respond to people with disabilities as individuals. People with disabilities may have in common a disability, but the consequences of their disabilities will vary considerably from person to person. Factors such as the degree of impairment, duration, individual coping strategies and styles, support structures available and personality traits will influence the nature of individuals' needs. Don't generalise about all people with disabilities from your knowledge of a few.
- Speak directly to the person, not to their carer or another third party. Do not assume that a carer is the mouthpiece or the advocate for a person with a disability. It is inappropriate and insensitive to talk in the third person about a person who is present.
- If a person with a disability has a communication problem they will usually let you know and indicate a preferred method of communicating.
- Listen to what the person says. Don't assume you know what they want or what is best for them. People with disabilities are no less capable of thinking for themselves than anyone else. There may be challenges in communicating their needs, but assumptions that they cannot decide what they need are offensive.
- A disability is not necessarily an illness. Do not treat people with disabilities as though they are sick. Treat them as healthy individuals.
- Don't assume people with a disability need your help. Ask before acting.
- Be yourself, be natural, don't force enthusiasm or be patronising.

## 4. The words we use

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In Australia we take a 'social model' approach to disability. This is distinct from the 'medical' model which treats disability as a condition rather than an experience, and the responsibility of the individual. Under the 'social model', we acknowledge that it is the barriers created by society that are 'disabling' to an individual, and that it is our collective responsibility to remove these barriers. The 'social' model puts the individual, not the disability, first.

It is important to maintain natural language when interacting with people with disabilities. It is okay to say to someone in a wheelchair "you have time to go for a walk before your appointment," or to say to someone who is blind "Do you see what I mean?".

The World Health Organisation encourages the following usages:

### **Impairment – the functional damage**

Refers to any loss or abnormality of bodily function, whether physiological, psychological or anatomical.

### **Disability – the restriction of activities**

Generally, a disability is a restriction or lack of ability to perform an activity in a normal manner, resulting from an impairment. The emphasis is on the practical problems faced in the performance of activities.

### **Handicap – the resulting social disadvantage**

Handicaps are the social, behavioural and psychological consequences of disabilities. They are the disadvantages facing the individual resulting from an impairment or disability which limits or prevents them from fulfilling a normal social role of someone of their age, sex and culture.

<b>Words to Watch</b>	<b>Acceptable Alternative</b>
Abnormal, subnormal (negative terms that imply failure to reach perfection)	Specify the disability
Afflicted with (most people with disabilities don't see themselves as afflicted).	Say "the person has...(the disability)"
Birth defect, deformity	Say "the person with a disability since birth", or "person with congenital disability"
Blind (the), visually impaired (the)	Say "person who is blind", "person with vision impairment"
Confined to a wheelchair, wheelchair-bound (a wheelchair provides mobility not restriction)	Say "uses a wheelchair" or is a "wheelchair user"
Deaf (the)	Only appropriate when referring to the Deaf community; say "person who is deaf"

<b>Words to Watch</b>	<b>Acceptable Alternative</b>
Deaf and dumb (the inability to hear and speak does not imply intellectual disability)	Say “hearing impaired” – lack of speech usually results from impaired hearing
Disabled (the)	Say “people with a disability”; “the disability community”
Epileptic	Say “person with epilepsy”
Fit, attack	Say “seizure”
Handicapped (the)	Say “person with a disability” unless referring to an environmental or attitudinal barrier such as “person who is handicapped by a disability”.
Insane – also mental patient, psychotic, schizophrenic, neurotic – are derogatory terms.	Say “person with a mental illness, or person with schizophrenia, or person with bi-polar disorder”
Invalid (literally means ‘not valid’)	Say “person with a disability”
Mentally retarded	Say “person with an intellectual disability”
Patient – only use in context of clinician/patient relationship	Say “person with a disability”
Physically/intellectually/vertically challenged	Say “person with a disability”
Spastic – a derogatory term that usually refers to a person with cerebral palsy or who has uncontrollable spasms.	Say “person with a disability”
Suffers from, sufferer, stricken with (Not all people with disabilities actually suffer. These terms should not be used indiscriminately).	Say “person with a disability”

Taken from *A Way with Words* (2005), Queensland State Government (Disability Services).

## **5. Blindness and vision impairment**

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Blindness and vision impairment can come in many forms. The most common causes of blindness and vision impairment among Australians are age related, with age-related macular degeneration, cataracts and glaucoma being the most common causes of blindness and vision impairment.

### **Tips for interacting with a person who is blind or vision impaired**

- Be descriptive. You may have to help orientate people with vision impairments and let them know what is coming up. If they are walking, advise them if they have to step up or down, let them know if the door is to their right or left and warn them of possible hazards.
- You do not have to speak loudly to people with vision impairments.
- Offer to read written information for a person with a vision impairment, where appropriate.
- If you are asked to guide a person with a vision impairment, offer your arm instead of grabbing theirs.
- Say goodbye when you finish a conversation and indicate when you are leaving the room.

Vision Australia, a peak advocacy group and service provider to people who are blind or vision impaired, recommends a 'Triple A' approach.

#### **1. Approach**

- If a consumer seems confused or unsure, walk up, greet them and identify yourself, as they will not be able to guess who you are by what you look like or the sound of your voice.
- State your role.
- It's polite to address the person directly, not through someone else. People who are blind or vision impaired can speak for themselves.
- If you approach a person with a guide dog, bear in mind that dogs in harness are working dogs and it is inappropriate, even dangerous if you feed, pat or distract them without asking the handler first.

#### **2. Ask**

- Ask "Would you like some help?" The person will accept your offer or tell you if they don't require assistance.
- Don't be offended if they thank you for offering but refuse your help. This doesn't mean they won't need in it a different situation in the future.

### 3. Assist

Assistance is generally

- a) describing objects or locations,
- b) guiding, or
- c) a combination of both

#### *Describing*

Speak naturally and clearly. It's okay to use words like "see" and "look" but try to avoid generalisations like "over there". Be specific, for example: "The receptionist is about two metres to your left."

#### *Guiding*

Sometimes people with a vision impairment find it helpful to be guided by someone who can see.

#### **Hints for guiding:**

- If a person asks you to guide them somewhere, don't grab, push or pull. Make contact by touching the back of their hand lightly with the back of your hand. They will take your arm just above the elbow. Walk at a pace that is comfortable for both of you, watching for narrow spaces and obstacles in front, above and below.
- Make sure floor space and passageways are as clear of obstacles as possible.
- Ask permission first before guiding a person's hand so they can find an object, eg a pen to sign their name.

## 6. Hearing Impairments

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People with hearing disabilities include those who:

- Cannot hear at normal levels because of a variety of factors which affect transference of sound.
- Due to communication or language difficulty, cannot easily understand what is being said to them in every situation and therefore can't always respond with confidence.
- People who are profoundly, pre-lingually deaf. These people may also have difficulty communicating in spoken English if Australian Sign Language (AUSLAN) is their first language.

Hearing impairments can be hereditary or caused by a variety of factors including viruses, diseases of the ear, exposure to noise, toxins and natural ageing.

There is no such term as 'legally deaf'. A person's level of hearing disability will depend on their degree of hearing impairment as well as the age at which it occurred and other factors which influence communication.

### **Profound deafness**

Profoundly pre-lingually deaf people are those who were born with insufficient hearing to enable them to acquire speech normally, or who lost their hearing prior to the age at which speech is acquired. Some profoundly pre-lingually deaf people do use speech to communicate and have been taught to speak at a young age. If their preferred mode of communication is verbal they may be termed Oral Deaf. They rely on lip-reading and may or may not use sign language. People who are profoundly deaf and who use sign language as their preferred mode of communication may identify strongly with the Deaf community. They have a strong sense of culture and community and within that community function at a high level as there is no language barrier. They are visually orientated and may have difficulty coping with spoken communication in what they term the "hearing world". While accepting that they are different, they may not necessarily agree with being labelled disabled. Deaf people may request the services of an AUSLAN interpreter.

People who become profoundly deaf after they have acquired speech are termed profoundly post-lingually hearing impaired. Usually they will not identify with the Deaf community or use sign language. Their own speech may not be affected by their loss of hearing although they may have difficulty with voice modulation. They will rely on visual spoken language to communicate and may become highly proficient lip-readers although individual ability will vary considerably from person to person. They may request information in written form and/or request the services of oral deaf interpreters.

## Hearing impairment

In the majority of cases, people who acquire a hearing impairment retain some level of hearing and continue to communicate in spoken language.

Although most people with impaired hearing can benefit from wearing a hearing aid or aids, many will neither acquire nor wear them. As well as the high cost involved and problems associated with sound reproduction, there is a social stigma attached to having a hearing impairment and many people will reject wearing an aid for this and cosmetic reasons.

The invisible nature of hearing impairment means that it is often not recognised and its impact on a person's ability to communicate has considerable implications for both their ability to function normally and the way that they feel about themselves.

### Tips for interacting with people who are deaf or hearing impaired

- Identify yourself and ask "May I help you?" Don't assume help is needed.
- Face people with hearing impairments when you talk to them so they can see your lips.
- Do not slow the rate at which you speak – just speak normally.
- Keep pens, hands and chewing gum away from your mouth as they make it difficult for people to lip read.
- Increase the level of your voice.
- Wherever possible, address people who are hearing impaired by name so they know you are speaking to them.
- Use gestures and if need be write your message down.
- Do not direct questions through their companion or an interpreter unless you are asked to.
- Do not walk away from a person who is hearing impaired while speaking to them.
- When asked a question, respond by answering that question with a simple "Yes" or "No" or by keeping your reply brief and to the point. Wait for a response from the hearing impaired person. Let them "lead" the conversation. Don't overburden them with a lot of unnecessary detail that they have not asked for.
- Use words like 'hear' and 'heard'; they are part of everyone's vocabulary. Otherwise, both you and the person who is hearing impaired will feel awkward.
- Do not pat, play with or feed hearing dogs. Always ask permission of the owner before interacting with a dog.
- Don't regard the use of a hearing aid as an indication of how much a person is able to hear.

## 7. Physical Impairments

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Physical disability goes beyond having to use a wheelchair or wear a back brace. There are many conditions, such as multiple sclerosis and chronic fatigue syndrome, which are outwardly invisible but result in physical disability. Each person will have different causes, symptoms and management strategies. Some people with a physical disability may also have intellectual, vision or hearing disabilities.

Physical disabilities can be caused by:

a) Accidents, which result in:

- spinal injury
- amputation
- acquired brain injury affecting motor skills and limb control.

b) Medical conditions such as:

- cerebral palsy
- spina bifida
- muscular dystrophy/atrophy
- multiple sclerosis
- nervous system diseases
- circulatory diseases
- respiratory diseases
- arthritis
- other musculo-skeletal disorders
- head injury/stroke
- post-polio syndrome
- inherited conditions passed on genetically (for example limb deficiency)
- exposure to drugs or chemicals during pregnancy (for example, thalidomide).

### **Tips for interacting with a person who uses a wheelchair**

- Do not assume assistance is needed – ask.
- Accept the person's right to refuse help.
- Be aware of what parts of your buildings and services might be accessible and inaccessible to people in wheelchairs.
- Find out how to assist a person using a wheelchair, how to get up and down steps, how to tip it backwards, how to use the brake and how not to lift by the arm rests or the wheels.
- Sit or crouch down to the approximate height of people in wheelchairs or scooters when you talk to them.
- Do not talk about the person as if they were not present.
- Do not ask personal questions about the disability or its origin until you know the person well enough.
- Do not rush the person.
- Do not be sensitive about using words like "walking" or "running". People in wheelchairs use the same words.

- Do not lean on a person's wheelchair unless you have their permission - it is their personal space.
- Do not try to move the person or their wheelchair without their permission to do so. Give a push only when asked.

### **Cerebral Palsy**

Cerebral Palsy refers to damage to areas in the brain which control movement, 'short circuiting' messages from the brain to different parts of the body. This results in difficulty in controlling different muscles. A person with Cerebral Palsy may experience weak and stiff muscles or uncontrolled movements. The type of physical disability will depend on the area of the brain damaged. While one person with Cerebral Palsy may use a wheelchair and have slurred speech, another may just have a little difficulty walking.

Cerebral Palsy occurs before or during birth, or in early childhood as a result of an accident or illness, such as:

- pre-natal rubella infection
- anoxia (lack of oxygen to the brain)
- premature birth
- childhood diseases (for example, meningitis)
- car accident.

If a person with Cerebral Palsy talks slowly, slurring their words, it does not mean that they can't understand you or don't know what to say. It simply means that there has been damage to the part of the person's brain which controls the person's speech and mouth muscles, not their ability to understand.

### **Tips for assisting people with Cerebral Palsy:**

- Look, listen, understand and treat the person as you would like to be treated.
- Conversation should always be directed at the person, not at any companion who may be with them.
- Take care serving hot drinks or food and provide necessary straws or eating utensils.
- Do not separate the person from their special aids or equipment.
- Find ways of communicating with the person. Maintain eye contact, sit down if appropriate.
- Be willing to communicate in different ways if necessary, such as using a communication board or other verbal and non-verbal cues.
- Be patient when talking to someone with a communication difficulty. Resist the temptation to interrupt or to answer on their behalf. At first the person's speech may be difficult to understand. After a while it usually becomes easier to follow.

### **Spina Bifida**

Spina Bifida is a developmental defect which occurs within the first six weeks of pregnancy, caused possibly by a combination of genetic and environmental factors. Disabilities associated with Spina Bifida vary from person to person. Many children with Spina Bifida attend regular preschool, primary and secondary schools and universities.

### **Multiple Sclerosis**

Multiple Sclerosis (MS) is a neurological condition which affects the central nervous system. Symptoms vary from person to person, but may include:

- vertigo (dizziness)
- eye trouble such as double vision
- speech difficulties, including slurring of words
- spasticity and/or weakness in the arms or legs
- loss of coordination
- numbness or 'pins and needles'
- staggering, loss of balance or dragging of the feet
- extreme tiredness
- memory lapses.

These symptoms are unpredictable and the well being of someone with MS will vary from day to day. With proper management, the effects of MS may be minimised and in most cases people affected by MS can still lead independent, active, satisfying lives.

## **8. Intellectual disabilities**

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An intellectual disability should not be confused with a psychiatric disability or mental illness, although a person with an intellectual disability may also have a psychiatric disability.

Examples of intellectual disability include:

- Down syndrome
- developmental disability
- Autism could also be included here.

Examples of psychiatric disability/mental illness include:

- schizophrenia
- anxiety disorders
- bipolar disorder (manic depression)
- anorexia
- post traumatic stress disorder.

While definitions of intellectual disabilities may provide some insight into the disability itself, it is important that these definitions do not label the person and that generalised assumptions are not made.

Causes of intellectual disabilities are many. They include an abnormal number of chromosomes, gene defects, maternal infections, Rh incompatibility, head trauma, anoxia, birth injury, early infant infection and, deprived normal development and growth experiences.

The level of intellectual disability is classified by intelligence quotient (IQ) scores and ranges from mild to profound. A person with an intellectual disability may:

- have difficulty speaking and understanding what is being communicated
- have a physical disability
- have difficulty in learning and concentrating
- display behaviour that would appear to be inappropriate
- may be unable to read or write
- may be unable to live independently
- may have difficulty in participating in group settings.

There is a high incidence of epilepsy among people with an intellectual disability.

## **Tips for interacting with people who have an intellectual disability**

- Use common courtesy and common sense.
- Do not question the person's disability.
- Remember to always think of the person before the disability.
- Clearly identify your role, state your first name and make it clear that you are seeking to assist.
- Talk directly to the person using simple sentences avoiding jargon and complex terminology.
- Don't be offended by a lack of response or unconventional behaviour – people with intellectual disabilities often respond in inappropriate or unexpected ways. For example, they may say nothing when asked a direct question, or may 'fiddle' with objects in their environment, or may crowd your personal space. Such behaviours are not generally intended to give offence.
- Maintain eye contact - this shows respect and courtesy to the person you are interacting with. It shows you are listening and trying to help.
- Offer physical assistance and direction.
- Wherever possible, address the person with an intellectual disability by their first name. People respond best to their first names and many people with intellectual disabilities are accustomed to being addressed by their first names.

## 9. Acquired Brain Injury

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The term Acquired Brain Injury (ABI) is used to describe all types of brain injury which occur after birth. ABI is not the same as an intellectual disability. People with brain injuries usually retain their intellectual abilities but have difficulty controlling, coordinating and communicating their thoughts and actions.

Traumatic brain injury is injury to the brain caused by a blow to the head or by the head being forced to move rapidly forward or backward, usually with some loss of consciousness. This may be the result of a motor vehicle accident, a fall, an assault, a sports accident, a gunshot wound or violent shaking.

The brain can also be injured as a result of a stroke, alcohol or drug abuse, tumour, poisoning, infection and disease, near drowning, haemorrhage, AIDS, and a number of other disorders such as Parkinson's disease, multiple sclerosis, and Alzheimer's disease.

The outcome of a brain injury will be different for each person, depending on how much injury has occurred and what part of the brain has been injured. For example, injury to the frontal lobes may lead to difficulty in controlling emotions, injury to the temporal lobes is likely to result in difficulty in remembering new things, and injury to the parietal lobes may effect a person's ability to tell left from right.

The long-term effects of ABI are not always easy to recognise. Most people with an ABI will experience increased fatigue (mental and physical) and some slowing down in the speed with which they can process information. Many people find it difficult to concentrate for long periods of time, and some people become easily irritated.

### **Tips for interacting with a person with an acquired brain injury**

- Repeat instructions or details at every opportunity; write information down clearly so that the person can easily refer to it.
- Ensure only one person speaks at a time during the appointment to avoid confusion and distraction.
- Allow time for the person to process information and answer questions.
- Be assertive but friendly in keeping the appointment on track, overlooking any excessive talking.
- If the patient loses their temper, if possible, remove them from the situation that has agitated them and remember that it is their condition which causes them to behave in such a way.

## 10. Dementia

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Dementia describes a set of symptoms that cause a progressive decline in a person's mental functioning. Alzheimer's disease is the most common cause of dementia accounting for around 50 – 70% of all dementia cases. There are more than 70 conditions which cause dementia.

Alzheimer's is a progressive, degenerative condition that causes brain cells to shrink or disappear and as this happens information cannot be recalled or assimilated. As different parts of the brain are affected, certain functions and abilities are lost.

Losing the ability to communicate can be one of the most frustrating problems for people with dementia. It is important to remember that even though they may not understand what is being said, people with dementia retain their feelings and emotions.

### **Tips for interacting with a person who has dementia**

When communicating

- Introduce yourself and explain your role
- Talk in a gentle, matter-of-fact way.
- Allow plenty of time for what you have said to be understood; silence can give time to think and respond.
- Ensure you have the person's eye contact and therefore attention before communicating
- Use touch to keep a person's attention and communicate that you are there to help.
- Acknowledge and respond to the person's attempts to communicate with you.
- Keep sentences short, focusing on one idea at a time.
- Use non-verbal communication such as smiling and head nodding to build rapport.
- Don't argue with or challenge the person's idea of reality. They have their own logic behind their behaviour and are more likely to respond positively if you validate their reality rather than challenge it.
- Don't rely on the person's memory

General principles

- Be aware that medical settings/different environments can increase emotional turmoil and confusion.
- Help the person to maintain their dignity and self-esteem – eg praising their efforts.
- Focus your efforts and attention on the person, and not on their challenging behaviour.
- It may be appropriate to have family or someone familiar with them throughout dental procedures as this may reduce anxiety.

*This chapter includes contributions from Alzheimers Victoria.*

## **11. Psychiatric disabilities**

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There is often confusion regarding the use of the terms 'mental illness' and 'psychiatric disability'. Disabilities are the consequences of an illness, that is, a person may have difficulty in being able to carry out tasks and roles as a result of having an illness. Not all people who have a mental illness will develop a psychiatric disability.

### **Mental illness**

Mental illness is commonly described as a chemical imbalance in the brain which affects people's thoughts, feelings and perceptions. Current research supports the idea that the development of mental illness is caused by a combination of the following three factors:

1. Biological factors – genetic factors resulting in people being predisposed to the development of mental illness.
2. Psychological factors – how individuals tend to cope with stress, or how resilient they are. People who are less resilient could be more susceptible to the development of mental illness if the other two factors are present.
3. Social factors – stress created by life events such as the birth of a baby, poverty, stressful relationships or going to university can contribute to the development of a mental illness.

Treatment and recovery from mental illness requires responding to all three factors. Medication is the main response to biological factors; counselling, social support and practical assistance are helpful for the psychological and social factors.

People with a mental illness do not always experience the illness throughout their lives, or at the same level of intensity every day. With medication and/or support, people can recover, or have periods of being relatively well. When working with a person with a mental illness, it is important to be aware that the person's capacity to cope could be quite different from one appointment to the next.

Mental illnesses are separated into two main categories:

(a) Psychotic illnesses and (b) non-psychotic illnesses.

### **(a) Psychotic illnesses**

The most common forms of psychotic illness are schizophrenia and bipolar disorder. During a psychotic episode, the person can lose touch with reality or be unable to distinguish between what is real and what is fantasy. People with a psychotic illness may take regular medication or may take medication only during certain periods of illness.

Common symptoms of psychotic disorders are:

- Alterations in thoughts. Examples of this are confused thoughts, lack of logical connection between thoughts and speech, the belief that other people can hear or read their own thoughts, and delusional thoughts (false beliefs that are not shared by other people with similar belief systems).
- Alterations in perceptions. These include hallucinations and changes in sensory awareness. Hallucinations are the perception of something which is not there in the external world. They can be auditory ("hearing voices") or involve the other senses of sight, touch, smell and taste.
- Alterations in emotions. The person may have abrupt changes in mood, experience conflicting emotions at the same time about the same thing, display inappropriate emotional responses, mania or elation that is excessive, depression and extreme sadness or despair.
- Alterations in behaviour. These are changes in the usual patterns of behaviour for the particular individual and can include restlessness, agitation, unusual reactions and responses and day/night reversal (sleeping during the day, awake during the night).

### **Schizophrenia**

Schizophrenia has the following features:

- Psychotic features – disruption to perception, feelings and thoughts which cause a loss of contact with reality. This aspect of the illness is most commonly episodic.
- Loss of motivation, loss of confidence, loss of energy. These symptoms will be worse on some days than others.

Schizophrenia has a common age of onset of between 16 and 24 years. This has a significant impact on people with the illness as this is generally the time of life when people are setting up their careers, going to university, establishing adult friendships, getting married. The lack of opportunity for these types of things to occur can result in poverty, lack of housing, lack of friendships and other social consequences.

### **Bipolar disorder**

Bipolar disorder was previously known as manic depression and is referred to as a mood disorder. It features periods of:

- Depression, during which people will become withdrawn, have persistent feelings of sadness and worthlessness, loss of or increase in appetite, and other symptoms.
- Mania, or elated mood. Delusions of grandeur ('I am Jesus Christ'), feelings of being indestructible ('I can fly'), and other thoughts can all result in people taking dangerous risks.

## **(b) Non-psychotic illnesses**

This group of mental illnesses used to be called neuroses and include anxiety disorders and depressive illness.

Anxiety disorders include phobias (including dental phobia), obsessive-compulsive disorder, post-traumatic stress disorder, agoraphobia, panic disorder and general anxiety disorder. They can cause physical symptoms such as heart palpitations, sweating, hyperventilation, dizziness, headaches and nausea. Dental phobia is most commonly experienced by people over 55 years of age, and is often related to a distressing dental or medical episode in a person's past, or some other traumatic event in a person's life.

Depressive illness or serious depression is different from the emotional ups and downs associated with everyday life. Major depression, postnatal depression and reactive depression (reacting to a distressing situation) are the main types of depressive illness.

## **Borderline personality disorders**

Personality disorders are not mental illness. They are a cluster of long-standing problems with relationships, identity, and the control of emotions and behaviour. Typically, personality disorders are shown as strong emotions being easily triggered, anger in particular; problems with self damaging behaviour; great sensitivity to rejection or criticism; problems in relationships including strong and changeable feelings of love and hate.

## **Tips for communicating with a person who is exhibiting symptoms of mental illness:**

- Minimise stress by calmly helping the person to know what to expect next. Avoid making the person feel rushed or pressured.
- Reduce stimulation – take the person to a quiet area, sit with the person looking in the same direction rather than toward them. Speak in a calm manner.
- Use clear and straightforward language. Avoid jargon and talking louder than or over the person.
- Take seriously the emotional concerns the person is presenting.
- Avoid getting too personal or asking for irrelevant personal details.
- Avoid getting too many people involved.
- Avoid agreeing with or trying to talk the person out of their delusions.
- Be clear about your role and the service you are providing.
- Do not take things said or done, personally.
- Try to make afternoon appointments as medications may prevent people from getting up early.
- Make reminder calls to let people know of their appointment.
- Suggest they bring someone with them for support.
- If possible, follow up missed appointments and suggest another try with extra support strategies.

*This chapter includes contributions from Mental Illness Fellowship Victoria.*

## **12. Invisible disabilities and medical conditions**

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Under the Disability Discrimination Act (1992), the definition of 'disability' includes the presence in the body of disease causing organisms, such as in the case of people living with HIV/AIDS.

For people whose disabilities or special medical needs are hidden, confidentiality is a priority concern.

Confidentiality is the right of an individual to not have personally identifiable information disclosed to others without that individual's express informed consent.

DHSV is subject to the *Health Records Act 2001* and the *Information Privacy Act*. All staff who come into contact with or have access to patient/staff information have a responsibility to maintain the confidentiality of that information. See DHSV's Confidentiality Policy PO-A003-02 for more information.

DHSV staff are also required by legislation and regulations to disclose medical information to registries and databases maintained by the Department of Human Services and other organisations, including the Infectious Diseases Registry and the Cancer Registry.

People with an invisible disability or medical condition should be able to expect the same high level of professionalism and discretion as other patients.

### 13. Working with carers

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Many people with disabilities visiting the hospital will be accompanied by a carer. The carer may be a spouse, domestic partner, parent or other family member, or they may be a professional carer.

The *Guardianship and Administration Act 1986* (Vic) defines who is able to give consent to medical or dental treatment for a person who is unable to make that decision themselves. If a person is not able to give informed consent for themselves, often their primary carer or nearest family member will be the person responsible for giving consent.

If a patient with a disability is cared for in an institution such as a hospital, community residential unit (CRU) or supported residential service (SRS), they may be accompanied to their appointment by a worker from their residence. A professional carer such as this is usually *not* able to give consent for medical or dental treatment.

If a patient is accompanied by two carers, establish early on which carer will be the person responsible for reading and signing paperwork.

See DHSV's Informed Consent Procedure [PR-A018-02] for more information on gaining consent.

Working with a carer is about working together in the best interests of the patient. As far as possible, you should attempt to find out what the patient's wishes are, and what the wishes of the patient's family are. It is also important to consider the patient's and carer's living situations, including social support networks and the characteristics of the patient's disability or condition.

#### **Tips for working with carers:**

- Listen to and acknowledge carers' experiences and concerns.
- Treat with sensitivity and empathy the past and present relationship between the carer and the patient.
- Don't assume that someone at home will automatically be able to provide care, or that they do so without back-up support and resources.
- Include carers in decision-making unless the patient specifically requests otherwise.
- Acknowledge the carer as a vital partner in providing care.
- Inform the carer of any changes that occur in the way the health service is delivered.
- Remember the carer has the right to voice suggestions, concerns or complaints without being judged or labelled.

*Adapted from information provided by Carers Victoria.*

## 14. Legislation

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The *Disability Discrimination Act 1992 (DDA)* came into effect in March 1993, making it unlawful to discriminate against people on the basis that they have, or may have, a disability.

The aims of the *Disability Discrimination Act* are:

- To eliminate, as far as possible, discrimination against persons on the ground of disability in the areas of:
  - (i) work, accommodation, education, access to premises, clubs and sport; and
  - (ii) the provision of goods, facilities, services and land; and
  - (iii) existing laws; and
  - (iv) the administration of Commonwealth laws and programs.
- To ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community.
- To promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community.

Disability discrimination occurs when people with a disability are treated less fairly than people without a disability. Disability discrimination also occurs when people are treated less fairly because they are relatives, friends, carers, co-workers or associates of a person with a disability.

If a person believes they have been discriminated against because they have a disability, they can make a complaint to the Human Rights and Equal Opportunity Commission (HREOC), which has the power to investigate the complaint.

In addition to meeting the requirements of the federal *DDA*, DHSV must also comply with the Victorian *Equal Opportunity Act 1995 (Vic)*. This act makes it illegal to treat someone unfairly because of their age, carer status, disability, industrial activity, lawful sexual activity, marital status, parental status, physical features, pregnancy, race or religious beliefs.

Information on the *Equal Opportunity Act* is available at <http://www.equalopportunity.wa.gov.au/discrimination.html>

Information on the *Disability Discrimination Act* is available at [http://www.hreoc.gov.au/disability\\_rights/dda\\_guide/dda\\_guide.htm](http://www.hreoc.gov.au/disability_rights/dda_guide/dda_guide.htm)

## **15. Related DHSV materials:**

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- Confidentiality Policy [PO-A003-02]
- Disability Access Policy [policy number to be added] (2005)
- Disability Access Procedure [ procedure number to be added] (2006)
- Disability Action Plan
- Informed Consent Procedure [PR-A018-02]
- Special Needs Patients Policy [PO-A008-03]
- Special Needs Patients at RDHM Procedure [PR-A038-02]
- Use and Disclosure of Information Procedure [PR-A024-02]
- Continuing Professional Development course: The Patient with Complex or Special Needs, Unit Head, DHSV Integrated Special Needs Unit.