

# Working as a team webinar transcript

Webinar Transcript | 18th September 2023

Welcome, everyone. Today's webinar is on Working as a team: Knowledge sharing and collaboration.

While we hold that theme in our thoughts, I wish to begin the webinar by acknowledging the traditional custodians of country around Australia, including the land the Whadjuk Noongar nation from which I'm presenting today. I pay my respects to Elders past and present and extend that to any First Nations people who are watching.

The deafblind team is a multidisciplinary team that works in conjunction with potentially the person with deafblindness if they have the communication skills to do so, with the family or guardian, and with the people who spend the most time with the person with deafblindness. There could be potentially many members who make up the team for deafblindness and, indeed, people who start working in this space and talk about a meeting that they attended are often blown away by the number of people who attend the meeting and contribute to it.

Your deafblind team could consist of a deafblind consultant, and I will go into more details about some of these roles in the coming slides. The communication guide, the teacher of the deafblind and a deafblind aware broader team that may consist of the orthoptist and audiologist, the orientation and mobility instructor, an allied health team and education team, interpreters, medical team, and in Australia in the current context, the National Disability Insurance Agency and scheme and its respective systems and supports. I will give you a little bit more detail about some of the roles on that list that you may not be overly familiar with.

The first of those was a deafblind consultant. They are the person that brings the deafblind flavour to the team and the strategies and assessments that occur and the discussion that goes on, so they're, I guess, the constant deafblind reminder in the team. They have a deep understanding of the impact of a combined vision and hearing loss. They have knowledge of deafblind communication methods, strategies and techniques. They link people with appropriate services and networks and they can anticipate and advocate for appropriate adjustments needed in a variety of settings to ensure full access. The deafblind consultant may be, but not always, the one coordinating the team. If they're not in the coordinating role, they're definitely in the consultative role to, as I said, bring that deafblind flavour into services and supports.

In the context of the NDIS, the deafblind consultant is most likely to be an allied health professional with additional training and expertise in deafblindness, but they don't have to be an allied health professional. They could be a positive behaviour support practitioner. Theoretically they could be the one with the most deafblind knowledge and expertise on the team. That may be the teacher of the deafblind, it could be a support worker or even a parent. As long as that deafblind expertise is represented, then that person, I guess, takes on the role of the deafblind consultant in the team.

The next role we will look at more detail in is the commguide, and that is an abbreviation for "communication guide". That is a term coined in Australia, but overseas you might have a term such as "intervenor" might be used instead, but the role is similar. So, the commguide has specific skills in supporting people with deafblindness and, in particular, skills to help them access communication and the environment. So, to be able to help them through the environment, understand what's around them and move them through it safely. They may have Auslan. They may have signing skills, but their role is not as the interpreter. They may facilitate engagement in and completion of daily activity and tasks, not to do for but to do with, or to provide the appropriate bridge or support to make that happen, for daily activities and tasks, maybe attendance at special events, appointments and recreational activities. I guess they're a bit of a bridge to society and a bridge to the hearing and sighted world that the deafblind person is operating in. More often than not in Australia the communication guide is a support worker who has received specialist training or been upskilled in providing commguide support for a particular individual, but theoretically you can have a commguide in the classroom but they may actually be an education assistant with those same skills.

The next professional that is important to know about in the deafblind team that you may not be familiar with is the orthoptist. They are an eye health professional with a bachelor's degree in orthoptics. Their role is to detect, diagnose and manage eye diseases and neurological vision disorders and they perform functional vision assessments. The difference between a vision assessment that an ophthalmologist might to, or an optometrist might do, is that they actually look at the levels of vision and how that person uses that vision in day to day life, whether there are any kind of aids, equipment or strategies that could maximise the use of that vision. I guess they're probably one of the most important team members if the rest of the team is to understand the impact of the vision on that person and how to support them best if they are going to be using their vision for access.

The next team member is the O and M specialist. "O and M" stands for "orientation and mobility", so orientation being knowing where you are and knowing what is around you, and mobility being knowing how to get around safely, and that may include the use of mobility aids. In early childhood O and Ms also have a role in helping someone develop early cognitive concepts. They're also instrumental in building sensory awareness, so building awareness of the other senses and the other senses that can help them and potentially compensate for their vision loss. You don't have to be moving yet to use the skills of an O and M specialist because of their role in early concept development, and helping the deafblind person systemically explore and orient to the space around them, so rather than that exploration being random, that there is a systematic way that is taught that can help the person understand their space quickly and efficiently and use those skills in new environments as well. It's those things that actually might be the crucial factor in facilitating movement, not necessarily the actual physical skills of the person themselves. It may be the lack of orientation that is the barrier to movement rather than a lack of movement. You have to feel safe and you have to feel oriented before you're willing to move. That’s our O and M specialist

We have the creative arts therapists as well. Again, not a particularly well known therapeutic field, but one that can be really instrumental, particularly in deafblindness where there is a lack of shared communication options, so potentially communication without language. The creative art therapists have skills and training in facilitating that sort of connection. You may be a creative arts therapists in various creative realms such as art, various forms of art, in music, in dance and movement and in drama, and creative arts therapists have a master's degree and complete supervised practice to then be able to work as a creative arts therapist. They use at their core, regardless of which creative realm they operate in, they use art forms and creative processes to build social connection to develop cognitive skills, to provide a form of expression for the person with deafblindness, to support emotional and mental health and to encourage movement and coordination skills.

Sometimes it can be the creative arts therapists that have more training and skill in facilitating communication and interaction, possibly more so than allied health professionals in certain situations, so always worth exploring the perspective of a creative arts therapist for someone with deafblindness, particularly what I said in forms of communication not well established or understood.

The last role that I will discuss in more detail is the teacher of the deafblind. The terminology around the country varies somewhat from state to state, so there could be a specialist called a "specialist teacher", an itinerant teacher, a visiting teacher or an advisory teacher. Also in the current climate it is very rare to find a teacher of the deafblind. You are more likely to find a teacher specialising in deaf and hard-of-hearing services or a teacher specialising in services for students with vision impairment. There has been a time, though, where the teacher of the deafblind was separate to those two roles as well. I am going to talk about this concept of a deafblind teacher even though they might not actually exist in certain areas or states or services. They're a teacher with additional qualification in a form of sensory impairment and then, probably, if they're working in deafblindness, with that extra degree of work experience and deafblind knowledge, a bit like a deafblind consultant. They could work in a consultancy way or directly with a student and the staff in that school. They might provide advocacy for the access, around access needs, and they might also be instrumental in teaching the student self-advocacy, so advocating for themselves. They also are involved in providing access in the school environment, but also to learning materials and that might involve adjusting the curriculum, actually adjusting the learning materials used, and they may even be involved in providing and setting up technology support in the classroom as well.

Okay. So, a quick revisit of the life space model, which was a topic of our webinar, the previous webinar, and I guess encouraging you to think about each of the spaces and who in that big, long list of people in the deafblind team might be able to help you understand each of the spaces.

Let's think about the auditory space first. So, people most likely and immediately think of the audiologist, so they're the ones who conduct hearing tests and tells you that this deafblind person can hear this, this and that and can't hear that, that and that, and this is maybe their hearing level, how they can hear with certain pieces of technology or these are the kind of technologies that are going to improve their access to sound.

It might also be the teacher of the deafblind or the teacher of the deaf who can provide information on access in access to sound, or encourage other forms of access if they can't rely on auditory stimuli to receive information. You might get information from the medical team about the hearing condition, the speech pathologist might give you insight into how they're making sense of what they're hearing and their understanding of spoken language potentially.

You might even consult with the orthoptist because often audiological assessment is based on a visual response, and if the audiologist doesn't understand the vision or the visual responses of the person or what their eyes might or might not be telling them, then potentially they might be misinterpreting or misreading what that person's eyes are doing, so if they have roving eye movements, for example, if they land on a particular target, does that mean that they've seen it or does that mean that that's just part of their roving eye movements? So, the orthoptist can help the audiologist understand and maybe help them interpret whether their findings are based on valid visual cues or responses.

I’m going to move to the visual space. As mentioned, the orthoptist provides really useful practical information on supporting vision and what vision levels are. An O and M can also understand these vision assessments and explain the results, but they're also observing how a person uses their vision out and about in familiar and unfamiliar environments.

You will have medical information from the ophthalmologist, possibly even a neurologist if the vision condition is affected by the person's neurology, maybe a neuropsychologist, and optometrist might provide information about visual acuity and lenses that that person might be using or not using, and then you've got your specialist teachers as well in vision or deafblind, and the deafblind consultant is usually pretty good at interpreting vision assessments, but they usually don't do that alone, but usually in consultation with the orthoptist.

We have got the grasp space. So that’s the space that you can reach to with any part of your body. The obvious one, because there is movement involved, we're going to have our physical therapist there and provide insight into movement and whether that movement is controlled or whether it is controlled and voluntary, where there is involuntary movement and how to support that movement and how positioning can affect that movement.

There might also be a dance or movement therapist that's involved in exploring expression through movement, but also those who can provide information about motivators for movement, for the deafblind consultant may discuss this or bring in an O and M instructor to relook at how we can extend the tactile space, how we can orient to motivate for movement, and whether visual targets or auditory targets are motivating and accessible.

You've got the teacher of the deaf and deafblind. So, lots of people could actually contribute to information about the grasp space. The same with the tactile and olfactory space. You’ve got your physical therapists there, OT, neurology, but also just day to day observations of how somebody's responding to different touch, what touch they're seeking. Lots of team members can bring their day to day observations into that knowledge space.

The other state, the internal state, that's a really complicated one, and I think a lot of people might have a lot of things to say or hypothesise about the internal state. The experts may well be the family who are observing them for many more hours a day than other people, but definitely I think a whole team approach is needed to really develop appreciation of a particular individual's internal state and different situations. It might be the deafblind consultant who is keeping everybody informed about this theory and growing body of knowledge. There's a little reflection about what people can bring, what information they can bring.

The next part of the presentation is just a little exploration or reflection on the qualities that you need to be able to function in a team providing deafblind services. The slide is titled "Curious, informed, open and collaborative". I’ve just included a few statements and reflections, and maybe like even I kind of use it as a reminder for my own practice.

So, qualities of a team member in deafblindness. Each team member of a deafblind team seeks to: suspend their sighted or blind or deaf or hard of hearing or hearing beliefs, values and assumptions and continually build their deafblind knowledge; they seek to understand the deafblind person's world, knowledge and perspective, and recognise what that deafblind person's actions and reactions means. They seek to respect and discuss each team member's perspectives and theories and seek to reach consensus about access, approach, interaction, communication and learning. They seek to be ready to review this with every new observation or piece of information and seek to be consistent in application of this team knowledge. The deafblind team operates in environments that have policies, processes and funding to do this. So there's my little dream, I guess, for a deafblind team.

The deafblind team are also involved in discussion, documenting and providing support in times of transition, and transition doesn't necessarily mean big change. It just might mean a little change or something different is happening, something different than you're used to is happening.

Documenting strategies, documenting deafblind communication, documenting new developments, either in video, written or photographic form, that the whole team has access to. Recognising transitions big and small. It could be a new place, it could be a new activity, it could be a new school year, it could be new people. All of them need thought and planning and care in introducing and that the team has additional time for planning. So anything with deafblindness often takes much longer, so there's additional time required for planning, for documenting and for meeting and discussing.

I am going to finish the webinar with a few case studies. Let me just find my notes. Each case study is not a full exploration of everything that the deafblind team did, accomplished or achieved, but I guess an overview and a selective picking of various workings and outcomes. I start from, I guess, the initial point of contact and maybe how the referral came to the deafblind team.

This person refuses to move and they're antisocial. With a little bit of history taking and information gathering, we find out that this person has CHARGE syndrome and that they attend primary school. Things that the service provider found concerning was that they lie on the floor instead of sitting in chairs or sitting on the floor with other children. They might scratch and kick teachers and peers. They have been observed to walk well, maybe a bit wobbly, but they won't walk, so they refuse to walk, and the other thing that they found concerning was that the person threw or hid their hearing aids. Communication – when asked about, the communication provided for the student was in a verbal form. Pictures were also used and occasional key word signs. The communication used by the student of the child was mostly gestural. They did have some speech, but it was hard to understand. You had to be quite familiar with them to know what they were saying. They used some formal signs. They would point to pictures but mostly just through the pictures. There's some preliminary information.

There is a physiotherapist involved who was working on the walking. They were working in a multidisciplinary team, an allied health team, as part of a disability service, and working on building strength and balance skills to then hopefully encourage more frequent and independent walking.

A vision assessment was available. It mostly talked about visual fields and acuity, which seemed to be adequate for safe mobility. There was a speech pathologist involved in supporting picture-based communication systems because speech was there but difficult to understand, but also providing some picture cues for supporting the comprehension of the verbal language that was provided. So that’s preliminary kind of information and assessment of the situation, and it’s not all aspects. It’s just some of the ones that were a focus for change.

The first port of call was, I guess, the discussion around, so rather than attitude causing behaviours of things that you observed, what would be some other reasonable explanations for the reluctance to walk and the reluctance to use hearing aids? The O and M teamed up with the physiotherapist to help understand, you know, orientation and observing how that person moved through their environment, whether the O and M could provide some more insight there.

Information on CHARGE syndrome was shared widely with all team members and then the deafblind consultant also got involved particularly around questioning the reluctance to use hearing aids.

Then this resulted in some outcomes, which determined that Billy needs a human guide for moving from place to place when: moving from one textured surface to another, such as brick to lawn, a change in brick pattern, or concrete to carpet, so there's some examples. It's when the surface or the texture changed he would need a guide.

Walking or running on uneven ground and when light levels change suddenly. So, the O and M was able to identify that this person was confident to walk in some situations but not all because of the visual characteristics or the unpredictability of the ground surface. It wasn't in all situations, but there were some situations where a human guide would provide reassurance and safety for Billy.

Billy needs access to a sign language interpreter in the classroom who wears plain clothing to contrast to their skin, so there's a big shift in the form of access to communication. Rather than picture based it became sign based, and this all happened through numerous discussions with lots of people and re-evaluation.

Billy also needs people who communicate and interact with him to do so at eye level, so that Billy didn't have to tip back or change his point of balance to be able to see people or to get people within their visual field or Billy's visual field, and that people who communicate and interact with Billy are mindful that their positioning doesn't result in light shining into Billy’s eyes, so therefore reducing visual access to them, their face, maybe their signing, and what they’re doing.

And everyone to recognise that lying on the floor is a sign of such things as vertigo, distress, fatigue, overwhelm and they support by: communicating their understanding by signing “lie on the floor, okay”; showing empathy by lying down next to Billy, giving Billy time to recover and for symptoms to pass and engaging in ongoing team discussion to identify causes contributing to the need to lie down and exploring preventative and responsive strategies.

The next case discussion is Riley, and the referral came in to help Riley use their communication device. The preliminary information gathered, Riley had Cornelia de Lange syndrome as a teenager, there was a frequent changing of service providers and care arrangements. Riley runs away a lot, throws their communication device. They’re very social. They have a sense of humour, and they like music and dancing. When asked about the communication, the communication was bilingual verbal. The communication device was regularly available, pretty much always available, and its use was occasionally modelled. The communication used by Riley, predominantly gesture, vocalisation, some speech, but again too intelligible to a familiar listener, and only a few words. They would use leading, so showing their communication partner what they wanted, so taking them to the place and showing them, and then they would use their device occasionally, but it was noted that they accessed that by putting their nose on the screen.

After a little bit, so this is early in the discussion, there were a number of things that needed to be I guess thought about, so there is a speech pathologist involved because that was the nature of the referral, who checked in with the deafblind consultant because of the way that Riley looked at the communication device screen, they were curious about how they were visually accessing it. They also noted a high incidence of hearing loss in this particular syndrome.

The plan going forward from that point was that Riley needs vision and hearing assessments, current ones. So, there was some history searching done and any medical information was from over ten years prior and it noted myopia and a mild hearing loss. So, some recent assessment information was needed to help guide decision making. There was probably going to be some adjustment to access needed according to the findings, including how Riley was going to access communication methods.

The team needed to build some knowledge around the health and dietary needs of someone with Cornelia de Lange syndrome and needed more history about Riley and to establish a relationship with the current carers, and it was likely that Riley was going to need a deafblind team. That's where we got to with Riley.

The final case study, the referral came from another service in a remote area of the state, so without access to kind of metropolitan services. This person seems able but they're very passive. History: they're an adult. They're presumed to be congenitally deafblind, although there wasn't a lot of actual hard evidence of this. From more recent assessment they had no functional vision and severe hearing loss, again assumed probably from birth but again no hard evidence to indicate that. Its cause was unknown and not stated in any of the documentation or any of the records that were held for this person. They wore their hearing aids consistently, so put them on in the morning when they woke up, and took them off for showering and swimming and then took them off again at the end of the day for bed.

There was quite a bit of documentation around their communication and their recreation options. They're a single occupant in a house in a supported living arrangement. There was deafblind support available remotely, so from a little bit of deafblind support from the metro region, but there were no allied health services engaged.

There were a number of behaviours that the support team were concerned about. The person was also gaining weight quite rapidly, even though they were very mobile and quite active every day, but they were also dependent for many activities of daily living, so very engaged in recreation and very physically able, but didn't do a lot in their own home around daily living activity.

Again, discussions started, ongoing, frequent, long term and resulted in a list of needs. Hunter needed communication guides who signed. Staff needed to be trained in deafblindness and particularly with social interaction and supporting early deafblind communication development and development of concepts, team meetings and medical assessment to provide insight into the cause of weight gain, which as it turned out was a result of a very frequent schedule which coincided with morning shift, afternoon shift and evening shift and the lack of communication there to know that Hunter was actually engaging in treat eating three times a day as well as normal meal schedule.

Hunter needed allied health support. To support communication guides ongoing, Hunter’s diet and building involvement in daily life. There was definitely physical ability but the concepts needed to be developed and supported, and the allied health team to work in conjunction with the deafblind consultant, and continuation with the recreation incorporating retelling experiences. So, spending time after each of those activities that Hunter was so engaged in, actually reflecting and talking on them in using some deafblind early social interaction methods.

They're just a little sample of some different cases, but a deafblind team is going to be different for every person and in every situation and every service because of the team members that are available. Who coordinates and communicates between team members might not necessarily be the deafblind consultant. In some cases it might be the parent who is taking and gathering information from everyone and sharing that across. Once again, it just depends on the situation. Maybe it's a key worker from an allied health team who takes on that role of keeping everyone informed and up to date. It will be affected by the processes in different organisations and the service delivery models that each team member is working under, and it also comes down to a matter of funding, who is funded to do what, but you can take, I guess, the ideal examples discussed here and incorporate those into the requests for funding and how your organisation will provide those services and recognise the need for those services.

If you want to find out a little bit more about some of the team members discussed today, then on the Deafblind Information Australia website, if you go to the services menu and then into NDIS, you will find video presentations on a range of services available to people with deafblindness under the NDIS.

That brings us to the end of the presentation. I am going to open the floor up to questions now.

End of webinar transcript.