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National Diabetes Services Scheme

An Australian Government Initiative

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Effective communication with people who have an intellectual disability about their diabetes

A guide for health professionals



ADEA is a National Health
Professional Body Agent for the NDSS



The NDSS is administered by Diabetes Australia

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The Australian Diabetes Educators Association and Diabetes Australia take no responsibility for any adverse consequences that arise as a result of using the content of the guide for clinical purposes. Trainees and other health professionals need to consider the individual circumstances and needs of people with diabetes when they are applying the skills outlined in this resource in their clinical practice information.

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Foreword

It is a great privilege to introduce you to this guide for health professionals, on communicating with people who have an intellectual disability (ID) about their diabetes.

This document, in conjunction with the corresponding online training module, aims to provide practice recommendations to health professionals to better support people living with an ID and diabetes, as well as their families, carers and support workers.

This guide has been funded through the National Diabetes Services Scheme (NDSS) and developed by the Australian Diabetes Educators Association (ADEA). The NDSS is an initiative of the Australian Government, administered by Diabetes Australia. The NDSS aims to enhance the capacity of people with diabetes to understand and self-manage their life with diabetes. The ADEA is the leading Australian organisation for health care professionals providing diabetes care and education. ADEA advocates for evidenced-based best-practice diabetes education to ensure optimal health and wellbeing for all people affected by, and at risk of, diabetes.



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If you require further information about this resource, please contact ADEA on **02 6287 4822** or email **admin@adea.com.au**.

Please refer people with diabetes to the NDSS Helpline on **1800 637 700** or **ndss.com.au** for information, self-management support or products.

Abbreviations

AAC	Augmentative and alternative communication
ABS	Australian Bureau of Statistics
ADEA	Australian Diabetes Educators Association
CDE	Credentialed Diabetes Educator
DSME	Diabetes self-management education
ID	Intellectual disability
NDIS	National Disability Insurance Scheme
NDSS	National Diabetes Services Scheme
UK	United Kingdom
WHO	World Health Organization

Introduction to intellectual disability

An intellectual disability, also known as an intellectual disability (ID), originates during the developmental period (before 18 years) and involves impairments in both intellectual functioning and adaptive behaviour^{18,19}.

Intellectual function refers to general mental capacities such as learning, reasoning and problem solving¹⁸. Adaptive behaviour is the collection of conceptual, social and practical skills that are learned and performed in everyday life¹⁸. In general, people with an ID may find it more difficult to learn new things, understand concepts, solve problems, concentrate and remember things. Some people with an ID may also have difficulties in managing their behaviour, emotions, interpersonal relationships, and in maintaining motivation during the learning process²⁰.

ID is often divided into categories, including mild, moderate, severe and profound, based on standardised intelligence testing and assessment of adaptive behaviour (Table 1). In general, the more severe a person's intellectual disability, the more their day-to-day functioning, mental abilities and communication may be impaired²¹.

However, the impact of an ID and the level of support a person needs will vary from one individual to the next and is dependent on a number of factors including their environment and level of family and community support. Most people living with an ID are considered to have a mild disability. With support they can generally learn the skills to lead relatively independent adult lives.

There are many causes of intellectual disability including underlying genetic abnormalities and problems during pregnancy, delivery, the neonatal period and childhood²².

An alternative definition is the social model of disability, which distinguishes impairment from disability. In this model, disability is seen to be the restriction of activity resulting from an environment (physical and social) that fails to accommodate the needs of people who have impairments²⁴. As a result, they are excluded from participating in mainstream social activities. The social model of disability advocates for a more inclusive environment that enables people with an impairment to participate on an equal basis to others. This encompasses not only environmental and structural changes but also addressing attitudinal barriers often faced by people with a disability. It has been argued that health professionals could improve their practice by learning more about this model and how it contrasts with the medical model of disability^{24–26}.

Table 1: WHO ICD-11 classification of disorders of intellectual development²

Classification	Description
Mild	Affected persons often exhibit difficulties in the acquisition and comprehension of complex language concepts and academic skills. Most master basic self-care, domestic, and practical activities. They can generally achieve relatively independent living and employment as adults but may require appropriate support.
Moderate	Language and capacity for acquisition of academic skills vary but are generally limited to basic skills. Some may master basic self-care, domestic, and practical activities. Most require considerable and consistent support in order to achieve independent living and employment as adults.
Severe	Affected persons exhibit very limited language and capacity for acquisition of academic skills. They may also have motor impairments and typically require daily support in a supervised environment for adequate care, but may acquire basic self-care skills with intensive training.
Profound	Affected persons possess very limited communication abilities and capacity for the acquisition of academic skills is restricted to basic concrete skills. They may also have co-occurring motor and sensory impairments and typically require daily support in a supervised environment for adequate care.

Intellectual disability and diabetes

In 2012 there were around 668,100 Australians (2.9%) with ID¹. While some evidence suggests that people with an ID may be at greater risk of diabetes than the general population, the prevalence of diabetes in people with ID remains unclear².

Research has found individuals with an ID not only have a higher prevalence of chronic health conditions, but they also receive significantly poorer management of these conditions³⁻⁵. For example, a United Kingdom (UK) study of 721 adults with an ID found that compared to the general population, a significantly lower proportion of those with an ID had the recommended screening checks for diabetes and they were less likely to meet recommended targets for optimal diabetes management, including glycosylated haemoglobin (HbA1c) and cholesterol levels³. This, in turn, may increase the risk of developing long-term diabetes-related health issues such as cardiovascular disease, retinopathy, nephropathy and neuropathy.

The authors of a 2014 systematic review of the prevalence, incidence and impact of diabetes in people with an intellectual disability identified a lack of research evidence to establish what might constitute effective evidence-based practice, including self-management for people with an ID². They concluded that it is highly probable that diabetes has a negative impact on the physical health and psychological wellbeing of people with an ID, including a contribution to premature morbidity and mortality.

The reasons for poorer health outcomes in people with ID are complex but include mainstream health services not always being well informed or well equipped to respond to the needs of people with disability⁶. Health professionals face many challenges when working with individuals with intellectual disability including communication difficulties, inaccessible or an incomplete medical history, lack of training in how to communicate with people with a disability, the complexity of care, inadequate professional support and fragmentation of disability support and health care⁷.



A qualitative study exploring the perceptions and experiences of 29 UK health professionals in diabetes and intellectual disability services identified three main themes relating to improving diabetes care in those with an ID⁸:

1. enabling access to services to meet diabetes-related care needs of people with an ID;
2. communication and service improvements between staff, people with an ID and across services;
3. providing person-centred diabetes care and developing adapted resources to increase self-care.

Practitioners reported not feeling fully prepared with sufficient knowledge, resources, accessible information and time to enable person-centred care that adequately meets care needs and addresses the challenges presented to services⁸.

Other research suggests that the sharing of health information in general practice care for people with an ID could be improved by increasing the duration of medical consultations, improved record keeping and sharing of information, better preparing for consultations and improving the knowledge and communication skills of health care practitioners⁹.

Several studies, both within Australia and overseas, have also identified issues with communication between people with an ID and their general practitioners¹⁰⁻¹⁴. These findings are equally relevant to other health professionals.

The findings of a small study of individuals with mild or moderate ID and diabetes found that none of the participants had received written information about diabetes that they could understand¹⁵. The study authors emphasised the need for the development of diabetes resources that people with an ID can understand, along with improving engagement in self-management and developing the confidence to use this information. In a second small study of individuals with mild ID and diabetes, participants expressed confusion and uncertainty about certain elements of their diabetes, highlighting the need for health professionals to present information to people with an ID in a way that they can understand¹⁶.

Diabetes self-management education (DSME) is an integral part of diabetes care for all individuals living with diabetes, including those with disabilities¹⁷. However, an ID may present barriers to accessing DSME and to the DSME process. Having an ID can also make it more difficult to carry out necessary self-care tasks. It is important that individuals with an ID are provided DSME in a way that enables them to achieve similar behaviour change goals as those without a disability¹⁷. This requires diabetes health professionals to have a good understanding of the impact of a person's disability and knowledge of how to best communicate with the person to provide tailored education and encourage self-management.

Having an ID can also make it more difficult to carry out necessary self-care tasks.



Purpose



The purpose of this document is to provide practice recommendations to health professionals to better support people living with an ID and diabetes, as well as their families, carers and support workers.

The term health professionals in this document refers to the range of health professionals who may work with people with an ID and diabetes including general practitioners, endocrinologists, paediatricians and other medical specialists, nurses, credentialed diabetes educators, dietitians, podiatrists, occupational therapists, speech pathologists, exercise physiologists, psychologists, psychiatrists, social workers, pharmacists, optometrists, dentists, radiographers, and phlebotomists.

The term carer has been used to describe an informal carer who is not receiving a wage or salary to provide support, but may receive government benefits to support a person with an ID and diabetes. This may include parents, siblings, friends, other family members, foster carers or other carers.

The term support worker has been used to describe a formal support worker receiving a wage or salary to assist a person with an ID and diabetes. This includes support workers who work within a supported living facility, those working for a support organisation that provides support to a person with an ID within their family home or in an independent living situation and those providing services such as respite care, day activities, holiday support, community support and supported employment.

It is acknowledged that the environment in which health professionals work is not always supportive of the health care needs of people with an ID and diabetes. Australia's National Disability Strategy is committed to improving access to health services for people with a disability and ensuring that all health services have the capabilities to meet the needs of people with a disability⁶. Yet, it is recognised that at present, individuals with a disability have comparatively poor health status and that the health system often fails to meet their needs. Challenges with communication between people with an ID and health professionals have been identified as a major contributor to suboptimal health care for these individuals¹⁰⁻¹³.

This document provides information for health professionals to improve their understanding of the health care challenges and needs of individuals with an ID and diabetes, particularly with respect to the communication of health care information. It also encourages all health professionals and their health service management to advocate for health organisations to consider and accommodate the needs of people with an ID and diabetes, along with their families, carers and support workers.

An online training module for health professionals has also been developed, providing more detail on the topics covered in this guide.

Development of this document

This guide was developed to assist health professionals in improving their communication with individuals with an ID and diabetes and/or their carers and support workers.

This document has been written following: a review of the current literature; a survey of health professionals, people with diabetes and ID, and carers and support workers of people with diabetes and ID; and with input from an expert reference group.

Overview

The health of people with an ID and diabetes is enhanced when they are engaged in their own health care. This can be facilitated by health professionals who tailor their communications to the needs of the individual.



Principles

1. People with an ID are entitled to receive the same preventative health care as others, but this does not always happen for reasons including physical barriers, lack of knowledge by health providers, stereotyping or communication difficulties⁶.
2. People with an ID are entitled to be treated in the same way as those without a disability while respecting their disability-related needs²⁷.
3. Each person with an ID is unique and requires an individualised approach to meeting their health care needs.
4. People with an ID vary greatly in their cognitive awareness and communication abilities. People with mild ID may have difficulties comprehending the complexities of health care consultations, effectively communicating their health care needs and understanding what is said during the consultation¹³. Additional skill, sensitivity and time are therefore required to initiate and maintain effective health communication with people with an ID¹³.
5. Barriers in exchanging health information with people with an ID include^{9,11,28–30}:
 - a. difficulties in understanding and communication
 - b. insufficient health information provided by carers/support persons
 - c. time constraints
 - d. difficulties retaining information from consultations and sharing this information with carers or support workers
 - e. insufficient information in carer or support worker records with regards to diagnosis, results and management plan
 - f. a mismatch between the working hours of carers/support people and health professionals
 - g. lack of experience and training of health professionals regarding the health care needs of people with an ID
 - h. a shortage of tailored information and educational resources for people with an ID.

6. Enablers to exchanging health information with people with an ID include^{9,11,28–30}:
 - a. health professionals preparing for consultations
 - b. the attendance of informed carers/support people during the consultation
 - c. tailored adjustments in communication by the health professional
 - d. longer consultation times
 - e. ongoing relationships between the individual with an ID and health professionals
 - f. ongoing relationship between the individual with an ID and their carers and support workers
 - g. provision of information in writing and requests for carers or support workers to record and share management plans.
7. Diabetes self-management education (DSME) is an integral part of diabetes care for all people with diabetes, including those with disabilities¹⁷. Many disabilities present barriers either to the DSME process or to the ability to carry out necessary self-care tasks. DSME for persons with disabilities must be provided in a way that allows them to achieve similar behaviour change goals as people with no current disability¹⁷.
8. When working with an individual with an ID, the health professional should assume responsibility in learning about both the effect of that individual's disability on DSME and the tools and techniques available for self-management with that disability¹⁷.
9. Educating individuals with diabetes and disability regarding their health care requires communication among all health care team members (with appropriate consent from the person with an ID or their nominee) and the sharing of information about the effects of the disability on an individual and on the DSME plan¹⁷.



Recommendations for practice

Health professionals support people with an ID and diabetes by:

- » preparing for health care consultations
- » considering the consultation environment
- » tailoring communication to the individual
- » considering language use
- » using appropriate tools and resources
- » understanding the NDIS and diabetes care
- » working in collaboration with carers and support workers.

Further information on each of these areas, including examples and case studies, are provided in the online learning module ***Tailor your communication skills: A training module for health professionals caring for adults with diabetes and an intellectual disability.***

Prepare for health care consultations

People with an ID have diverse health needs and managing and supporting them in their care can often be more complex and time-consuming than for people without a disability. Preparing for consultations can help to optimise the care and support of people with an ID and improve health outcomes.

It is recommended that health professionals^{13,31}:

- » Learn more about working with people with an ID, including communication challenges and needs, particularly if new to working with this population.
- » Become familiar with methods of alternative communication for people with an ID and how these are used.
- » Where possible, obtain the person's medical history prior to the consultation (after obtaining appropriate consent), particularly if this is the first consultation with them.
- » Make appropriate use of the person's health records (including their My Health Record) to support good information exchange.
- » Allocate a longer consultation time, to accommodate the communication needs of the person with an ID.
- » Send appointment reminders and ensure the person is prepared for the consultation, to reduce anxiety.
- » Avoid keeping the person waiting for long periods by scheduling appointments at less busy times and/or calling them if long delays are anticipated.
- » Encourage support persons to be prepared with a list of issues and questions to be raised, an up-to-date medical history and relevant observations and records that will assist with the consultation.



NDSS registration

People with an ID should be registered with the NDSS by health professionals who are authorised to certify eligibility. Registration with NDSS is free and open to all Australians who are diagnosed with diabetes. It is important that people with diabetes register with the NDSS so they can access information, support services and subsidised diabetes products.

More information can be found on the NDSS website at ndss.com.au/registration.

Consider the consultation environment

The environment in which health care consultations occur plays an important part in facilitating good communication and should be considered alongside improving the communication skills of individual practitioners.

It is recommended that health professionals and health services^{13,27,31}:

- » Locate diabetes services in a wheelchair accessible location.
- » Provide a space for communication, which is quiet and free from distractions.
- » Where possible, have the person with an ID see the same health professional at each visit, to allow them to get to know the person well and to better understand their nonverbal communication and other cues.
- » Provide suitable waiting room activities or an alternate room for waiting, if required.
- » Find out if the person wishes their carer or support worker to stay for the consultation, and if they are happy for them to speak on their behalf. If they stay in the consultation, seating should be arranged to ensure that the health professional focuses on the client rather than the carer or support worker.
- » Ensure the person has access to their communication device(s) if required.

Tailor communication to the individual

Many people with an ID have communication difficulties, particularly those whose disabilities affect speech, hearing or sight. However, every person with a disability is unique. The type and extent of their ability to communicate and the best way to address this will vary. The following are general recommendations to consider but it is important to tailor communication to the needs of each individual.

It is recommended that health professionals^{10,13,27,31}:

- » Treat each person with respect and dignity and avoid patronising tones or talking down to the person.
- » Speak directly to the person with a disability, rather than a family member/carer or support worker, regardless of the extent of their disability and their degree of comprehension.
- » If there are difficulties communicating with the person, ask for permission to direct your questions and conversation to their support person but continue to look back at them intermittently to help them feel engaged in the conversation.
- » Before speaking, gain the person's attention and eye contact, if possible.
- » Before beginning, explain what will happen in the consultation in simple terms.
- » Before examining them, tell the person what will be done and why.
- » Use age-appropriate language—i.e. avoid talking to an adult as if they were a child.
- » Use short, simple sentences and plain language—avoid jargon.
- » Use a normal tone of voice and do not raise your voice or shout, unless required (e.g. if someone has a hearing difficulty).
- » Be sensitive to nonverbal cues.
- » Be aware of and responsive to the emotional needs of the person, along with any fears or negative reactions they may experience.
- » Speak slowly and clearly and pause frequently, so as not to overload the person with information.
- » Before asking questions, find out how the person communicates—e.g. how they indicate 'yes' or 'no'.

- » If the person uses a communication device, ensure they have access to it during the consultation and find out how it is used.
- » Regardless of communication difficulties, encourage the person to be actively involved in the communication, either verbally or nonverbally.
- » Become comfortable with silence. Many individuals need extra time to process your questions and/or formulate a response. Talking while they are doing this could distract them.
- » Be aware that some people may have difficulties speaking but still be able to understand what is said to them. Conversely, some people's expressive speech may give the impression that they understand more than they actually do.
- » Check your understanding of what the person has said by repeating key points back to them and asking for confirmation or correction.
- » Do not pretend to understand what a person has said if you do not. Ask them to repeat or rephrase, or offer other methods of communication.
- » Provide clear explanations and always check that the person has understood what you have said by asking them to repeat it back in their own words.
- » Be aware that some people may have difficulty expressing their feelings and describing symptoms. In this case, involving carers or support workers who know them well may help.
- » For those who have difficulties speaking, use alternative communication tools.

Communication preferences of people with an ID

In a small qualitative study of individuals with a mild or moderate ID, participants formulated their preferences for communication with their doctors¹². These preferences can be summarised using the acronym LANGUAGE:

1. **Listen** carefully to me
2. **Allow** me to tell you about my symptoms
3. **Need** to take me seriously
4. **Give** sufficient time to the consultation
5. **Understand** and show consideration for what I want
6. **Ask** questions about my symptoms
7. **Gain** permission before talking to my support worker about me
8. **Explain** and demonstrate before starting a physical examination.



Consider language use

The Australian Network on Disability describes language as a powerful tool that can be used to create a sense of empowerment, pride, identity and purpose³². However, incorrectly used, it can have a devastating impact, even with the best intentions.

It is recommended that health professionals^{32,33}:

- » Be aware of the impact of the language they use when speaking to and about people with an ID and diabetes.
- » Use language that engages people with an ID and diabetes and supports their daily self-care efforts.
- » Avoid language that is patronising, that demotivates or that induces fear, guilt or distress.
- » Understand that each person is different and will have their own preferences with respect to language use, so ask the person what works for them, and respect their wishes.
- » Most importantly, focus on the person, not the disability.

Further information and practical examples on tailoring language to the individual can be found in section 4: Improving communication when working with people with an ID of the online training module for health professionals.

“The way language is used – both verbal and written – reflects and shapes our thoughts, beliefs and behaviours. Language has the power to persuade, change or reinforce beliefs, discourse and stereotypes – for better or for worse. Words do more than reflect people’s reality: they create reality”.

A new language for diabetes: Improving communications with and about people with diabetes. Diabetes Australia, 2011³³.

Table 2: Australian Network on Disability recommends the following in regards to language use in people with a disability³²

Terms to avoid	Terms to use instead	Rationale
Disabled or disabled person	Person with a disability or person living with a disability	Person-first language is considered best-practice in Australia and focuses on the person, not the impairment.
Non-disabled or able-bodied	Person without a disability	
Victim, suffering from, struck down by, afflicted by	Experiences, developed or has	Just because a person experiences disability, it does not make them weak, a victim or someone to be pitied. Remove the emotion from the language.
Wheelchair-bound	Wheelchair user	A person who uses a wheelchair is not bound by the chair; they are enabled and liberated by it, it can become an extension of their body.
Confined to a wheelchair	Person who uses a wheelchair	
Disclosure or declaration of a disability	Choose to share information about their disability/impairment	This can make it seem like the person is divulging a secret.
Disability Action Plans	Accessibility Action Plans or Access and Inclusion Plans	This makes the focus much more inclusive and incorporates the requirements of a diverse range of people who may have access needs.

The Australian Network on Disability also discourages the use of euphemisms and made up words (such as “differently abled” or “special needs”) or language that implies a person with a disability is courageous or inspirational simply because they experience disability, as both can be patronising and offensive, despite good intentions³².

Diabetes Australia has similar guidelines on recommended language use when communicating with or about people with diabetes, which should be used alongside the recommendations above³³. A few examples are provided in the table below. The full position paper can be accessed at diabetesaustralia.com.au/research-advocacy/position-statements.

Terms to avoid	Terms to use instead	Rationale
Diabetic	Person with diabetes, person living with diabetes	The term ‘diabetic’ defines the individual as their health condition. It is better to emphasise the person’s ability to live with diabetes.
Disease	Condition	Disease has negative connotations of something that may be contagious and nasty. Diabetes is a chronic condition that the person will live with for the rest of their life.
Normal, healthy (person, blood glucose level etc.)	People without diabetes; target, optimal blood glucose level	Referring to people who do not have diabetes as ‘normal’ implies that people with diabetes are ‘abnormal’. This is not the case and not the point. Similarly, referring to ‘normal blood glucose levels’ implies that levels outside this range are ‘abnormal’.
Poor control, good control, well controlled (referring to HbA1c or blood glucose levels)	Stable / optimal blood glucose levels, within the optimal range, or within the target range; suboptimal, high/low	Referring to ‘poor’ or ‘good’ control infers a moral judgement about the outcome, i.e. the person with diabetes has been good or bad. Taking the judgement out of the language acknowledges that a variety of factors affect optimal diabetes management, many of which are beyond the person’s control.
Blood tests, testing	Checking, monitoring, self-monitoring	‘Tests’ imply success or failure and an end result. Rather, people with diabetes need to monitor their changing blood glucose levels throughout their lives.

Use appropriate communication tools and resources

Communication difficulties in people with an ID can make the exchange of health information more challenging, leading to less effective consultations and suboptimal health care⁹. The use of appropriate tools and resources can help to aid communication and optimise health care outcomes.

It is recommended that health care professionals^{10,17,31}:

- » Become familiar with the various communication tools used by people with an ID and how they are used. Known as augmentative and alternative communication (AAC) systems, these can be formal or informal, and aided or unaided (Refer to text box Communication tools commonly used by people with an ID).
- » Identify an individual's preferred form of learning and personalise education accordingly.
- » Provide information and education resources which are tailored to the needs and learning styles of the person with an ID.

Communication tools commonly used by people with an ID^{10,31}

- 1. Communication books and boards** use pictures, symbols and/or the alphabet to communicate specific messages.
- 2. Electronic devices** vary in complexity from those with a limited number of messages to those which allow the user to construct longer messages by typing words or accessing picture symbols.
- 3. Key word signing** such as Makaton vocabulary which uses signs to indicate needs and wants or to formulate other messages.
- 4. Informal communication** such as facial expressions, gestures, body language, vocalisations or eye contact.



Understand the NDIS and diabetes care

The National Disability Insurance Scheme (NDIS) provides eligible participants with an ID with funding to support them in the management of diabetes. This includes development of a Diabetes Management Plan, training of their support workers and funding to support the implementation of the Diabetes Management Plan.

It is recommended that health professionals develop and maintain their knowledge of NDIS funding available to support people with an ID to receive quality diabetes care. More information can be found on the NDIS website ([ndis.gov.au/understanding/supports-funded-ndis/disability-related-health-supports](https://www.ndis.gov.au/understanding/supports-funded-ndis/disability-related-health-supports)).

Work with carers and support workers

Many people with an ID rely on the help of others to support them to live and actively participate in their community. This may include informal carers and/or formal support workers. According to the Australian Bureau of Statistics (ABS), in 2012 around two-thirds of people living with an ID received assistance with activities of daily living³⁴. Most of these individuals (78%) received assistance from informal carers, with parents making up a large proportion of this group. However, with the introduction of funding for supports through the NDIS, these numbers are likely to change.

Support people can play a key role in facilitating communication between the person with an ID and their health professionals⁵. They can also play an important role in helping the person with an ID to manage their diabetes. However, several studies have identified the need for better education of carers and support workers, to enable them to perform this role^{8,35,36}.

It is recommended that health professionals^{28,35}:

- » Establish good communication with the carers and/or support workers of people with an ID, to obtain relevant health information and to implement treatment/management recommendations.
- » Provide appropriate education and support (initial and ongoing) to carers and support workers to enable them to provide best-practice diabetes care and/or to facilitate and encourage diabetes self-management in the individuals with an ID who they care for.
- » Where there are multiple carers/support workers, facilitate the sharing of information by providing written guidelines and encouraging the use of communication books.

Summary

Good communication between health professionals and people with an ID and their carers/support workers is essential for optimising health outcomes for these individuals. This is particularly the case for people with an ID and diabetes, due to the important role of self-management in diabetes care.

Improving a health professional's understanding of the diabetes support needs of people with an ID increases their capacity to deliver effective diabetes care and self-management education. Effective communication strategies outline how the individualised needs of the person with an ID can be addressed and the role they and their carers/support workers can play in putting the plan into action. Maintaining a focus on the needs of the individual will, over time, improve the health outcomes of people with an ID and diabetes.



Further information

Diabetes Australia Position Statement. A new language for diabetes: Improving communications with and about people with diabetes. diabetesaustralia.com.au/position-statements

National Disability Services.

nds.org.au

Australian Network on Disability.

and.org.au

The National Disability Strategy 2010-2020.

dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-disability-strategy-2010-2020

NDIS: disability – related health supports

ndis.gov.au/understanding/supports-funded-ndis/disability-related-health-supports

NDSS registration

ndss.com.au/registration

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