Australian Government

Department of Health and Aged Care

Intellectual Disability Health Capability Framework

Acknowledgement of Country

The Department of Health and Aged Care acknowledges the traditional owners of Country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to elders both past and present.

We pay our respects to all First Nations people with intellectual disability and acknowledge the higher prevalence of intellectual disability among First Nations peoples and the distinct challenges they face, along with the contributions they make to society.

Acknowledgement of people with intellectual disability and their support networks

The Department of Health and Aged Care acknowledges people with intellectual disability and the people who support them who have fought and advocated for improved health care for people with intellectual disability. We acknowledge people with intellectual disability and their support networks who have shared their knowledge and experiences that have contributed to creating the Intellectual Disability Health Capability Framework.

CREDITS
Front cover image
Sam Maharaj - Untitled (2023)
Image this page
Katherine Procter - Pond with Flowers (2022)

Contents

Foreword

My name is Naomi, I like to be a voice for people who can't speak up for themselves. I am committed to improving health outcomes for people with disability and proud to be a health ambassador with Down Syndrome Australia and Down Syndrome Western Australia. I am a member of the Roadmap Implementation Governance Group and Intellectual Disability Focus Group with the Department of Health and Aged Care, where I am listened to and have my voice heard. I am also a published author.

I know that a lot of doctors and health care workers don't get training about how to look after people with intellectual disability. The implementation of the Framework is going to be important for health care workers and for people with intellectual disability. There are a lot of people with intellectual disability that will benefit from health care workers getting better training. I am so happy that I was part of the process to make this Framework.

Health care workers need to understand their patients and their needs (for example if they have special health care needs). Health care workers just speaking to parents or carers can make people with intellectual disability feel invisible. I am the expert in what I need… involve me in my health care.

Health care workers need to respect and listen to people with intellectual disability, we deserve the same quality of care as everyone else. The Framework will help health care students learn how to treat us equally and have better communication. They will be more confident with diagnosis and treatment. It will make their jobs so much easier.

I just want health care students to know that we are all individuals and have the right to safe and quality health care.

I really look forward to seeing this Framework improve training for health care students so there are better health outcomes for people with intellectual disability.

Naomi Lake

Hannah French
Painting Painting: Green (2021)

Executive summary

People with intellectual disability have poorer health outcomes compared to people without intellectual disability, including higher rates of morbidity and preventable deaths[1-2]. This population faces multiple barriers to timely and effective health care including limited health workforce capacity in this area, in part due to insufficient and inconsistent intellectual disability health education within Australian pre-registration health profession programs. Submissions to the ***Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*** identified continued systemic neglect of health needs of people with cognitive disability, which includes people with intellectual disability, in the Australian health system[3]. The Commission recommended improved education and training of health professionals in this area and the development of a capability framework as key actions to address these barriers.

In response to the identified health needs of this population, the ***National Roadmap for Improving the Health of People with Intellectual Disability*** (the Roadmap) was released in August 2021 by the Department of Health and Aged Care[4]. A key objective of the Roadmap was to provide support for health care professionals to deliver quality care to people with intellectual disability. A key action was the Intellectual Disability Health Curriculum Development Project, which set out to develop the Intellectual Disability Health Capability Framework (the Framework). The development of the Framework was led by the Department of Health and Aged Care in conjunction with the Education and Training Expert Advisory Group. The Framework was drafted by a group of experts in intellectual disability health and education, guided by extensive consultation with people with lived experience of intellectual disability, their families, carers and support networks, and accreditation, education, and health professional experts.

The Framework aims to equip future health professionals with the required core capabilities to provide quality health care to people with intellectual disability. Associated learning outcomes support the progressive development of the intellectual disability health core capabilities (the Capabilities). The Framework has tailored guidance for accreditation authorities and self-regulating health professions to support the integration of the Framework into accreditation standards. There is also tailored guidance for pre-registration education providers including deans, education and curriculum leaders and managers, and curriculum coordinators, placement coordinators and educators to integrate the Framework into curricula to improve health graduate competency in this area. Suggested methods of assessment, key resources, and tools to assess current capacity and teaching are included to support the implementation process.

There is considerable scope for all health disciplines to integrate specific mention of intellectual disability content into existing standards and curricula content. In addition to tailored new content where required, this will ensure that all health graduates are equipped to respond to the individual needs of people with intellectual disability. The integration of intellectual disability curricula can also illustrate how equitable care can be provided for other populations with specific needs. Enhancing the capacity of all health professionals to provide quality health care to people with intellectual disability will contribute greatly towards the overall aim of improved health outcomes for this population.

Acknowledgements

The drafting of the Intellectual Disability Health Capability Framework has been led by an expert drafting group engaged by the Department of Health and Aged Care. The drafting group comprises of members representing the Australian Medical Council, the Department of Developmental Disability Neuropsychiatry at UNSW Sydney, Flinders University, Australasian Council of Dental Schools and Medical Deans Australia and New Zealand.

Drafting group: Ms Claire Eagleson, Dr Louise Roberts, Dr Jenna Zhao and an Australian Medical Council (AMC) representative

Expert advisors: Dr Seeta Durvasula, Prof Nigel Robb, Prof Julian Trollor, Prof Stephen Trumble and Dr Janelle Weise

Lived experience researcher: Ms Katrina Sneath

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The drafting group would like to thank all individuals and organisations who have taken part in consultations and contributed feedback toward the Framework. We gratefully acknowledge members of the Health and Disability Interface Section within the Australian Government Department of Health and Aged Care for their contribution to and guidance throughout this project, specifically Kat Davies, Zoe Hannah-Whitehouse, Lauren Mauger and Erin Werkmeister.

We also appreciate the valuable contributions and advice provided by Intellectual Disability Focus Group members Ben Zarew, Donna Best, Hugo Taheny, Larry Simpson, Naomi Lake and Uli Cartright, and the Education and Training Expert Advisory Group (see ***Appendix 1*** for membership). We extend our thanks to Belinda Gibb, who is a Dharug woman and is the Manager of Indigenous Strategy and Programs at the Australian Medical Council, for her contribution to the yarning circles.

The artwork throughout the Framework has been created by people with lived experience of disability. Artwork has been provided by ***Studio ARTES***, a community organisation that provides creative and life skills programs for adults with disability.

Language used in the Intellectual Disability Health Capability Framework

The Intellectual Disability Health Capability Framework uses current best practice for communicating about a person with intellectual disability, including person-first language when referring to people with intellectual disability. However, we acknowledge that language preferences may vary between individuals. We use the term First Nations people to recognise the diversity of Aboriginal and Torres Strait Islander people. The Framework uses general terms commonly used within the accreditation and education sector, but we recognise that term usage will vary across disciplines and institutions. A glossary of terms is included on the following pages.

Glossary

accessible – Environments, facilities, services, products and information that people are able to use and interact with in a way that suits their needs[3].

accreditation authority – An entity performing professional accreditation functions under the National Law and may be an external accreditation entity (usually an accreditation council) or an accreditation committee[5].

accreditation standard(s) – A standard(s) used by an accreditation authority to assess whether a program of study, and the education provider that provides the program of study, provide persons who complete the program with the knowledge, skills and professional attributes necessary to practise the profession in Australia[5].

Augmentative and Alternative Communication (AAC) – Methods of communication personalised to enable the participation of a person who may experience barriers to spoken communication. They include unaided forms, such as eye contact, gestures, facial expression, vocalisations and sign language, and aided forms that use devices to communicate[3].

capacity to consent – A person's ability to make decisions. A person is generally presumed to have capacity if they can understand facts and choices involved, weigh up consequences, and communicate their decisions. Legally, adults are presumed to have capacity to consent until otherwise indicated. Capacity to consent is time and situation specific[6].

clinical placement – The component of a program of study, undertaken with supervision, in a clinical or professional practice environment, which assists students to put theoretical knowledge into practice. *Also known as work-integrated learning (WIL), work-based learning, professional experience placement (PEP), professional placement, professional experience, work placement, midwifery practice experience (MPE), clinical experience, clinical attachments, practice placements, clinical internship, clinical rotation, clinical observation, or experiential learning[5].*

co-design – A design process where stakeholders are equal partners and take leadership roles in the design of products, services, systems, policies, laws and research[3].

Consumer Advisory Groups – Community members including people with intellectual disability and their support networks who can advise on curriculum design, development, and delivery.

cultural safety – An outcome that respects, supports and empowers the cultural rights, identity, values, beliefs and expectations of First Nations peoples while providing quality services that meet their needs[3].

culturally safe practice – The ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive health care free of racism[5].

curriculum coordinator – Individual(s) in an education institution who oversees the design, development, and implementation of course curricula.

diagnostic overshadowing – The misattribution of symptoms to the person's disability rather than to a health or mental health concern[7].

dignity of risk – The legal right of people with disability to make decisions that involve risk[8].

Disability Representative Organisation (DRO) – A peak organisation providing systemic advocacy and representation for people with disability[3].

Easy Read – Easy Read materials adapt standard information into a briefer copy using easier-to-understand language and pictures to support comprehension of the text.

experiential learning opportunities – Opportunities for students to learn through experience, preferably involving direct contact with people with intellectual disability or their support networks in this context. This may include simulations, role plays, placements, and contact with people with intellectual disability and their support networks when they are delivering education content such as lectures.

First Nations peoples – The Aboriginal people of mainland Australia, Tasmania and other islands off the continent, and the people of the Torres Strait Islands. This term reflects the social and governance structures and systems in place prior to colonisation[3].

groups with diverse needs – Groups who may have unique needs, or experience health inequities and barriers to accessing health care. In addition to people with intellectual disability, this may include people with other types of disability, First Nations peoples, individuals from culturally and linguistically diverse groups, people who identify as LGBTQIA+, people living in rural and remote communities, and people from low socioeconomic backgrounds.

guardian – Someone who is appointed under a guardianship order to make decisions about another person's health care, finances, accommodation, services, relationships or some other personal matters[3].

informal supports – The social support networks that provide protection for people with disability by increasing connections, relationships and visibility in the wider community[3].

intellectual disability – Term used to describe the impairment of general mental abilities that impacts domains of adaptive functioning, originating in the developmental period (before 18 years of age)[9].

intellectual disability champion – Educator or health professional who has expertise or an interest in intellectual disability.

interprofessional – Involving two or more professions or types of professionals.

interprofessional education – In this context, when students from two or more disciplines or professions undertake education together to learn about, from and with each other.

intersectoral – Collaboration of health professionals from different sectors.

learning outcomes – The expression of the set of knowledge, skills and the application of the knowledge and skills a person has acquired and is able to demonstrate as a result of learning[10].

multidisciplinary – General term to denote health professionals from multiple professional backgrounds working together (covers multidisciplinary, interdisciplinary, and transdisciplinary practice).

person-centred care – This approach means putting the person with intellectual disability at the centre of planning and decision-making about their own support and services and encompasses the principles of equality, choice, and inclusion.

pre-registration health education providers – This includes universities and other higher education providers that provide education and training that leads to the attainment of registration as a health professional.

program – A degree (undergraduate, postgraduate), or vocational education and training course provided by an education provider leading to registration as a health professional.

reasonable adjustments – In health care include policies, processes, systems and communication that adjust for the needs of the person with intellectual disability. Reasonable adjustments prevent direct and indirect discrimination against a person with disability[11].

restrictive practice – Any action, approach or intervention that has the effect of limiting the rights or freedom of movement of a person. Restrictive practices include physical restraints, chemical restraints, mechanical restraints, environmental restraints and seclusion[3].

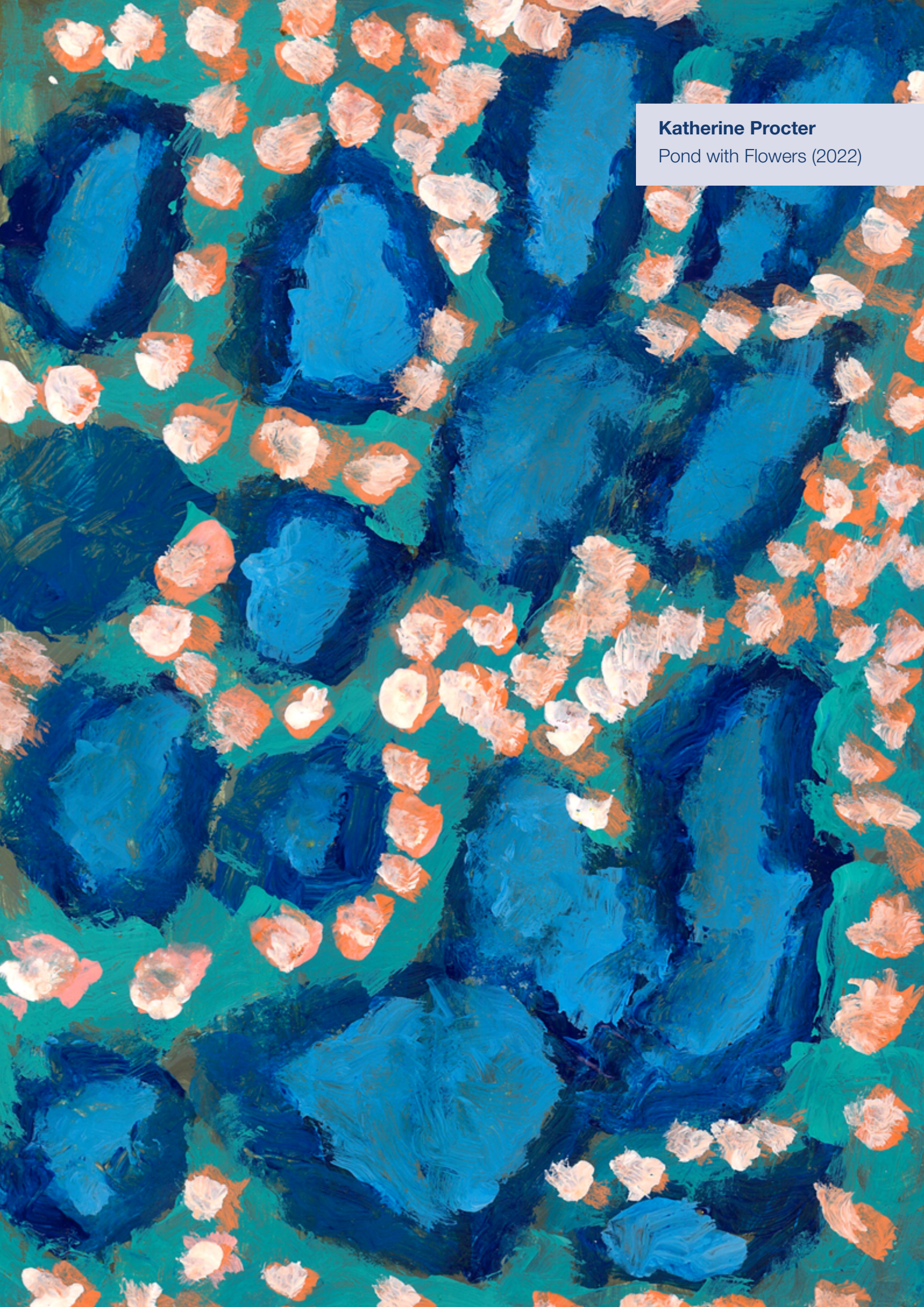
self-regulating profession – Involves professional peers in establishing and monitoring professional standards at both the collective level, through setting entry and ongoing education standards, and the individual level, such as through monitoring standards of ethical conduct[12].

simulation-based learning – Interactive educational methods or clinical experiences that evoke or replicate real-life characteristics of an event or situation as the basis for developing skills, confidence and problem-solving abilities in a safe, controlled and monitored environment. Also known as simulation-based education and training (SBET) and pedagogical innovation[5].

substitute decision-making – A range of processes and regimes that involve a person making decisions on another person's behalf. Substitute decision-making includes appointment of guardians, administrators and financial managers to make certain decisions on another person's behalf[3].

support networks – Includes carers, families, support workers, advocates, and friends.

supported decision-making – Processes and approaches that assist people to make a decision, including giving them the tools they need to make the decision for themselves. Supported decision-making does not mean making a decision for or on behalf of another person[3].



Katherine Procter
Pond with Flowers (2022)

Introduction

The Framework will help people in health care and people with intellectual disability to be involved and engaged in appointments. Sharing our experiences will help us to get good health care and learn how to look after ourselves better.

Katrina Sneath, lived experience researcher

The Intellectual Disability Health Capability Framework articulates a national benchmark for the capabilities required by health graduates to effectively deliver health care to people with intellectual disability. It aims to support accreditation authorities and higher education providers to integrate intellectual disability health care principles into accreditation standards and pre-registration education and training programs. The need for such a framework is reinforced by findings from the ***Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*** (Disability Royal Commission)[3]. The Commission recommended education and training for health professionals as a key issue to addressing barriers to effective health care and high rates of potentially avoidable deaths of people with cognitive disability, which includes people with intellectual disability. The Commission also recommended a capability framework that specifies the core knowledge, skills and attributes required to provide quality health care.

The Framework was developed with extensive input from, and partnership with, a wide range of stakeholders across Australia, including people with lived experience of intellectual disability, their support networks, and academic, accreditation and health professional experts. It articulates the intellectual disability health core capabilities and associated learning outcomes required by health graduates. The Capabilities are applicable to any graduate who will provide health care and are not restricted to a defined list of health disciplines. The Framework also provides tailored guidance and resources to support implementation of the Capabilities into accreditation standards and pre-registration education curricula.

The Framework is not intended to be prescriptive and can be used in conjunction with other available frameworks.

The Framework contains three sections:

Section 1 Background	Context of intellectual disability health, and the history to the development of the Framework.
Section 2 The Capabilities	A model outlining the intellectual disability health capabilities required by health graduates, with measurable associated learning outcomes.
Section 3 Implementation Guidelines	Guidelines and tools to assist accreditation authorities and higher education providers in implementing intellectual disability health content into accreditation standards and curricula, including suggestions for learning assessment.

Users of the Framework

The Framework is primarily designed for use by:

- Health education accreditation authorities and self-regulating health professions
- Pre-registration health education providers including:
  - — Deans, and education and curriculum leaders and managers
  - — Curriculum coordinators, placement coordinators and educators

Specific guidance is provided for these groups in the ***Implementation Guidelines*** section.

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Section One
Background

Emily Tomasetti
Em's Flowers (2023)

We are individuals and should be accepted, respected and treated as such.

Naomi Lake, Intellectual Disability Health Focus Group member

The context for the development of the Framework

The ***National Roadmap for Improving the Health of People with Intellectual Disability*** was released in August 2021[4]. A key objective in the implementation of the Roadmap is to provide support for health care professionals to help them deliver quality care to people with intellectual disability.

The Intellectual Disability Health Curriculum Development Project (the Project), led by the Department of Health and Aged Care (the Department), supports accreditation authorities and higher education providers to improve pre-registration education for health professionals to ensure that these professionals have the right knowledge, skills, and attitudes to deliver quality care for people with intellectual disability. A key component of the Project was the development of the Intellectual Disability Health Capability Framework.

Context of health of people with intellectual disability

Key points

- The life expectancy of people with intellectual disability is on average 26 years less than the general population and with double the number of potentially avoidable deaths.
- High morbidity contributes to higher health service use and potentially preventable hospitalisations for people with intellectual disability.
- People with intellectual disability experience barriers to accessing health services including communication difficulties between the person and the health professional, a lack of reasonable adjustments, insufficient health professional knowledge and skills in this area, and stigmatising attitudes.

Health outcomes for people with intellectual disability are significantly worse than those for the general population. People with intellectual disability have a life expectancy that is, on average, 26 years less than the general population, and experience double the percentage of deaths from potentially avoidable causes[1]. Compared with the general population, people with intellectual disability also experience high morbidity[2]. They have a higher prevalence of physical conditions, including epilepsy, sensory impairments, diabetes, dental disease and osteoporosis[2,13-17], and mental health conditions[18-19].

The high morbidity within this population has contributed to high health service use[1, 20-21]. For example, Srasuebkul and colleagues[22] found that in 2014-15 people with intellectual disability made up 6.3% of public mental health service users in NSW, despite comprising only 1.1% of the NSW population. People with intellectual disability also experience higher rates of potentially preventable hospitalisations, especially for acute conditions like epilepsy[23]. These stark health inequalities point to the need for health and allied health professionals across a range of disciplines to provide improved preventative health care, early detection and intervention, and coordinated close management of complex health needs for people with intellectual disability.

People with intellectual disability often experience significant barriers to both physical and mental health service use and good quality care. Common barriers described by people with intellectual disability and their support networks include communication difficulties between the person and the health professional[24-26], a lack of reasonable adjustments being made to communication or practice[27-28], health professionals' inadequate skills and knowledge about the health needs of people with intellectual disability[24,27-29], stigmatising attitudes[30] and diagnostic overshadowing[29,31]. Diagnostic overshadowing refers to the misattribution of symptoms or behaviours to the person's disability rather than to a health or mental health problem[7].

The numerous barriers mentioned in research studies, particularly the lack of knowledge and preparedness of health professionals to provide appropriate care to people with intellectual disability, point to the need for additional and targeted education and training in this area.

Intellectual disability health in higher education

Key points

- There are minimal learning opportunities around intellectual disability health for Australian health professionals.
- Many health professionals report that they do not feel confident to meet the needs of people with intellectual disability and want more education and training in this practice area.
- There is a need to articulate the capabilities required of health graduates to provide quality care to people with intellectual disability. These capabilities can then be used to inform the development of education and training.

A capable workforce across the health disciplines is essential to ensuring that the health needs of people with intellectual disability are met, given that health care for this group is inherently interprofessional[32]. However, the Disability Royal Commission's hearing[3] into the education and training of health professionals ascertained that there is no requirement to deliver education or training about intellectual disability health. The Commission also heard that there is no consistent approach used by health education providers to teach intellectual disability content and found the need for a set of Capabilities to guide education in this area.

Systematic audits conducted in Australia found that there is minimal content related specifically to intellectual disability health in medical and nursing education[33-35]. There has been little overall improvement in the amount and nature of intellectual disability health education for medical students in the last 20 years[36]. A median of less than three hours of compulsory intellectual disability content was found in Australian medical curricula across 12 universities[34]. Similarly, intellectual disability content is scarce in nursing curricula, with over half of the schools audited offering no intellectual disability content[35]. These findings indicate that health students entering into professional practice are likely to graduate with minimal training in the provision of care to people with intellectual disability.

Surveys of practising health professionals suggest a lack of confidence and adequate training to provide care to people with intellectual disability[37-42]. A considerable percentage (38%) of General Practitioners said that they would not be confident in treating people with intellectual disability[37]. In another study, General Practitioners reported that they were inadequately trained in areas such as behavioural and mental health conditions, complex medical problems and preventative health care, and were interested in further education[38].

Mental health professionals also reported a lack of confidence to provide mental health care to people with intellectual disability[39] and have expressed support for increased specialised training[40-41]. Allied health and medical staff within child and adolescent services in NSW also reported a strong desire for training and skill development[42]. These findings suggest the need for intellectual disability content to be included in pre-registration curricula to ensure adequate training of health professionals before they enter the workforce.

A clear workforce development plan, including clearly articulated intellectual disability health capabilities that can be used consistently across health disciplines, is needed to improve the preparedness of health graduates to provide care to people with intellectual disability.

Development of the Framework

The Department, in collaboration with the Intellectual Disability Health Capability Framework Drafting Group and the Intellectual Disability Health Education and Training Expert Advisory Group (EAG) led the development of the Framework.

The Framework was developed over three phases including:

1. Scoping review and gap analysis
2. Development of the Capabilities
3. Finalisation of the Framework

A wide range of stakeholders including people with intellectual disability, their families, carers and support workers, accreditation authorities, universities, health professionals, academic experts, and First Nations people were involved in each of the development phases.

Phase 1: Scoping review and gap analysis

The University of Queensland completed a ***scoping review and gap analysis***[43] of existing health professional pre-registration education on intellectual disability health and resources. The analysis compared the current state of intellectual disability health education with the gold standards identified through literature review and stakeholder consultation and made key recommendations for pre-registration education practice and resources.

Phase 2: Development of the intellectual disability health core capabilities

Drawing on current evidence and expert knowledge, at the start of the Project the Department, with the EAG, had developed draft intellectual disability health capabilities in five areas including i) Understanding the health of people with intellectual disability, ii) Communication, iii) Clinical Care, iv) Coordination and Collaboration, and v) Responsible, Safe and Ethical Practice. These key areas formed the foundation for Phase 2 consultations.

A mixed methods approach was used to refine and further develop the list of intellectual disability health capabilities.

This approach included:

1. Focus groups with people with intellectual disability, families, carers, and support workers of people with intellectual disability, academics, and health professional experts (August – September 2022).
2. Online survey with academic and health professional experts (September 2022)
3. Feedback from the EAG (November 2022)
4. Public open consultation (November 2022 – January 2023)
5. Modified online Delphi survey with experts in intellectual disability health and education to reach consensus on the final list of Capabilities (March – June 2023).

A total of 259 people/organisations contributed to the refinement of the Capabilities (see Table 1). Forty-six capabilities across six areas resulted from the consultation.

Table 1: Stakeholder groups who contributed to the refinement of the Capabilities

Approach	Stakeholder group	No. of participants
Focus groups	People with intellectual disability	6
	Families, carers, and support workers	5
	Academics and health professional experts	29
Online survey	Academics and health professional experts	98
Feedback from EAG	EAG members	12
Public open consultation	Individuals/consumers	22
	Organisations	37
	Groups within an organisation	34
Modified online Delphi	Intellectual disability health and education experts	16

Phase 3: Finalisation of the Framework

Finalisation of the Framework involved drafting learning outcomes and implementation guidance.

A total of 56 individuals contributed to the finalisation of the Framework.

Consultation involved:

1. Interviews and focus groups with 18 First Nations people (August – October 2023)
2. A focus group with five people with intellectual disability (27 September 2023)
3. Public open consultation, receiving 33 responses (October 2023)

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Section Two

The Intellectual Disability Health Capabilities and Learning Outcomes

Rachelle Rodriguez
Flower Garden (2016)

Listen and respect me. Hear my voice and don't ignore me.

Ben Zarew, Intellectual Disability Health Focus Group member

The Intellectual Disability Health Core Capabilities articulate the knowledge and skills health graduates require to effectively deliver health care to people with intellectual disability. This attainment of knowledge and skills should also involve having an attitude towards people with intellectual disability that is conducive to the provision of equitable, quality health care.

The Capabilities are organised into six areas:

1. Intellectual Disability Awareness
2. Communication
3. Quality Evidence-Informed Health Care
4. Coordination and Collaboration
5. Decision-Making and Consent
6. Responsible, Safe and Ethical practice

Principles that underpin the Capabilities include:

- social justice
- person-centred care
- partnerships
- supported decision-making
- cultural safety
- evidence-informed health care

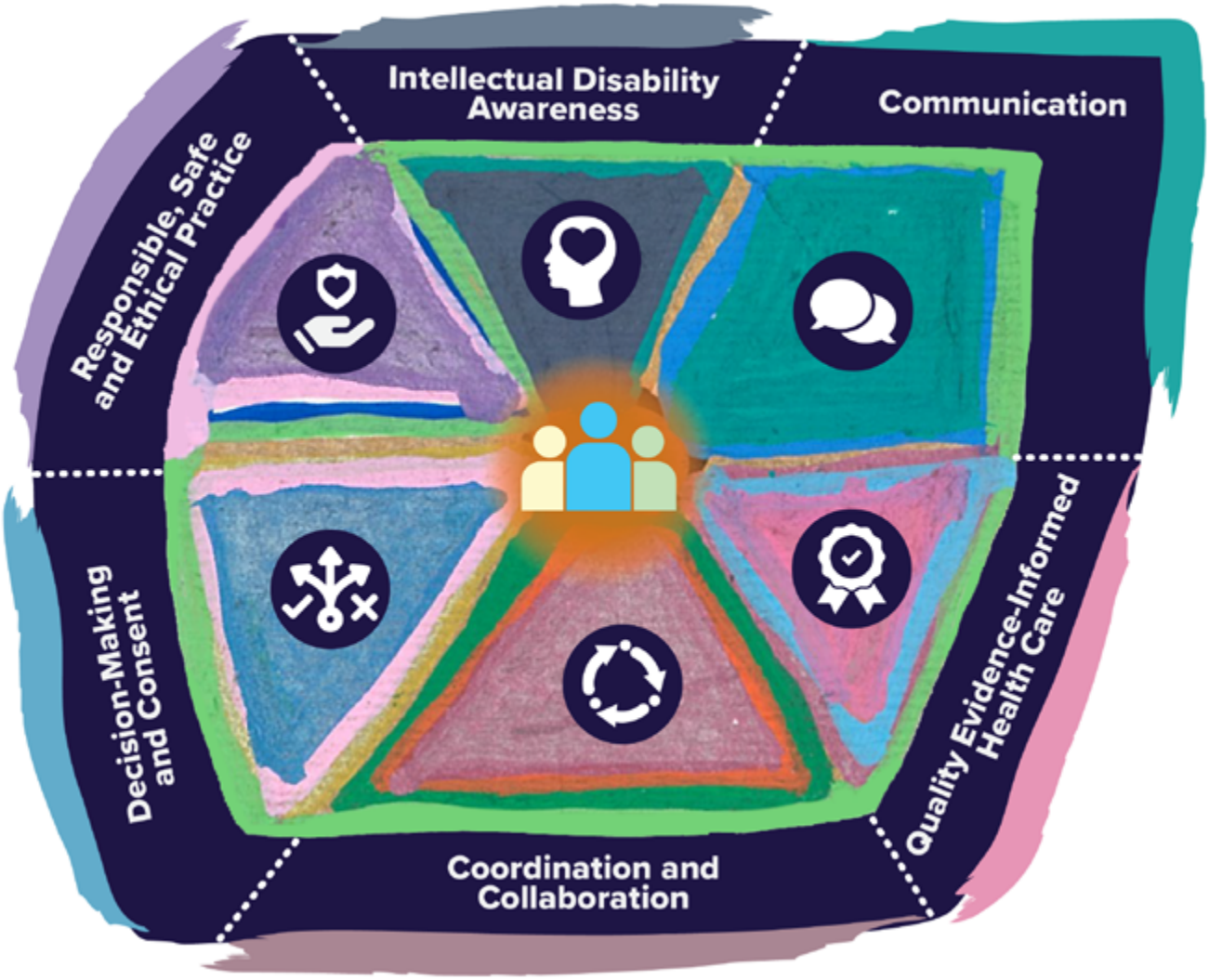
Each capability has been assigned learning outcomes at three different levels of learning[44]. These levels are:

1. Know about (define, identify, outline, discuss, describe key concepts, summarise)
2. Know how (sort, compare, contrast, interpret, organise)
3. Shows how/does (perform, apply, diagnose, demonstrate, analyse, critique, create, design, debate)

The learning outcomes are designed to be used as building blocks to progressively develop knowledge and skills throughout the pre-registration education journey and denote attainment of the Capabilities[45]. The verb used to describe each level of learning can be tailored for integration into current curricula.

The Capabilities and associated learning outcomes have been designed to allow flexibility in when and how health graduates achieve each capability during their pre-registration program, depending on the priorities of each discipline. This flexibility can help Framework implementers to overcome barriers such as overcrowded curricula. Additional suggestions for overcoming barriers to implementing the Framework are provided in the ***Implementation Guidelines*** section.

The image below is a visual representation of the six core capability areas of the Framework. Adapted from a section of Rachelle Rodriguez's artwork Flower Garden (2016).



Disability is a part of diversity and I would like to see that students have that context in which their learning is occurring around disability, not that they're listing lists of pathology, but rather that they see people with disability as part of the spectrum of humanity.

Dr Jane Tracy, previous Head, Centre for Developmental Disability Health Victoria (2013-2019)

1. Intellectual Disability Awareness

Develop and apply knowledge about people with intellectual disability to ensure intersectional care for this population and improved health outcomes.

Capability	Description	Learning Outcomes	Level of Learning
1.1 Human rights of people with disability	Practise in a manner that promotes and upholds the human rights of people with intellectual disability, in keeping with the United Nations Convention on the Rights of Persons with Disabilities.	Discuss the key features of the United Nations Convention on the Rights of Persons with Disabilities, other key policies and standards, and how they apply to people with intellectual disability.	1
		Examine how the human rights of people with intellectual disability can be promoted within practice.	2
		Critique the challenges of upholding human rights within practice and strategies that would maintain and promote the human rights, respect, and dignity of people with intellectual disability.	3
1.2 Attitudes, values and beliefs about people with intellectual disability	Practise in a manner that recognises, respects, values and includes the lived experience and lives of people with intellectual disability.	Discuss the stigma and discrimination experienced by people with intellectual disability and their support networks when accessing and receiving health care.	1
		Discuss how attitudes, beliefs, and values about people with intellectual disability shape health care provision and health outcomes.	1
		Compare and contrast strength and deficit-based approaches when working with people with intellectual disability and the value of lived experience.	2
		Evaluate current examples of health care practice and how attitudes, values and beliefs can be modified to improve health care provision and health outcomes for people with intellectual disability.	3
1.3 Power differentials	Recognise power differentials between health professionals and people with intellectual disability and their support networks and proactively work to remove them, acknowledging people's unique experiences, with the goal of supporting people with intellectual disability to maximise control over their own health care.	Describe the concept of power differentials and how they can influence health interactions and provision of health care for people with intellectual disability.	1
		Identify how autonomy over health care decisions can be maintained for people with intellectual disability.	1
		Examine strategies to reduce power differentials in health care interactions with people with intellectual disability and their support networks.	2
		Initiate conversations with the person with intellectual disability, their support networks and other health professionals using identified strategies to assist in maximising the control people with intellectual disability have over their own health care.	3
		Design a treatment or care plan that supports the self-determination of a person with intellectual disability.	3

Capability	Description	Learning Outcomes	Level of Learning
1.4 Causes of intellectual disability, co-occurring conditions and variability across individuals	Apply knowledge of the causes of intellectual disability and associated conditions to provide comprehensive individualised care.	Identify the different causes of intellectual disability, common co-occurring health conditions and the evidence that underpins their management.	1
		Examine how co-occurring conditions may affect care provision and contribute to complex care needs for people with intellectual disability.	2
		Critique how lifestyle and formal and informal supports affect the management of co-occurring conditions for people with intellectual disability.	3
1.5 Historical and current models of disability and health care for people with intellectual disability	Apply current best practice models of disability and health care for people with intellectual disability, with an awareness of historical models, to inform equitable and person-centred health care provision.	Discuss historical models of disability and how they shaped practice and perceptions of people with intellectual disability.	1
		Identify and reflect upon instances where best practice models of disability and health care have been used.	1
		Compare and contrast current best practice models of disability, including the social and human rights model of disability, and models of health care, and consider how they apply to best health care practice.	2
		Evaluate how models of disability underpin equitable and person-centred health care provision.	3
1.6 Determinants of health for people with intellectual disability	Apply knowledge of the determinants of health of people with intellectual disability and the corresponding available evidence base to inform health care provision.	Discuss the social determinants of health and their effect on health outcomes for people with intellectual disability.	1
		Identify gaps in the health care system, community services and individual care provision that influence health outcomes for people with intellectual disability and identify ways to mitigate them.	2
		Propose examples of potential pathways that support individual strengths, positive behaviours and empower the individual's support network to improve health outcomes.	3
1.7 Health status of people with intellectual disability	Apply knowledge of the unique health status of people with intellectual disability to inform health care provision from prevention to recovery.	Discuss why people with intellectual disability have increased prevalence of chronic, multiple, and complex health conditions.	1
		Develop person-centred and recovery-focused care plans to address the needs of people with intellectual disability within your professional scope of practice.	3
		Integrate knowledge about health status into practice when working with people with intellectual disability.	3
1.8 Barriers and enablers to health care access	Facilitate equitable access to the health care you provide for people with intellectual disability and adapt your practice to provide optimal care by applying knowledge of the enablers and additional barriers to health care experienced by people with intellectual disability.	Identify health care access barriers and enablers that people with intellectual disability may experience.	1
		Describe how barriers and enablers influence health outcomes for people with intellectual disability.	2
		Identify practice adaptations that could be made to provide equitable access and care to people with intellectual disability.	3

Capability	Description	Learning Outcomes	Level of Learning
1.9 Intersectionality of care	Provide culturally safe care and practise in a manner that acknowledges that a lived experience of intellectual disability can intersect with other aspects of a person's identity, creating unique needs, experiences, and barriers and enablers to care.	Discuss the principles of culturally safe care and how they apply to people with intellectual disability.	1
		Discuss how individuals and communities of people with intellectual disability can describe their identity and intersectionality.	1
		Identify specific health and community services and supports that exist for First Nations people with intellectual disability.	1
		Discuss how aspects of a person's identity (e.g., gender, sexuality, culture, relationships, faith, social connections etc.) can intersect with their lived experience of intellectual disability and how this can create unique health care needs.	2
		Critique examples of culturally safe and unsafe care for people with intellectual disability and demonstrate culturally safe practice.	3
1.10 Role of support networks	Apply knowledge of the key role support networks have in the lives of people with intellectual disability, recognising their role and experience, their knowledge of the person's health history and presentation, potential to support and monitor care plans, and their own support needs.	Describe the key role of support networks in the lives of people with intellectual disability and how to identify support networks.	1
		Discuss how to apply the knowledge provided by the support networks of people with intellectual disability to their care.	2
		Design strategies that would support and include the person with intellectual disability's support networks in their care and monitoring of health status.	3

2. Communication

They always talked to my mother about the surgery. But I was the one who was having the surgery. I know my mum is really nice and she cares for me and she explains it to me, but still, I think it's important for the doctors and specialists to talk to the individual, talk to me. And explain it clearly without using too many big, medical terminology.

Ben Zarew, Intellectual Disability Health Focus Group member

When communicating with a person with intellectual disability, adapt verbal, non-verbal and written communication to the person's preferred and most effective style and methods. Recognise behaviour as a form of communication and potentially the primary mode of communication.

Capability	Description	Learning Outcomes	Level of Learning
2.1 Communicate directly with the person with intellectual disability	Communicate and engage directly with every person with intellectual disability, using their support networks to facilitate this when appropriate.	Discuss effective and ineffective communication when interacting with people with intellectual disability.	1
		Demonstrate strategies to engage and directly communicate with people with intellectual disability, using their support networks as appropriate.	3
2.2 Adapt communication	Determine the person's preferred and most effective communication style and adapt accordingly, including seeking advice from the person and their support networks and using communication aids.	Identify how communication might be adapted to a person with intellectual disability's preferred ways of communicating and how Augmentative and Alternative Communication (AAC) resources may support this.	1
		Develop strategies on how to include support networks in communication as appropriate.	3
		Demonstrate the ability to adapt communication to directly engage with the person at the centre of care including the use of Augmentative and Alternative Communication (AAC).	3
2.3 Behaviour as a form of communication	Recognise that behaviour is a form of communication and use it to inform assessment, diagnosis and care for people with intellectual disability.	Discuss why it is important to recognise behaviour as a form of communication.	1
		Describe the causes, manifestations, and potential interpretations of behaviour as a form of communication to inform assessment, diagnosis, and care provision for people with intellectual disability.	2
		Investigate how a person's behaviour has changed, the potential causes, and what it may be communicating, utilising support networks' knowledge, as appropriate.	3
2.4 Communicate to reassure	Recognising that people with intellectual disability may have differing levels of understanding of health care situations and procedures, communicate directly with the person in a way that seeks to include them in health care discussions and inform them of what is occurring and its purpose, giving a sense of control and improved comfort.	Describe what you may need to communicate to a person with intellectual disability regarding what will happen during a health care interaction.	1
		Demonstrate the ability to include a person with intellectual disability in a health care discussion and provide information and reassurance using appropriate communication methods.	3
		Evaluate the person's understanding throughout the health care interaction and respond with appropriate information.	3
		Engage support networks, as appropriate, to assist in making the person with intellectual disability feel comfortable, reassured and in control throughout the health care interaction.	3

3. Quality Evidence-Informed Health Care

Sometimes I go to the hospital unplanned. When this happens, my GP calls me. He makes sure I'm okay and understand why I was in hospital and what I need to do next. He knows that sometimes I don't understand the doctors at the hospital.

Larry Simpson, Intellectual Disability Health Focus Group member

Apply knowledge of evidence-informed, person-centred care that incorporates reasonable adjustments, responsive health care, and proactive approaches to preventative physical and mental health care across the lifespan.

Capability	Description	Learning Outcomes	Level of Learning
3.1 Dignity and respect	Treat all people with intellectual disability with dignity and respect, seeing them as a person first.	Use current best practice, person-centred language and terminology when discussing and working with people with intellectual disability.	1
		Demonstrate respect and support for the right to self-determination and dignity for people with intellectual disability.	3
3.2 Evidence-informed practice	Evaluate, apply and contribute to evidence-informed practice in the health care of people with intellectual disability.	Identify research and areas of evidence-informed practice for people with intellectual disability.	1
		Discuss the advantages and disadvantages of applying evidence-informed health practices drawn from the general population to people with intellectual disability.	2
3.3 Person-centred care	Adopt a person-centred approach to care to ensure that the person with intellectual disability is at the centre of planning and decision-making about their care.	Summarise the principles of person-centred care and their importance to the provision of health care for people with intellectual disability.	1
		Apply the principles of person-centred care to work in partnership with people with intellectual disability and their support networks to identify their goals, motivations, preferences, and priorities.	3
		Work in partnership with people with intellectual disability and their support networks to develop individualised person-centred care plans.	3
3.4 Reasonable adjustments	Make reasonable adjustments to care, including adapting the environment, to meet the individual needs of the person with intellectual disability.	Give examples of reasonable adjustments that could be made in a health care environment to meet the individual needs of people with intellectual disability.	1
		Identify which reasonable adjustments are appropriate for an individual with intellectual disability and explain when they are needed.	2
		Develop a plan to implement reasonable adjustments to meet the individual needs of the person with intellectual disability.	3

Capability	Description	Learning Outcomes	Level of Learning
3.5 Partnership in care	Promote inclusion of people with intellectual disability, and their support networks where appropriate, in all stages of their care including asking people their needs, preferences and values, informing them of what is happening, including them in care planning, and offering a full range of choices.	Develop a plan for the inclusion of people with intellectual disability and their support networks during the assessment and management stages.	3
3.6 Appropriate assessment	Employ appropriate assessment procedures and tools to inform diagnosis of health conditions, with an awareness that modified diagnostic criteria and reasonable adjustments may be required for assessment of people with intellectual disability.	Identify modifications to diagnostic criteria and reasonable adjustments that may be required when conducting an assessment for people with intellectual disability.	1
		Describe the role of a multidisciplinary team and the person's support network in providing an accurate diagnosis for people with intellectual disability.	1
		Use appropriate assessment procedures and tools and make reasonable adjustments when providing care for people with intellectual disability.	3
3.7 Diagnostic overshadowing and other reasons for misdiagnosis	Apply knowledge of diagnostic overshadowing and atypical presentations and their role in under-diagnosis and misdiagnosis in people with intellectual disability.	Explain the concept of diagnostic overshadowing as it applies to people with intellectual disability.	1
		Give examples of atypical clinical presentations in people with intellectual disability and how they can lead to misdiagnosis.	1
		Limit diagnostic overshadowing by evaluating when presentations are attributable to health and/or mental health concerns rather than intellectual disability.	3
3.8 Complex care needs	Apply knowledge of the unique clinical, social and contextual factors contributing to complexity of health care for people with intellectual disability and be able to respond accordingly to complex care needs.	Analyse the inter-relationship of clinical, social, and contextual factors that contribute to complexity in health care for people with intellectual disability.	2
		Propose approaches to practice that address complex care needs.	3
3.9 Deterioration in function	Working in partnership with those who know the person well, recognise deterioration in function particularly when communication or care needs are complex, and respond as appropriate to address deterioration and improve quality of life.	Name the factors that may impede recognition of deterioration of function in people with intellectual disability.	1
		Formulate a plan for early recognition and management of a deterioration in function of people with intellectual disability that is readily accessible for people with intellectual disability and their support networks.	3
3.10 Best practice approaches to management for people with intellectual disability	Use best practice approaches (non-pharmacological and/ or pharmacological) taking into consideration individual needs to manage health conditions for people with intellectual disability.	Discuss the elements of best practice approaches to manage health conditions for people with intellectual disability.	1
		Identify relevant best practice non-pharmacological interventions to manage health-related issues for people with intellectual disability.	2
		Identify relevant best practice pharmacological considerations to manage health-related issues for people with intellectual disability.	2
		Demonstrate how to use best practice non-pharmacological and/or pharmacological approaches to manage health-related issues for people with intellectual disability.	3
3.11 Responsible management of medications	Build awareness of the implications of medications, their use, and interactions for people with intellectual disability and apply these within scope of practice.	List the factors to be considered when prescribing or monitoring medications for people with intellectual disability.	1
		Develop a plan for medication monitoring and review in people with intellectual disability.	2

Capability	Description	Learning Outcomes	Level of Learning
3.12 Working with people who have behaviours of concern	Use best practice and, where at all possible, non-restrictive (otherwise least-restrictive) techniques to work safely with people who may display behaviours of concern relevant to your area of practice.	Define behaviours of concern and identify their main causes.	1
		Describe non-restrictive techniques to work safely with people who display behaviours of concern.	1
		Identify the roles of health and disability professionals in the multidisciplinary assessment and management of behaviours of concern in people with intellectual disability.	1
		Demonstrate how you would use a behaviour support plan when working with a person with intellectual disability.	3
3.13 Lifespan approach to health care	Apply an approach that considers the health needs of people with intellectual disability across the lifespan, particularly during times of transition and life events.	Name the key transition points for people with intellectual disability across the lifespan and associated health and support needs.	1
		Develop an example health care plan for: (i) an adolescent with intellectual disability who is leaving school; (ii) an adult with intellectual disability who is ageing.	3
3.14 Preventative health care and promotion	Employ proactive health care practices and health promotion activities that are adapted and responsive to the needs of people with intellectual disability and correspond to known health risks at a population and individual level.	List the main health enablers and health risks for people with intellectual disability.	1
		Identify the screening and health promotion activities relevant for people with intellectual disability.	2
		Discuss how to adapt preventative health and health promotion activities to the needs of people with intellectual disability.	3
3.15 Responding to trauma	Work in a way that sensitively considers and responds to the greater likelihood that a person with intellectual disability may have experience of trauma, including health care related trauma.	Explain the ways that traumatic health care experiences can influence health seeking behaviour and engagement with health care providers.	1
		Identify resources and services available to support people with intellectual disability who have experienced trauma.	1
		Describe how to apply the principles of trauma-informed care to the care of people with intellectual disability.	2
		Demonstrate how to recognise and respond to signs of trauma in people with intellectual disability.	3
3.16 Health literacy for people with intellectual disability and their support networks	Facilitate quality health care for people with intellectual disability by fostering health literacy in people with intellectual disability and their support networks, and providing accessible information.	Discuss strategies to contribute to health literacy for people with intellectual disability and their support networks.	1
		Provide accessible and relevant health information to people with intellectual disability and their support networks.	3
		Work collaboratively with people with intellectual disability and their support networks to foster health literacy.	3

4. Coordination and Collaboration

You go to an OT. You tell them your story. Then you see a speech therapist. Then you go see a psychologist. Then you have to repeat everything all over again. Why can't they just work together?

Donna Best, Intellectual Disability Health Focus Group member

Engage and work collaboratively with people with intellectual disability and their support networks, including disability, health, allied health, and other professionals to provide well-coordinated care for people with intellectual disability across services, sectors, and transitions.

Capability	Description	Learning Outcomes	Level of Learning
4.1 Care navigation through health and disability services	Support people with intellectual disability and their support networks to navigate available health, disability, and community services according to needs.	Discuss common challenges and gaps in the navigation between health, mental health, and community services for people with intellectual disability.	1
		Identify and compare local, State or Territory and National health, mental health, disability, and community services that may be available within your scope of practice that would support people with intellectual disability.	2
		Critique formal and informal services and supports and their role in advocacy and in navigating health services for people with intellectual disability.	3
4.2 Relationships of trust	Facilitate trust with people with intellectual disability and their support networks during each interaction.	Describe the importance of trust and positive health care interactions for people with intellectual disability.	1
		Create strategies to build positive relationships with people with intellectual disability and their support networks and manage information sharing and conflict.	3
		Demonstrate skills to facilitate and support people with intellectual disability's inclusion in the health care relationship.	3
4.3 Collaborative partnerships	Work collaboratively with the person with intellectual disability, their support networks and professionals, applying knowledge of who is involved and their roles and expertise.	Describe the concept of collaborative partnerships and who and what they entail when providing care for people with intellectual disability.	1
		Compare the roles, skills, and resources that different groups (e.g., community services, specialist services, language services, positive behaviour support, First Nations services) bring to the collaborative partnership for people with intellectual disability and their support networks.	2
		Demonstrate an effective collaborative partnership that is inclusive of the person's support networks.	3
4.4 Collaborate with other professionals	Collaborate as appropriate with other professionals across all stages of a care pathway to ensure successful integration of care for people with intellectual disability.	Identify ways that professionals can effectively collaborate and share information at each stage of a care pathway including assessment, care planning and management.	1
		Interpret and integrate information from other professionals into care planning, delivery and practice when caring for people with intellectual disability.	2
		Demonstrate skills in working with interprofessional teams to benefit the health outcomes of people with intellectual disability.	3

Capability	Description	Learning Outcomes	Level of Learning
4.5 Continuity in care during transitions	Support continuity of care and effective transfers of care between health professionals and services for people with intellectual disability by using or finding effective care pathways.	Identify enablers and barriers to continuity of care and the effective transfer of care for people with intellectual disability.	1
		Compare and discuss specific considerations for different stages of care (e.g., primary to secondary care, paediatric to adult services, acute back to community care) for people with intellectual disability.	2
		Critique different models of care and how they address integration of care and support transitions through care for people with intellectual disability.	3
4.6 Structure and function of the disability support system and its workers	Apply knowledge of the structure and function of the disability support system to inform practice recommendations to support the health of people with intellectual disability within your scope of practice.	Outline key State or Territory and National disability support services and what they provide to assist people with intellectual disability.	1
		Discuss what supports are available in your area of practice and how they might augment your provision of care for people with intellectual disability.	2
		Debate the benefits and limitations of current support services and how they may impact access, engagement, and health outcomes for people with intellectual disability.	3

5. Decision-Making and Consent

If I think about the values and what I see being espoused by the good clinicians and less espoused by the weak clinicians, is that idea of valuing inclusion and valuing autonomy for every single client they come across.

Dr Karen Wylie, researcher, clinician and educator

Facilitate and respect the inclusion of people with intellectual disability in all aspects of decision-making about their care. Use supported decision-making to enable people with intellectual disability to make their own decisions wherever possible. Work within and uphold applicable legislation and policies related to consent and supported decision-making.

Capability	Description	Learning Outcomes	Level of Learning
5.1 Supported decision-making	Facilitate supported decision-making to maximise the capability of all people with intellectual disability to make or be involved in decisions about their care, involving support networks where appropriate.	Summarise the key principles of supported decision-making for people with intellectual disability.	1
		Identify resources to support people with intellectual disability, their families and carers, and health professionals with supported decision-making and consent.	1
		Compare the types of supported decision-making arrangements that may exist.	2
		Demonstrate how to integrate supported decision-making into a health care interaction.	3
5.2 Communicating the significance of supported decision-making	Communicate clearly with the person with intellectual disability and their support networks about the importance and benefits of supported decision-making and how this differs to substitute decision-making.	Discuss the relevant legislation and potential benefits, risks, and ethical implications of supported decision-making.	1
		Compare supported decision-making to substitute decision-making.	2
		Communicate the differences between supported decision-making and substitute decision-making to people with intellectual disability and their support network.	3
5.3 Assess capacity to consent	Adapt practices as required to assess the capacity of a person with intellectual disability to consent to each decision about their health care, using supported decision-making practices and reasonable adjustments, in line with relevant legislation.	Summarise the relevant legislation that relates to capacity to consent in a health care context.	1
		Summarise how reasonable adjustments could be made when assessing a person with intellectual disability's capacity to consent.	1
		Recognise how and when to assess capacity to consent, including an understanding of presuming capacity, understanding that capacity to consent is decision-specific and how to review existing arrangements for consent.	2
		Differentiate between when a person with intellectual disability does and does not have capacity to consent to a decision.	3

Capability	Description	Learning Outcomes	Level of Learning
5.4 Consent and substitute decision-making	Support a person with intellectual disability to provide consent where they have capacity using reasonable adjustments or identify and work with guardians/appointed decision-makers where required and continue to involve the person with intellectual disability in the process.	Summarise the elements of consent, and how reasonable adjustments can be made to support a person with intellectual disability to provide consent.	2
		Demonstrate how to involve guardians or appointed decision-makers in health care decision-making where required.	3
		Show how to continue to involve a person with intellectual disability in their own health care when a substitute decision-maker or guardian is making decisions.	3
5.5 Balancing dignity of risk and duty of care	Demonstrate the ability to balance a person with intellectual disability's right to dignity of risk while upholding duty of care.	Discuss the concept and importance of dignity of risk and how it relates to capacity to consent and supported decision-making.	1
		Analyse considerations when balancing a person with intellectual disability's right to dignity of risk and a health care provider's duty of care.	2

6. Responsible, Safe and Ethical Practice

It's about education, but it's more than that. It's the way we see people with intellectual disability.

Jayne Lehmann, mother and Director EdHealth Australia

Engage in practices that uphold legislative frameworks relevant to working with people with intellectual disability, and promote safety and people with intellectual disability's right to access quality health care.

Capability	Description	Learning Outcomes	Level of Learning
6.1 Advocacy	Advocate for the needs of people with intellectual disability and support people with intellectual disability to engage in self-advocacy or find a suitable advocate.	Explain the principles of health advocacy, including altruism, social justice, autonomy, integrity, and idealism.	1
		Identify key resources to support people with intellectual disability to self-advocate or choose a suitable advocate.	1
		Design a health advocacy plan with a person with intellectual disability and/or their support network, guardian, or appointed decision-maker.	3
6.2 Safe and quality practices	Apply knowledge of the risks that may be associated with accessing health care for people with intellectual disability to consider the care environment, inform safe service provision and report risks.	Discuss the principles of quality and safety regarding the care of people with intellectual disability.	2
		Apply ethical principles to health care decisions involving people with intellectual disability.	3
		Demonstrate how to create a safe health care environment for people with intellectual disability and report risks.	3
		Evaluate and effectively communicate the risks of accessing health care to a person with intellectual disability.	3
6.3 Safeguards against potential exploitation, violence, abuse and neglect	Identify and know how to act on signs of exploitation, violence, abuse and neglect against people with intellectual disability, and practise in a manner that safeguards people with intellectual disability against potential harms.	Describe the different forms of exploitation, violence, abuse, and neglect that people with intellectual disability may experience.	1
		Explain mandatory legal and professional reporting obligations for when exploitation, violence, abuse, and neglect against people with intellectual disability is suspected.	1
		Recognise signs of exploitation, violence, abuse, and neglect against people with intellectual disability.	2
		Demonstrate strategies to intervene, report and prevent exploitation, violence, abuse, and neglect against people with intellectual disability.	3
6.4 Legislation and other frameworks	Uphold applicable legislation, policy, frameworks and practice guidelines relevant to working with people with intellectual disability, including being aware of the increased potential for harm when a person with intellectual disability comes into contact with the health system.	Explain the implications of applicable legislation, policy, frameworks, and practice guidelines for the care of people with intellectual disability.	1
		Apply applicable legislation, policy, frameworks, and practice guidelines when working with people with intellectual disability.	3
		Communicate information about health care rights, mechanisms for making complaints, accessing legal support, and seeking redress to people with intellectual disability and their support network in accessible ways.	3
6.5 Reflect on and enhance capabilities	Be aware of your own capabilities around intellectual disability health and seek professional development opportunities and advice from intellectual disability specialists to enhance knowledge and skills where required.	Analyse personal practice and professional development needs with regards to working with people with intellectual disability.	3

3

Section Three
Implementation guidelines

Laura Smit
Pink! (2023)

This section provides advice and guidance for accreditation authorities, including self-regulated health professions, and pre-registration education providers to implement the Framework within their standards and curricula.

The advice in this section is not intended to be prescriptive. Accreditation authorities and pre-registration education providers are encouraged to flexibly use this section to decide what would work best for the implementation of the Framework in their local context.

Key points

- The Framework is designed to be used in conjunction with accreditation standards and other health and disability curriculum and professional frameworks.
- Partnerships are vital to support the implementation of the Framework. This may include partnerships with people with intellectual disability and their support networks; experts in the field; health care providers; disability, advocacy, and professional organisations; Disability Representative Organisations; and organisations representing diverse groups.
- Accreditation authorities are encouraged to implement the Capabilities in accreditation standards to ensure that all students within their discipline will receive intellectual disability health education.
- Deans, and education and curriculum leaders and managers are encouraged to build momentum for curriculum change by identifying intellectual disability champions (with expertise or an interest in intellectual disability) within their institution, considering capacity in this area across their education workforce, and providing sufficient resources to facilitate implementation.
- Curriculum coordinators, placement coordinators and educators will likely find synergy between some existing curriculum content and the Framework, for example communicating with people. There is much scope for flexibility when including intellectual disability content into curricula, from the integration of the Capabilities and learning outcomes into existing course sections, to the creation of interprofessional foundational courses.
- Potential solutions and resources are provided for challenges such as overcrowded curricula and limited workforce capacity. Intellectual disability content can be integrated progressively across the course of a program.

How to use the Framework alongside other frameworks

Key points

- The Framework is not intended to be used in isolation. It can be used in conjunction with accreditation standards and other health and disability curriculum and professional frameworks.
- Relevant national and state disability policies should also be considered.

The Framework focuses specifically on the capabilities required to provide high quality care to people with intellectual disability and is not intended to be used in isolation. The integration of intellectual disability content from diverse frameworks can strengthen interprofessional and multidisciplinary collaboration. Other frameworks can also be used to supplement content and principles that are only covered briefly in the Framework.

The Capabilities and principles from the Framework can be used to bolster content from existing frameworks, especially those that are already implemented into accreditation standards and curricula, by considering:

- any common concepts across frameworks, for example, if person-centred care content from another framework has been integrated into accreditation standards and curricula, intellectual disability-specific content could be integrated into the same section
- where intellectual disability-specific content provides unique considerations for health care provision if overlapping concepts are identified across frameworks, for example:
  - understanding how the overprescription of psychotropic medications in the absence of a psychiatric condition is particularly prevalent in people with intellectual disability
  - relating to the understanding and approach to multimorbidity, complex care and intersectionality considerations in health care; and
  - around intersectionality of care, for example, use the Framework with the ***Aboriginal and Torres Strait Islander Health Curriculum Framework*** so that intellectual disability health can be integrated into cultural safety learning and vice versa.

Partnerships

Key points

- Partnerships between accreditation authorities, pre-registration education providers, and people with lived experience, experts in the field, and professional and community organisations are key to the successful implementation of the Framework.
- People with intellectual disability and their support networks should be involved in the implementation process early; a co-design process will help to create a curriculum that meets the needs of people with intellectual disability and fosters innovative approaches to teaching future health professionals in this area.

Strong partnerships are important to support the implementation of the Framework. These include partnerships between accreditation authorities, pre-registration education providers, and multiple stakeholders including:

- **People with a lived experience of intellectual disability** – It is integral that people with intellectual disability are involved in the design, delivery, and evaluation of education content. Within some university courses, a person with lived experience of intellectual disability delivers a presentation that they developed to first year medical students during a lecture on intellectual disability. Approaches also include employing people with lived experience for simulation sessions or as tutors. Consumer Advisory Groups can guide the implementation of the Framework. It is important that accessible information tailored to people's needs is available when working with people with intellectual disability, for example, plain English or Easy Read information.
- **Support networks of people with intellectual disability** – This may include carers, family, support workers, and advocates. This group is also integral to shaping and delivering education around intellectual disability health from the carer-supporter perspective. They too can also be invited to be members of Consumer Advisory Groups.
- **Research centres within universities** – Intellectual and developmental disability research centres can offer advice around foundational resources, training, and co-design opportunities.
- **Health care providers** – Pre-registration education providers will likely have existing partnerships with diverse health care providers. Existing or new partnerships with health care providers that see people with intellectual disability can offer clinical or community placement opportunities or supervision, support preparation for workplace learning and assessment, foster connections with experts in the field for future consultation and advise on education and teaching resources.
- **Disability, advocacy and community organisations, and Disability Representative Organisations** – These organisations could provide assistance and ongoing advice when seeking people with lived experience to be involved in the co-design and delivery of curriculum content and community members or actors for simulation activities and assessments. They can also provide potential placement opportunities for immersive experience that will aid students' understanding of intellectual disability.
- **Peak professional bodies** – Peak bodies can provide continuing professional development opportunities and discipline-specific foundational intellectual disability health resources.
- **National Boards** – Partnerships with National Boards can be utilised to ensure that curriculum content is aligned with professional standards.
- **Organisations representing groups that may experience health inequities** – This may include organisations that represent groups such as First Nations people and culturally and linguistically diverse individuals. These organisations can provide advice and resources around the intersection between the group they represent and intellectual disability.

Accreditation authorities and pre-registration education providers are encouraged to identify existing partnerships with key stakeholder groups early in the implementation process, identify gaps, and seek new partnerships accordingly. This may start with existing clinical or community placements or Consumer Advisory Groups, and progress to seeking new partnerships through intellectual disability champions, research centres within universities, and health and disability organisations.

Implementing the Framework

I think people underestimate just how many people a person with intellectual disability is in contact with, across their day, across the year, across their life. If you added them all up – I know at one stage when Sarah was younger, we had over 40 services, or health professionals working with her.

Jayne Lehmann, mother and Director EdHealth Australia

This section contains tailored guidance for accreditation authorities, self-regulating health professions, and pre-registration education provider leaders and educators. The guidance in this section is around implementing the Framework into accreditation standards, self-regulatory standards, and curricula, with suggestions to overcome identified barriers.

The advice in this section is not intended to be prescriptive. Flexible options are provided to accommodate the varying needs of institutions across a variety of health disciplines.

Accreditation authorities and self-regulating health professions

This section is for accreditation authorities and self-regulating health professions.

It aims to assist them to assess where and how they can implement the Capabilities in accreditation standards and self-regulatory standards and codes.

Key points

- Implementing the Capabilities within accreditation standards leads to the development of quality health care for people with intellectual disability and drives inclusion of content in pre-registration education curricula.
- The Capabilities could be integrated in multiple ways, including mandating that the Capabilities be implemented through accreditation standards; identifying where the Capabilities could be integrated into existing standards; or referring to intellectual disability in the guidance section of accreditation standards until a full review can be undertaken during the next review cycle.

As outlined, people with intellectual disability experience significant health inequity and poorer health outcomes than the general population. Health professionals play a critical role in reducing health inequity and providing people with intellectual disability with safe and good quality health care. The education and training of health professionals needs to prepare them for this role. The purpose of the Framework is to set out clear core capabilities and learning outcomes regarding health care for people with intellectual disability.

Accreditation authorities and standards for programs of study contribute to this process by stating the requirements programs and their education providers must meet and requiring education providers to demonstrate how they meet the standards.

When developing and reviewing accreditation standards for programs of study, accreditation authorities operating under the Health Practitioner Regulation National Law are required to show how the standards support or contribute to improving patient safety, effective care, and health outcomes, including for vulnerable members of the community and Aboriginal and Torres Strait Islander Peoples[46]. The Capabilities are intended to help to prepare future health professionals to provide people with intellectual disability with safe and good quality care. Accreditation authorities are asked to support these Capabilities. Self-regulating health professions are encouraged to include the Framework into self-regulatory standards and codes as appropriate.

The Framework is designed to be applicable to the education and training of a range of health professions and therefore, to be appropriate for a range of accreditation standards and self-regulating professions.

How accreditation authorities use the Framework will be influenced by factors including accreditation standards review cycles, health profession specific curriculum priorities, and the granularity of language within accreditation standards. Different accreditation approaches are possible and are offered below. A combination of approaches could be utilised.

Accreditation authorities could:

- Promote the Framework as good practice and reference the document in accreditation standards and explanatory guidance and require education providers to show how they have used the Framework in their programs of study.
- Mandate that the Framework be implemented by education providers through the accreditation standards.
- Identify where the Capabilities could be included in existing standards (e.g., curriculum, assessment, teaching and learning, outcomes standards) and/or language (e.g., marginalised populations, communication, social accountability, patient safety).
- Make specific reference to the need to provide safe and good quality care for people with intellectual disability in the guidance material that sits alongside the accreditation standards until the Framework can be included in accreditation standards in the next standards review cycle.
- Describe use of the Framework as an example of how an education provider could demonstrate that they are graduating practitioners with the knowledge, skills, and professional qualities needed to practice the profession in Australia and that they can meet the needs of Australian communities.
- Review graduate outcomes or capabilities for alignment with the Framework and amend as appropriate or encourage the profession to review them.

See the ***Accreditation standards development tool*** in Appendix 2.

Pre-registration education providers

My experience of lived experience education at universities is it comes in all forms. Some of it seems to just be show and tell ... "Here's someone. Let me tell you my story." But it's what you actually do with that story that's really important, and how that gets unpacked in terms of the teaching and learning. And what we're aspiring to, and I'm pretty sure we're getting it wrong a lot of the time, but right some of the time in the units as we're working collaboratively with my co-teachers is, I actually want my co-teachers to be actively teaching my students something, so that the students can articulate what they have learned from that person with lived experience."

Dr Karen Wylie, researcher, clinician and educator.

Deans, and education and curriculum leaders and managers

This section is for deans, and education and curriculum leaders and managers within pre-registration education providers.

It aims to assist leaders to assess existing intellectual disability health capacity in their faculty, discipline or school, gain traction for implementing the Framework, and facilitate the initial steps to begin implementation.

It includes i) Steps for implementing the Framework and ii) Overcoming challenges to implementing the Framework.

Steps for Implementing the Framework

Key points

- Identifying intellectual disability champions among staff can be a great first step in implementing the Framework.
- Leaders are encouraged to consider attitudes towards intellectual disability, in addition to knowledge and skills, across their institution and discuss potential barriers and facilitators to implementing the Framework early.
- Assess intellectual disability health capacity across the workforce to map i) potential members of a working group and ii) staff who could teach intellectual disability content.
- If insufficient resources are available to implement the Framework effectively, consider collaborating with other disciplines or schools.
- Consider opportunities for professional development and capacity building for staff.

Historically, intellectual disability champions have advanced research and clinical practice in this area; thus we now need champions and committed education leaders to successfully implement the Framework into curricula.

Leaders are encouraged to reflect on:

- individual and organisational attitudes towards intellectual disability across their institution and support for the inclusion of intellectual disability content into curricula,
- networks available to facilitate leadership and commitment to implementing the Framework,
- opportunities to build on existing curriculum content, and
- relevant policies and strategies to support implementation.

Table 2 outlines the initial key steps deans, and education and curriculum leaders and managers can flexibly take to commence the Framework implementation process.

Table 2: Steps for implementing the Framework: Deans, and education and curriculum leaders and managers

Step description	Considerations and strategies
Identify potential barriers and facilitators to implementation	Discuss barriers and facilitators to implementing the Framework early in the process and formulate potential solutions. See the ***Overcoming Challenges to Implementing the Framework section*** below and ***Appendix 2: Capacity assessment tools***.
Engage key stakeholders to promote the implementation	Engage people with lived experience of intellectual disability and their support networks, disability and advocacy organisations, Disability Representative Organisations, and intellectual disability health professionals early to help promote the need for, and benefits of, implementing the Framework to faculties, disciplines, and schools where required. See the ***Partnerships*** section. Include ongoing representation of people with intellectual disability and their support networks on curriculum review and development committees or Consumer Advisory Groups. Employ people with intellectual disability as part of your team.
Consider workforce capacity and needs	Identify key staff to support the integration of the Framework and its oversight prior to curriculum review cycles. This includes intellectual disability champions who have an interest or expertise in intellectual disability. Assess intellectual disability health capacity across your workforce. See the ***Education team intellectual disability capacity tool***. Allocate key staff to: • review current intellectual disability content in the curriculum. See the ***Program content mapping tool***. • develop an implementation strategy, and • oversee the integration and evaluation of student progress towards demonstrating that they have met the Capabilities. All these steps are fundamental to supporting the integration of the Framework.
Allocate resources	Allocate resources to support the implementation of the Framework. This might include: • allocating protected time for working group members and curriculum coordinators to work on implementing the Framework including mapping how intellectual disability content can fit into existing curricula, • allocation of time to intellectual disability content within the curricula, • funding for necessary resources (see Appendix 3: Supporting resources) to i) train educators so they have core knowledge and skills in intellectual disability health (e.g., training courses/workshops, e-learning, and webinars) and ii) use during teaching or provide to students for personal study, and • funds to pay lived experience educators to design, develop, and deliver intellectual disability content.
Consider interprofessional collaboration	If insufficient resources are available to implement the Framework effectively, consider collaborating with other disciplines or schools to, for example, develop a foundational interprofessional course that students from several disciplines can undertake. Examine how resources can be shared between pre-registration education providers to promote knowledge exchange, develop best practices, and build capacity.

Overcoming Challenges to Implementing the Framework – Deans, and education and curriculum leaders and managers

Key points

- Curriculum change always involves inherent challenges to overcome. Here, we offer some potential solutions for issues such as overcrowded curricula, limited education workforce knowledge in this area, and a lack of time and resources to implement the Capabilities.
- Integration of the Capabilities and associated learning outcomes can occur progressively across the course of a program.

It is acknowledged that there are various challenges and concerns around implementing the Framework into curricula. Some potential solutions are offered below. It is acknowledged that the implementation of intellectual disability content into curricula may occur in stages over several years.

An overcrowded curriculum ➔

- Content that focuses specifically on intellectual disability health can be integrated into existing curriculum content areas. Curriculum coordinators can be asked to map the Capabilities to existing curriculum content to find commonalities.
- Intellectual disability content can be integrated across all years of a course, from foundational to advanced levels.

Limited educator intellectual disability content knowledge and skills, and few intellectual disability champions working within institutions ➔

- Acknowledge that it will take time to integrate the Framework into the curriculum.
- Seek out individuals and organisations with specialist knowledge for advice and consultation within other faculties or schools of your institution or externally. This could extend to experts in other disability areas or, for example, human rights.
- Encourage curriculum coordinators, placement coordinators and educators to take advantage of the diverse foundational resources that are available (See ***Appendix 3: Supporting resources***).

Limited time and resources to change the curriculum ➔

- Review of the curriculum to implement the Framework can be undertaken during planned review cycles.
- Seek opportunities to work with other disciplines so that resources can be shared.
- Where possible, utilise the knowledge of intellectual disability champions who will likely already have a clear idea of key education aims in this area.

Educators' attitudes towards intellectual disability health ➔

- Where educators are unaware of the poor health status and needs of people with intellectual disability, provide them with health outcomes data for people with intellectual disability; for example, recent evidence from the Disability Royal Commission[3], Trollor et al. (2017)[1], Liao et al. (2021)[2] and Cooper et al. (2015)[47].
- Organise presentations by people with intellectual disability and their support networks as to why curriculum change is necessary. Contact local disability groups and advocacy agencies in your area for advice and ideas.
- Organise meetings or avenues for feedback to address staff concerns and gather ideas.

Curriculum coordinators, placement coordinators and educators

This section is for curriculum coordinators, placement coordinators and educators within pre-registration education providers who will be involved in implementing and delivering the Framework content.

It aims to assist educators to determine where and how intellectual disability content could be integrated within the existing curriculum, include people with lived experience in the design and delivery of intellectual disability content, and equip educators to teach the content.

It includes i) Steps for implementing the Framework and ii) Overcoming challenges to implementing the Framework.

Steps for Implementing the Framework

Key points

- One of the first steps for curriculum coordinators is to review the current curriculum to help inform where intellectual disability health content can be integrated.
- There are several approaches to the implementation of content, from integration into existing curriculum areas, to the creation of interprofessional foundational or discipline specific advanced courses. There are flexible options that can suit all disciplines and programs.
- Look for opportunities to include people with intellectual disability and their support networks in the development and delivery of content. This can help to improve students' confidence and competence, and address negative stereotypes.
- Placements can provide valuable direct contact.
- Resources are available to educators for professional development and to provide to students. See Appendix 3: Supporting resources list.
- Several mapping and self-assessment tools are provided in Appendix 2.

Table 3 contains general advice around considerations and strategies for implementing the Framework that can fit within your institution's curriculum review practices. The advice is not intended to be prescriptive and can be used flexibly depending on local context.

Table 3: Steps for implementing the Framework: Curriculum coordinators, placement coordinators and educators

Step description	Considerations and strategies
Review current curriculum to help inform where and how the Capabilities can be integrated.	Map current curriculum content against the Capabilities and identify i) gaps and ii) potential areas to incorporate specific intellectual disability content. See the ***Program content mapping tool*** we have developed to assist in this review. Consider when placements should occur in relation to required learning outcomes.
Examine potential integration approaches, depending on gaps identified. This may include integrating content into existing areas or introducing new items in the curriculum.	Potential approaches to implementing the Framework in courses include: • Integration of intellectual disability health content within existing curriculum areas where there is conceptual overlap with Framework content (e.g., focus on adapting communication for people with intellectual disability within existing 'communicating with people' content). – It is recommended that teaching overtly focuses on intellectual disability, rather than merely covering content with reference to groups with diverse needs, to ensure the specific needs of this population are met. – Content such as reasonable adjustments, person-centred care, and capacity to consent is also applicable for other groups with diverse needs. – Educators will likely find considerable conceptual overlap between Framework and curriculum content; new sections of curriculum content will not be required in many cases. • Creation of a module within an existing course. – This allows for a specific focus on intellectual disability and may be the most appropriate option if similar content is not identified in the existing curriculum. • Creation of an interprofessional course – Interprofessional education is foundational for interprofessional and intersectoral practice[48] and can help prepare students to practice collaboratively improving multidisciplinary care for people with intellectual disability. – Create a foundational course (e.g., first year) for interprofessional students that incorporates introductory Framework content (see *Level 1 learning outcomes*). – Course coordinators can consider developing interprofessional intellectual disability health courses that can either be i) attended by students from multiple disciplines (e.g., social work, speech pathology, and dietetics etc.), or ii) further tailored to suit individual discipline needs (e.g., medicine or dentistry). – The creation of an interprofessional course allows for the effective use of limited resources with the development of content and resources able to be shared across disciplines, reducing the time commitment and costs for any one discipline. • Creation of discipline-specific course – There is scope for discipline-specific education, particularly at the advanced level following an interprofessional foundational course.

Step description	Considerations and strategies
Identify opportunities for the inclusion of people with lived experience of intellectual disability and their support networks in the design, delivery, and evaluation of curriculum content.	This has been identified as a best practice approach[49]. This may involve: • using the ***Inclusion of people with lived experience tool*** to identify examples of inclusive practice across a program • utilising a co-design approach to develop curriculum content and experiential learning opportunities with people with intellectual disability and their support networks (e.g., lecture or tutorial content, producing case studies or videos, designing simulations) • people with intellectual disability and their support networks delivering content (e.g., in lectures or tutorials) • simulation role plays with people with intellectual disability (actors or members of the community) as a teaching or assessment exercise. It is important to provide commensurate remuneration for people with intellectual disability and their support networks involved in content development and teaching.
Facilitate placements that allow direct contact with people with lived experience of intellectual disability.	• Providing students with respectful opportunities to have direct contact with people with intellectual disability and their support networks early in their training is key. It can help to improve students' confidence and competence to meet individual needs and reduces stigma and negative stereotypes[48, 50-52]. However, it is recognised that identifying intellectual disability specific services that can offer placements can be difficult. • Where there is a shortage of opportunities or they are not feasible for certain health disciplines, community-based placements are an option. They can provide students with i) real world experience, ii) allow for interprofessional collaboration, iii) increased awareness of the broad range of supports and services that people with intellectual disability utilise, and iv) make a positive contribution to the community. If long-term placements are not a viable option, consider day visits. • Coordinators can i) compile databases with information about potential placement sites and ii) work with peak professional bodies to facilitate placements. • It is recognised that there is competition for placements across disciplines and universities. Examine opportunities to collaborate across disciplines (and universities where possible) to support and maximise equitable access to placements. • Placements should be carefully chosen to provide the likelihood of positive experiences for people with intellectual disability and students. Similarly, placements in this practice area may be best completed towards the end of a program.

Step description	Considerations and strategies
Equip staff with the core capabilities and skills to employ the recommended approaches to including intellectual disability content in curricula.	• Educators can assess their current intellectual disability health knowledge and skills against the Capabilities. See the ***Knowledge/ skills self-assessment tool for educators***. • Address gaps in knowledge and skills with education and training. Seek out continuing professional development opportunities with allocated time for staff to complete them and provide resources such as e-learning and webinars (see ***Appendix 3: Supporting resources***). • Form partnerships and seek advice from i) intellectual disability health champions within your institution, ii) intellectual disability research centres, iii) disability organisations, and iv) peak professional bodies.
Establish knowledge/resource swaps with other education providers, research centres, and experts in the field.	Several universities have research centres in intellectual and/or developmental disability. Seek advice from these research centres, and expert contacts.
Hold meetings and workshops with educators around implementing the curriculum content.	• Each institution will have their own processes. • Use these opportunities to problem solve any issues raised by educators. • Involve people with lived experience of intellectual disability and their support networks where possible.
Establish ways to assess and measure learning outcomes associated with the Capabilities	Learning outcomes can be measured and assessed using methods routinely utilised in health program curricula. See ***Appendix 4*** for example assessment methods.

Overcoming Challenges to Implementing the Framework – Curriculum coordinators, placement coordinators and educators

Key points

- It is recognised that there are numerous challenges to overcome when implementing curriculum change. Here, we offer some potential solutions for issues such as overcrowded curriculum, limited educator knowledge in the area of intellectual disability health, limited time and resources to implement the Framework, and a lack of clinical placements.
- Implementing the Framework does not mean creating a new curriculum. It is likely that similar content is already taught in other practice areas and can be used to signpost where content that focuses on intellectual disability can be added, for example, effective communication and person-centered care.

It is acknowledged that there are various challenges and concerns around implementing the Framework into curricula. Some solutions are offered for each. It is acknowledged that the implementation of intellectual disability content into curricula may occur in stages over several years.

An overcrowded curriculum ➔

- Content that focuses specifically on intellectual disability health can be integrated into existing curriculum content areas. Examples include:
  - — determining people with intellectual disability's preferred and most effective communication style and adapting accordingly (e.g., Learning outcome 2.2.1) within content teaching effective communication with people
  - — specific focus on reasonable adjustments for people with intellectual disability (e.g., Learning outcome 3.4.2) when teaching clinical skills
  - — facilitating supported decision-making to assist people with intellectual disability to make decisions (e.g., Learning outcome 5.1.4) when providing education around supporting people to make informed choices around health management.

It is important that the specific needs of people with intellectual disability and ways to work effectively with them are embedded into curricula, rather than just a brief mention of this group when teaching relevant content (e.g., effective communication) or discussing groups that experience health inequities.

- The Capabilities only need to be achieved by graduation. Integration of intellectual disability content can be spread out across all years of a program, from foundational to advanced levels.
- Achieving the Capabilities in intellectual disability health may also help students achieve capabilities in other course areas. For example:
  - — advanced communication skills are helpful for successfully engaging with people who may have varied receptive and expressive communication needs and knowledge, and
  - — skills to facilitate supported decision-making can be helpful for other people who may have impaired decision-making abilities.

Limited educator intellectual disability content knowledge and skills, and few intellectual disability champions within institutions ➔

- Acknowledge that it may take time to implement the Framework into the curriculum considering time to build educator knowledge and skills in this area through continuing professional development.
- Take advantage of the diverse foundational resources that are available for both educators and students (see ***Appendix 3: Supporting resources***).
- Seek out individuals and organisations with specialist knowledge for advice and consultation, for example around content, teaching resources, and including people with lived experience in the design and delivery of content.
- Help fulfil continuing professional development requirements by learning knowledge and skills around intellectual disability.
- Form a community of practice with other pre-registration education providers to share ideas, discuss barriers and facilitators, share content and resources, and connect staff.
- Organise for educators to undertake disability awareness training that is offered by various disability organisations (face-to-face and online).

Limited time and resources to change the curriculum ➔

- Seek opportunities to work with other disciplines to share resources, curriculum content, and consider interprofessional courses.
- Work towards the implementation of all Capabilities incrementally; start with those that are most relevant and important to your discipline, or those where clear areas for integration have been identified.
- Connect with education providers who have already developed intellectual disability health curriculum content; organise a presentation to demonstrate the impact and outcomes of curriculum change.

A lack of available clinical placements where students have direct contact with people with intellectual disability ➔

- Consider community-based placements. If long-term placements are not a viable option, consider visits to day programs and centres. Students could contribute to the organisation through the completion of a project. They could also assist with community activity or exercise programs as mentors.
- There are varied other ways for students to have direct contact with people with intellectual disability and their support networks (e.g., simulation role plays, presenting lecture or tutorial content, guest presentations, and innovative techniques such as drama programs)[53].
- Take advantage of interprofessional partnerships; for example, students from disciplines with fewer opportunities to have direct contact with people with intellectual disability could attend clinics or shadow a practitioner where people with intellectual disability are seen, even if it is within another discipline.
- Research projects can also provide students with direct contact with people with intellectual disability, along with building students' knowledge and skills, and contributing to the evidence base in this area.

Attitudes of pre-registration education leaders towards intellectual disability health ➔

- If leaders are not aware of the poor health outcomes and needs of people with intellectual disability, course coordinators or intellectual disability champions could provide them with health outcomes data for people with intellectual disability; for example recent evidence from the Disability Royal Commission[3], Trollor et al. (2017)[1], Liao et al. (2021)[2] and Cooper et al. (2015)[47].
- Organise presentations by people with intellectual disability and their support networks as to why curriculum change is necessary.
- Outline potential benefits of improved health care for people with intellectual disability such as more efficient use of finite health care resources through fewer avoidable hospital admissions and shorter inpatient stays. At present people with intellectual disability are overrepresented users of health services with higher associated costs, partly due to their needs not being met[22-23,54].

Ongoing Quality Improvement of pre-registration curricula

Evaluation of the Framework implementation and ongoing quality improvement is necessary to ensure that the Framework has been incorporated in a way that leads to the overall goal of improvements in health delivery and outcomes for people with intellectual disability. This includes continuing professional development for educators and attainment of the Capabilities for students in intellectual disability health, and meaningful contribution and positive experiences for educators with lived experience.

Appropriate staff can be enlisted to undertake specific process and outcomes evaluations for the implementation of the Framework in addition to existing evaluation processes.

Process evaluation can:

- review how the Framework has been implemented,
- establish engagement with the content,
- help determine barriers and facilitators to implementation, and
- gather feedback from stakeholders who have been involved in the process.

Methods could include surveys or interviews with curriculum development committees/ working groups, leaders, and people with lived experience who have been involved in the process.

Outcomes evaluation can review:

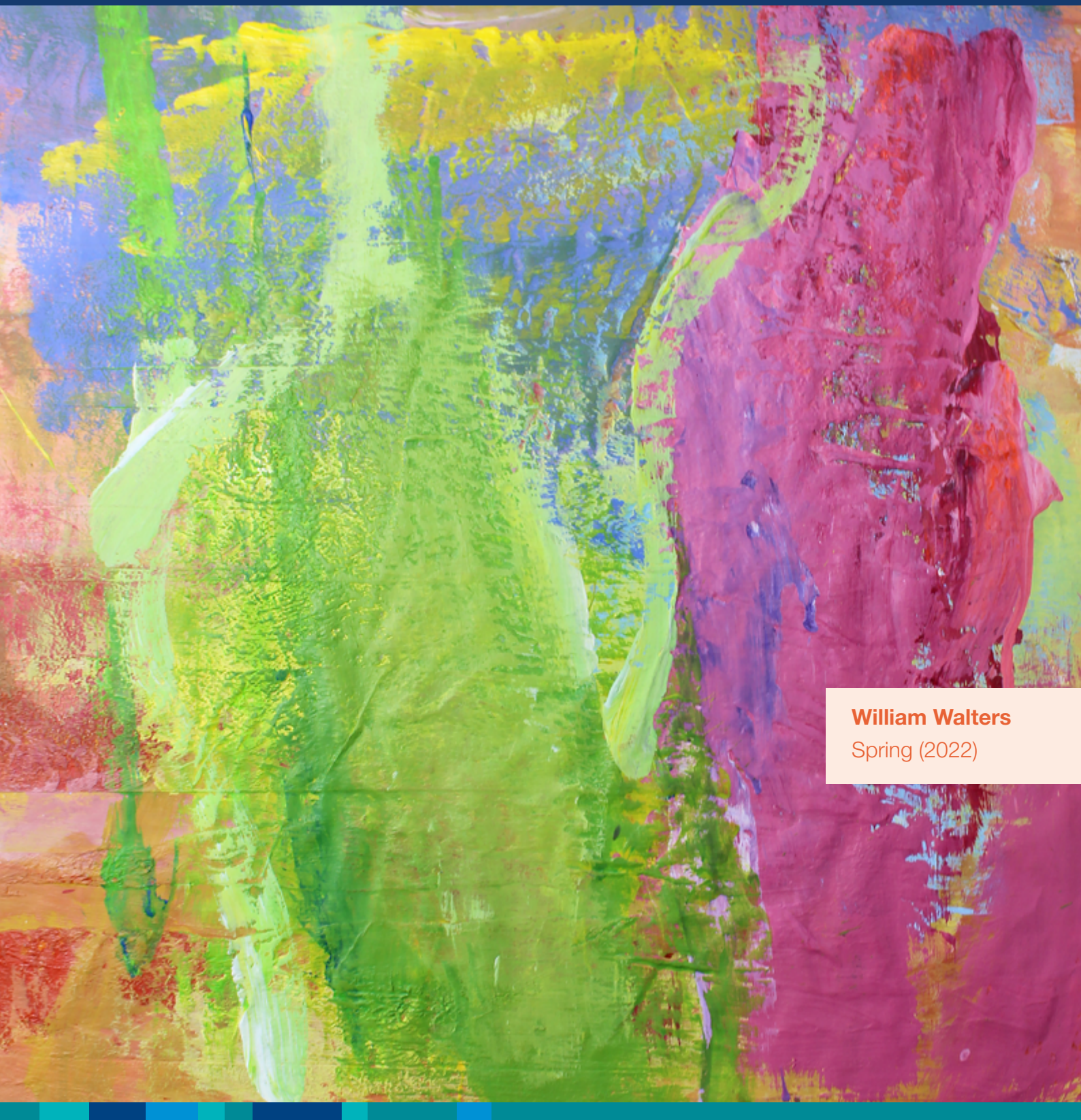
- the impact the Framework implementation has had on student satisfaction,
- knowledge, skills, attitudes, and confidence of students,
- educators' experiences designing and delivering the content (including people with lived experience), and
- the experiences of people with intellectual disability in the community (e.g., those attending clinics where students have undertaken placements), where possible.

Methods could include enrolment/attendance statistics, student surveys, surveys and interviews with educators, and brief feedback questions for individuals in the community.

Results can inform ongoing quality improvement measures and provide evidence to accreditation authorities of review and continual enhancement.

Educational institutions could also engage an external independent body to undertake an evaluation of how the Framework has been implemented to promote further quality improvement.

Appendices



William Walters
Spring (2022)

Appendix 1:
Education and Training Expert Advisory Group Membership

The following groups and organisations are represented on the Education and Training Expert Advisory Group:

Parent advocates

Special needs dentists

Council for Intellectual Disability

Leaders in Indigenous Medical Education (LIME)

University of Melbourne

University of Queensland

Department of Developmental Disability Neuropsychiatry (3DN), UNSW Sydney

The Centre for Developmental Disability Health, Monash Health

Professional Association of Nurses in Developmental Disability Australia

Council of Deans of Nursing and Midwifery Australia & New Zealand

Medical Deans Australia and New Zealand

Australian Council of Deans of Health Science

Australasian Council of Dental Schools

Universities Australia (Health Professions Education Standing Group)

Australian Medical Council

Australian Dental Council

Australian Nursing and Midwifery Accreditation Council

Health Professions Accreditation Collaborative Forum

Appendix 2:
Intellectual Disability Health Capability Framework – Capacity assessment tools

There are also modifiable versions of these tools available on the Framework download page.

Intellectual Disability Health Capability Framework – Program content mapping tool

The aim of this tool is to assist educators such as curriculum coordinators to map current curriculum content against the Capabilities and identify i) gaps and ii) potential areas to incorporate specific intellectual disability content. Mapping can occur at the core competency level, or higher area level depending on needs.

Program/degree: .....

Undergraduate or postgraduate .....

Are people with intellectual disability and/or their families and support networks involved in the design or delivery of curriculum content? (✓): Yes ☐ No ☐

If yes, note details of courses and see *Inclusion of people with lived experience tool* .....
.....
.....
.....

Intellectual disability champion/s on staff for advice/consultation?.....
.....

Mapped by: .....Role: .....

Date: .....

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/ placement and content.	b) If no to a), suggest potential course/unit/ placement content that could be added.	
Area 1. Intellectual disability awareness						
1.1 Human rights of people with disability	Practise in a manner that promotes and upholds the human rights of people with intellectual disability, in keeping with the United Nations Convention on the Rights of Persons with Disabilities.					
1.2 Attitudes, values and beliefs about people with intellectual disability	Practise in a manner that recognises, respects, values and includes the lived experience and lives of people with intellectual disability.					
1.3 Power differentials	Recognise power differentials between health professionals and people with intellectual disability and their support networks and proactively work to remove them, acknowledging people's unique experiences, with the goal of supporting people with intellectual disability to maximise control over their own health care.					
1.4 Causes of intellectual disability, co-occurring conditions and variability across individuals	Apply knowledge of the causes of intellectual disability and associated conditions to provide comprehensive individualised care.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/ placement and content.	b) If no to a), suggest potential course/unit/ placement content that could be added.	
1.5 Historical and current models of disability and health care for people with intellectual disability	Apply current best practice models of disability and health care for people with intellectual disability, with an awareness of historical models, to inform equitable and person-centred health care provision.					
1.6 Determinants of health for people with intellectual disability	Apply knowledge of the determinants of health of people with intellectual disability and the corresponding available evidence base to inform health care provision.					
1.7 Health status of people with intellectual disability	Apply knowledge of the unique health status of people with intellectual disability to inform health care provision from prevention to recovery.					
1.8 Barriers and enablers to health care access	Facilitate equitable access to the health care you provide for people with intellectual disability and adapt your practice to provide optimal care by applying knowledge of the enablers and additional barriers to health care experienced by people with intellectual disability.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/ placement and content.	b) If no to a), suggest potential course/unit/ placement content that could be added.	
1.9 Intersectionality of care	Provide culturally safe care and practise in a manner that acknowledges that a lived experience of intellectual disability can intersect with other aspects of a person's identity, creating unique needs, experiences, and barriers and enablers to care.					
1.10 Role of support networks	Apply knowledge of the key role support networks have in the lives of people with intellectual disability, recognising their role and experience, their knowledge of the person's health history and presentation, potential to support and monitor care plans, and their own support needs.					
Area 2. Communication						
2.1 Communicate directly with the person with intellectual disability	Communicate and engage directly with every person with intellectual disability, using their support networks to facilitate this when appropriate.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/placement and content.	b) If no to a), suggest potential course/unit/placement content that could be added.	
2.2 Adapt communication	Determine the person's preferred and most effective communication style and adapt accordingly, including seeking advice from the person and their support networks and using communication aids.					
2.3 Behaviour as a form of communication	Recognise that behaviour is a form of communication and use it to inform assessment, diagnosis and care for people with intellectual disability.					
2.4 Communicate to reassure	Recognising that people with intellectual disability may have differing levels of understanding of health care situations and procedures, communicate directly with the person in a way that seeks to include them in health care discussions and inform them of what is occurring and its purpose, giving a sense of control and improved comfort.					
Area 3. Quality Evidence-Informed Health Care						
3.1 Dignity and respect	Treat all people with intellectual disability with dignity and respect, seeing them as a person first.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/ placement and content.	b) If no to a), suggest potential course/unit/ placement content that could be added.	
3.2 Evidence-informed practice	Evaluate, apply and contribute to evidence-informed practice in the health care of people with intellectual disability.					
3.3 Person-centred care	Adopt a person-centred approach to care to ensure that the person with intellectual disability is at the centre of planning and decision-making about their care.					
3.4 Reasonable adjustments	Make reasonable adjustments to care, including adapting the environment, to meet the individual needs of the person with intellectual disability.					
3.5 Partnership in care	Promote inclusion of people with intellectual disability, and their support networks where appropriate, in all stages of their care including asking people their needs, preferences and values, informing them of what is happening, including them in care planning, and offering a full range of choices.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/ placement and content.	b) If no to a), suggest potential course/unit/ placement content that could be added.	
3.6 Appropriate assessment	Employ appropriate assessment procedures and tools to inform diagnosis of health conditions, with an awareness that modified diagnostic criteria and reasonable adjustments may be required for assessment of people with intellectual disability.					
3.7 Diagnostic overshadowing and other reasons for misdiagnosis	Apply knowledge of diagnostic overshadowing and atypical presentations and their role in under-diagnosis and misdiagnosis in people with intellectual disability.					
3.8 Complex care needs	Apply knowledge of the unique clinical, social and contextual factors contributing to complexity of health care for people with intellectual disability and be able to respond accordingly to complex care needs.					
3.9 Deterioration in function	Working in partnership with those who know the person well, recognise deterioration in function particularly when communication or care needs are complex, and respond as appropriate to address deterioration and improve quality of life.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/ placement and content.	b) If no to a), suggest potential course/unit/ placement content that could be added.	
3.10 Best practice approaches to management for people with intellectual disability	Use best practice approaches (non-pharmacological and/or pharmacological) taking into consideration individual needs to manage health conditions for people with intellectual disability.					
3.11 Responsible management of medications	Build awareness of the implications of medications, their use, and interactions for people with intellectual disability and apply these within scope of practice.					
3.12 Working with people who have behaviours of concern	Use best practice and, where at all possible, non-restrictive (otherwise least-restrictive) techniques to work safely with people who may display behaviours of concern relevant to your area of practice.					
3.13 Lifespan approach to health care	Apply an approach that considers the health needs of people with intellectual disability across the lifespan, particularly during times of transition and life events.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/placement and content.	b) If no to a), suggest potential course/unit/placement content that could be added.	
3.14 Preventative health care and promotion	Employ proactive health care practices and health promotion activities that are adapted and responsive to the needs of people with intellectual disability and correspond to known health risks at a population and individual level.					
3.15 Responding to trauma	Work in a way that sensitively considers and responds to the greater likelihood that a person with intellectual disability may have experience of trauma, including health care related trauma.					
3.16 Health literacy for people with intellectual disability and their support networks	Facilitate quality health care for people with intellectual disability by fostering health literacy in people with intellectual disability and their support networks, and providing accessible information.					
Area 4. Coordination and Collaboration						
4.1 Care navigation through health and disability services	Support people with intellectual disability and their support networks to navigate available health, disability, and community services according to needs.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/placement and content.	b) If no to a), suggest potential course/unit/placement content that could be added.	
4.2 Relationships of trust	Facilitate trust with people with intellectual disability and their support networks during each interaction.					
4.3 Collaborative partnerships	Work collaboratively with the person with intellectual disability, their support networks, and professionals, applying knowledge of who is involved and their roles and expertise.					
4.4 Collaborate with other professionals	Collaborate as appropriate with other professionals across all stages of a care pathway to ensure successful integration of care for people with intellectual disability.					
4.5 Continuity in care during transitions	Support continuity of care and effective transfers of care between health professionals and services for people with intellectual disability by using or finding effective care pathways.					
4.6 Structure and function of the disability support system and its workers	Apply knowledge of the structure and function of the disability support system to inform practice recommendations to support the health of people with intellectual disability within your scope of practice.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/ placement and content.	b) If no to a), suggest potential course/unit/ placement content that could be added.	
Area 5. Decision-Making and Consent						
5.1 Supported decision-making	Facilitate supported decision-making to maximise the capability of all people with intellectual disability to make or be involved in decisions about their care, involving support networks where appropriate.					
5.2 Communicating the significance of supported decision-making	Communicate clearly with the person with intellectual disability and their support networks about the importance and benefits of supported decision-making and how this differs to substitute decision-making.					
5.3 Assess capacity to consent	Adapt practices as required to assess the capacity of a person with intellectual disability to consent to each decision about their health care, using supported decision-making practices and reasonable adjustments, in line with relevant legislation.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/ placement and content.	b) If no to a), suggest potential course/unit/ placement content that could be added.	
5.4 Consent and substitute decision-making	Support a person with intellectual disability to provide consent where they have capacity using reasonable adjustments or identify and work with guardians/ appointed decision-makers where required and continue to involve the person with intellectual disability in the process.					
5.5 Balancing dignity of risk and duty of care	Demonstrate the ability to balance a person with intellectual disability's right to dignity of risk while upholding duty of care.					
Area 6. Responsible, Safe and Ethical Practice						
6.1 Advocacy	Advocate for the needs of people with intellectual disability and support people with intellectual disability to engage in self-advocacy or find a suitable advocate.					
6.2 Safe and quality practices	Apply knowledge of the risks that may be associated with accessing health care for people with intellectual disability to consider the care environment, inform safe service provision and report risks.					

Core capabilities		Current curriculum content with mention of intellectual disability, developmental disability, cognitive impairment, disability, groups with diverse needs, human rights, or health inequities.		If no intellectual disability or related content found for core capability		Notes
		Curriculum content	Course/unit/placement the content is located. Include -Year - Mode of delivery	a) Existing course content intellectual disability education could be integrated? (e.g. consent, communication, mention of disability or groups with diverse needs) Include course/unit/placement and content.	b) If no to a), suggest potential course/unit/placement content that could be added.	
6.3 Safeguards against potential exploitation, violence, abuse and neglect	Identify and know how to act on signs of exploitation, violence, abuse and neglect against people with intellectual disability, and practise in a manner that safeguards people with intellectual disability against potential harms.					
6.4 Legislation and other frameworks	Uphold applicable legislation, policy, frameworks and practice guidelines relevant to working with people with intellectual disability, including being aware of the increased potential for harm when a person with intellectual disability comes into contact with the health system.					
6.5 Reflect on and enhance capabilities	Be aware of your own capabilities around intellectual disability health and seek professional development opportunities and advice from intellectual disability specialists to enhance knowledge and skills where required.					

Teaching methods notes

- Are there specific teaching methods used for current curriculum content in intellectual disability health?
- What teaching methods could be used for planned intellectual disability health curriculum content?

Assessment notes

- Is current intellectual disability curriculum content assessed? If yes, what are the assessment methods?
- How could planned intellectual disability health curriculum content be assessed?

Intellectual Disability Health Capability Framework – Accreditation standards development tool

The aim of this tool is for accreditation authorities and self-regulating health professions to map current mentions of intellectual disability and related concepts in their accreditation standards, consider potential new standard(s) to guide pre-registration education providers to implement the Framework in curricula, and determine if there are additional sections of the accreditation standards document where intellectual disability could be specified.

Accreditation standards: ……Year……..

Lead: ……Role: ……. Date: ……

Current accreditation standards or sections of the standards document with mention of:

- intellectual disability
- developmental disability
- cognitive disability
- disability
- groups with diverse needs
- human rights or health inequities

Integration of Framework content could be considered for standards or sections of the document with mention of intellectual disability or related concepts.

Standard/section of the standards document	Notes

Potential new standard(s)

For example, guiding pre-registration education providers to cover the six core capability areas in curricula.

1. Intellectual Disability Awareness – Develop and apply knowledge about people with intellectual disability to ensure intersectional care for this population and improved health outcomes.
2. Communication – When communicating with a person with intellectual disability, adapt verbal, non-verbal and written communication to the person's preferred and most effective style and methods. Recognise behaviour as a form of communication and potentially the primary mode of communication.
3. Quality Evidence-Informed Health Care – Apply knowledge of evidence-informed, person-centred care that incorporate reasonable adjustments, responsive health care and proactive approaches to preventative physical and mental health care across the lifespan.
4. Coordination and Collaboration – Engage and work collaboratively with people with intellectual disability and their support networks, including disability, health, allied health, and other professionals to provide well-coordinated care for people with intellectual disability across services and sectors, and transitions.
5. Decision-Making and Consent – Facilitate and respect the inclusion of people with intellectual disability in all aspects of decision-making about their care. Use supported decision-making to enable people with intellectual disability to make their own decisions wherever possible. Work within and uphold applicable legislation and policies related to consent and supported decision-making.
6. Responsible, Safe and Ethical Practice – Engage in practices that uphold legislative frameworks and promote safe and equitable access to quality health care for all people with intellectual disability.

Potential new standard(s)	Notes

Sections of the standards document with potential relevance to intellectual disability, or where intellectual disability could be mentioned/specified.

For example, definitions of groups who experience health inequities, and sections related to the design, development, delivery of curriculum content, placements and experiential learning opportunities, and governance (e.g. Consumer Advisory Groups).

Section of the standards document	Notes

Intellectual Disability Health Capability Framework – Inclusion of people with lived experience tool

The aim of this tool is for education and curriculum leaders, managers, curriculum coordinators or intellectual disability champions to review if people with lived experience are involved in education activities within faculties/schools/disciplines, how they are involved, and where there are opportunities for further involvement.

Program/degree: ……

Undergraduate or postgraduate: .....

Completed by: .....Role: ..... Date: .....

Course/unit (Year/mode of delivery/units)	How many people with lived experience are involved?		How are people with lived experience involved?		Specific topics people with lived experience design content for/deliver.	Teaching methods (e.g. lecture/ simulation/video)	Paid or voluntary?	Opportunities for further involvement of people with lived experience in the course	Are these opportunities applicable for use in other courses?	Notes
	People with intellectual disability	Families and support networks	Design?	Delivery?						

Intellectual Disability Health Capability Framework – Education team intellectual disability capacity tool

The aim of this tool is for education and curriculum leaders, managers, or curriculum coordinators to map out current staff capacity within their faculty/school/discipline to deliver intellectual disability health education. This can help identify intellectual disability 'champions', plan required continuing professional development for educators and inform future staff recruitment plans.

Program/degree: .....Undergraduate or postgraduate:.....

Completed by: .....Role: ..... Date: .....

Name	Role of staff member	[If staff member involved in teaching] Courses taught If known, note if intellectual disability content taught within course.	Identifies as an intellectual disability champion?	Self-assessment of their intellectual disability health knowledge and skills • No experience • Foundational • Intermediate • Expert List topics they have expertise in.	Education and training requirements e.g. Continuing professional development; resources.	Capacity to be involved in the implementation and/or teaching of intellectual disability curriculum content.	Notes E.g. Courses taught by a champion that have no intellectual disability content at present.

Intellectual Disability Health Capability Framework – Knowledge/skills self-assessment tool for educators

The aim of this tool is for educators such as lecturers to reflect on their current knowledge and skills around intellectual disability health in preparation for delivering education in this area. This can help determine the need for continuing professional education.

Name: .....Position: ..... Date: .....

Core Capability Areas with corresponding Capabilities	**Knowledge/skills related to capability area?** **Yes (Y)** **Developing (D)** **No (N)** **Not applicable (N/A)**	**Experience teaching content related to capability area?** **Current or past?**	**Plans to assist knowledge/skill development (where applicable)**	**Resources to assist knowledge/skills development**	**Timeframe**	**Notes**
1. Intellectual disability awareness						
1.1 Human rights of people with disability	Practise in a manner that promotes and upholds the human rights of people with intellectual disability, in keeping with the United Nations Convention on the Rights of Persons with Disabilities.					
1.2 Attitudes, values and beliefs about people with intellectual disability	Practise in a manner that recognises, respects, values and includes the lived experience and lives of people with intellectual disability.					
1.3 Power differentials	Recognise power differentials between health professionals and people with intellectual disability and their support networks and proactively work to remove them, acknowledging people's unique experiences, with the goal of supporting people with intellectual disability to maximise control over their own health care.					
1.4 Causes of intellectual disability, co-occurring conditions and variability across individuals	Apply knowledge of the causes of intellectual disability and associated conditions to provide comprehensive individualised care.					
1.5 Historical and current models of disability and health care for people with intellectual disability	Apply current best practice models of disability and health care for people with intellectual disability, with an awareness of historical models, to inform equitable and person-centred health care provision.					
1.6 Determinants of health for people with intellectual disability	Apply knowledge of the determinants of health of people with intellectual disability and the corresponding available evidence base to inform health care provision.					
1.7 Health status of people with intellectual disability	Apply knowledge of the unique health status of people with intellectual disability to inform health care provision from prevention to recovery.					
1.8 Barriers and enablers to health care access	Facilitate equitable access to the health care you provide for people with intellectual disability and adapt your practice to provide optimal care by applying knowledge of the enablers and additional barriers to health care experienced by people with intellectual disability.					
1.9 Intersectionality of care	Provide culturally safe care and practise in a manner that acknowledges that a lived experience of intellectual disability can intersect with other aspects of a person's identity, creating unique needs, experiences, and barriers and enablers to care.					
1.10 Role of support networks	Apply knowledge of the key role support networks have in the lives of people with intellectual disability, recognising their role and experience, their knowledge of the person's health history and presentation, potential to support and monitor care plans, and their own support needs.					

Core Capability Areas with corresponding Capabilities	Knowledge/skills related to capability area? Yes (Y) Developing (D) No (N) Not applicable (N/A)	Experience teaching content related to capability area? Current or past?	Plans to assist knowledge/skill development (where applicable)	Resources to assist knowledge/skills development	Timeframe	Notes
2. Communication						
2.1 Communicate directly with the person with intellectual disability	Communicate and engage directly with every person with intellectual disability, using their support networks to facilitate this when appropriate.					
2.2 Adapt communication	Determine the person's preferred and most effective communication style and adapt accordingly, including seeking advice from the person and their support networks and using communication aids.					
2.3 Behaviour as a form of communication	Recognise that behaviour is a form of communication and use it to inform assessment, diagnosis and care for people with intellectual disability.					
2.4 Communicate to reassure	Recognising that people with intellectual disability may have differing levels of understanding of health care situations and procedures, communicate directly with the person in a way that seeks to include them in health care discussions and inform them of what is occurring and its purpose, giving a sense of control and improved comfort.					
3. Quality Evidence-Informed Health Care						
3.1 Dignity and respect	Treat all people with intellectual disability with dignity and respect, seeing them as a person first.					
3.2 Evidence-informed practice	Evaluate, apply and contribute to evidence-informed practice in the health care of people with intellectual disability.					
3.3 Person-centred care	Adopt a person-centred approach to care to ensure that the person with intellectual disability is at the centre of planning and decision-making about their care.					
3.4 Reasonable adjustments	Make reasonable adjustments to care, including adapting the environment, to meet the individual needs of the person with intellectual disability.					
3.5 Partnership in care	Promote inclusion of people with intellectual disability, and their support networks where appropriate, in all stages of their care including asking people their needs, preferences and values, informing them of what is happening, including them in care planning, and offering a full range of choices.					
3.6 Appropriate assessment	Employ appropriate assessment procedures and tools to inform diagnosis of health conditions, with an awareness that modified diagnostic criteria and reasonable adjustments may be required for assessment of people with intellectual disability.					
3.7 Diagnostic overshadowing and other reasons for misdiagnosis	Apply knowledge of diagnostic overshadowing and atypical presentations and their role in under-diagnosis and misdiagnosis in people with intellectual disability.					
3.8 Complex care needs	Apply knowledge of the unique clinical, social and contextual factors contributing to complexity of health care for people with intellectual disability and be able to respond accordingly to complex care needs.					

Core Capability Areas with corresponding Capabilities	Knowledge/skills related to capability area? Yes (Y) Developing (D) No (N) Not applicable (N/A)	Experience teaching content related to capability area? Current or past?	Plans to assist knowledge/skill development (where applicable)	Resources to assist knowledge/skills development	Timeframe	Notes
3.9 Deterioration in function	Working in partnership with those who know the person well, recognise deterioration in function particularly when communication or care needs are complex, and respond as appropriate to address deterioration and improve quality of life.					
3.10 Best practice approaches to management for people with intellectual disability	Use best practice approaches (non-pharmacological and/or pharmacological) taking into consideration individual needs to manage health conditions for people with intellectual disability.					
3.11 Responsible management of medications	Build awareness of the implications of medications, their use, and interactions for people with intellectual disability and apply these within scope of practice.					
3.12 Working with people who have behaviours of concern	Use best practice and, where at all possible, non-restrictive (otherwise least-restrictive) techniques to work safely with people who may display behaviours of concern relevant to your area of practice.					
3.13 Lifespan approach to health care	Apply an approach that considers the health needs of people with intellectual disability across the lifespan, particularly during times of transition and life events.					
3.14 Preventative health care and promotion	Employ proactive health care practices and health promotion activities that are adapted and responsive to the needs of people with intellectual disability and correspond to known health risks at a population and individual level.					
3.15 Responding to trauma	Work in a way that sensitively considers and responds to the greater likelihood that a person with intellectual disability may have experience of trauma, including health care related trauma.					
3.16 Health literacy for people with intellectual disability and their support networks	Facilitate quality health care for people with intellectual disability by fostering health literacy in people with intellectual disability and their support networks, and providing accessible information.					
4. Coordination and Collaboration						
4.1 Care navigation through health and disability services	Support people with intellectual disability and their support networks to navigate available health, disability, and community services according to needs.					
4.2 Relationships of trust	Facilitate trust with people with intellectual disability and their support networks during each interaction.					
4.3 Collaborative partnerships	Work collaboratively with the person with intellectual disability, their support networks and professionals, applying knowledge of who is involved and their roles and expertise.					
4.4 Collaborate with other professionals	Collaborate as appropriate with other professionals across all stages of a care pathway to ensure successful integration of care for people with intellectual disability.					
4.5 Continuity in care during transitions	Support continuity of care and effective transfers of care between health professionals and services for people with intellectual disability by using or finding effective care pathways.					
4.6 Structure and function of the disability support system and its workers	Apply knowledge of the structure and function of the disability support system to inform practice recommendations to support the health of people with intellectual disability within your scope of practice.					

Core Capability Areas with corresponding Capabilities	Knowledge/skills related to capability area? Yes (Y) Developing (D) No (N) Not applicable (N/A)	Experience teaching content related to capability area? Current or past?	Plans to assist knowledge/skill development (where applicable)	Resources to assist knowledge/skills development	Timeframe	Notes
5. Decision-Making and Consent						
5.1 Supported decision-making	Facilitate supported decision-making to maximise the capability of all people with intellectual disability to make or be involved in decisions about their care, involving support networks where appropriate.					
5.2 Communicating the significance of supported decision-making	Communicate clearly with the person with intellectual disability and their support networks about the importance and benefits of supported decision-making and how this differs to substitute decision-making.					
5.3 Assess capacity to consent	Adapt practices as required to assess the capacity of a person with intellectual disability to consent to each decision about their health care, using supported decision-making practices and reasonable adjustments, in line with relevant legislation.					
5.4 Consent and substitute decision-making	Support a person with intellectual disability to provide consent where they have capacity using reasonable adjustments or identify and work with guardians/appointed decision-makers where required and continue to involve the person with intellectual disability in the process.					
5.5 Balancing dignity of risk and duty of care	Demonstrate the ability to balance a person with intellectual disability's right to dignity of risk while upholding duty of care.					
6. Responsible, Safe and Ethical Practice						
6.1 Advocacy	Advocate for the needs of people with intellectual disability and support people with intellectual disability to engage in self-advocacy or find a suitable advocate.					
6.2 Safe and quality practices	Apply knowledge of the risks that may be associated with accessing health care for people with intellectual disability to consider the care environment, inform safe service provision and report risks.					
6.3 Safeguards against potential exploitation, violence, abuse and neglect	Identify and know how to act on signs of exploitation, violence, abuse and neglect against people with intellectual disability, and practise in a manner that safeguards people with intellectual disability against potential harms.					
6.4 Legislation and other frameworks	Uphold applicable legislation, policy, frameworks and practice guidelines relevant to working with people with intellectual disability, including being aware of the increased potential for harm when a person with intellectual disability comes into contact with the health system.					
6.5 Reflect on and enhance capabilities	Be aware of your own capabilities around intellectual disability health and seek professional development opportunities and advice from intellectual disability specialists to enhance knowledge and skills where required.					

Appendix 3: Supporting resources

Learning resources for students and educators

Resource name	Provider	Discipline area(s)	Description	Resource link
The ABLEx Series	Mater Intellectual Disability and Autism Service (MIDAS)	All disciplines	Free self-paced Massive Open Online Course that aims to improve the health of people with intellectual disability. The courses can be used with pre-registration students or for workforce education, and are split into three tiers of learning.	*https://qcidd.centre.uq.edu.au/resources/ablex-series*
Australasian Society for Intellectual Disability (ASID) Webinars	Australasian Society for Intellectual Disability (ASID)	All disciplines	Recorded webinars on a variety of topics related to intellectual disability health and mental health.	*https://asid.asn.au/webinars/*
Developmental Disability	Therapeutic Guidelines	All disciplines (particularly medicine and pharmacy)	The Therapeutic Guidelines provide clear, practical, and up-to-date therapeutic information, based on the latest international literature.	*https://tgldcdp.tg.org.au/topicTeaser?guidelinePage=Developmental+Disability&etgAccess=true*
Down Syndrome: The Essentials	Down Syndrome Australia	All disciplines	An e-learning course that covers the knowledge and skills needed to improve the health and wellbeing of people with Down syndrome.	*https://study.unimelb.edu.au/find/short-courses/down-syndrome-the-essentials/*
Every Nurse's Business	Professional Association of Nurses in Developmental Disability Australia (PANDDA)	Nursing and midwifery	Free online program to build nurses' capacity to address the health care needs of people with intellectual disability and/or autism in mainstream health settings. The content is split into three tiers of learning: foundational, intermediate, and advanced.	*https://learning.pandda.net/*
Inclusive Communication: Improving Health Outcomes for People with Down Syndrome	Down Syndrome Australia	All disciplines	Webinars and recordings of face-to-face presentations by Down Syndrome Australia Health Ambassadors, a group of individuals with Down Syndrome who work to inform health care workers about the best way to include people with Down Syndrome in their own health conversations.	*https://www.downsyndrome.org.au/advocacy/health-ambassadors/health-ambassador-work/*
Intellectual Disability Health Education	Department of Developmental Disability Neuropsychiatry (3DN)	All disciplines	Online, self-paced learning on intellectual disability health and mental health to improve the knowledge, skills and confidence of health professionals, disability professionals and carers who support people with intellectual disability.	*https://idhealtheducation.edu.au/*
Intellectual Disability Mental Health Connect	Department of Developmental Disability Neuropsychiatry (3DN)	All disciplines	Website with information about intellectual disability mental health for people with intellectual disability, their support networks and mainstream health professionals.	*https://idmhconnect.health/*
Intellectual Disability Training Videos	Agency for Clinical Innovation, NSW Government	All disciplines	A series of videos to help health professionals understand the care needs of a person with intellectual disability. The videos cover a range of topics, including mental health, hospitalisation, respiratory health, diagnosis, continuity of care and access to services.	*https://aci.health.nsw.gov.au/resources/intellectual-disability/intellectual_disability_training/id-training-videos*

Teaching resources

Resource name	Provider	Discipline area(s)	Description	Resource link
Discharges from Hospital – Case Studies of People with Intellectual Disability	Agency for Clinical Innovation, NSW Government	All disciplines	Ten de-identified case situations around discharge of a patient with intellectual disability from a public hospital, accompanied by general discussion questions.	*https://aci.health.nsw.gov.au/resources/intellectual-disability/toolkit/intellectual-disability-toolkit/discharges-from-hospital-intellectual-disability-case-studies*
Simulation Training to Support Healthcare Professionals to Meet the Health Needs of People with Intellectual Disabilities	Billon et al. (2016)	All disciplines	Study exploring the impact of a simulation training course on improving the provision of health care to people with intellectual disability.	*https://www.emerald.com/insight/content/doi/10.1108/AMHID-08-2016-0018/full/html*

Appendix 4:
Intellectual Disability Health Capability Framework – Example learning outcome assessments

The table below provides a series of examples of how the learning outcomes can be assessed within a broad variety of contexts.

Category	Example learning outcomes	Example assessment
Written	**1.3.1** Describe the concept of power differentials and how they can influence health interactions and provision of health care for people with intellectual disability.	**Short answer questions:** Define the concept of "power differentials" in health care. How do power differentials affect the provision of health care for people with intellectual disability?
	1.3.3 Examine strategies to reduce power differentials in health care interactions with people with intellectual disability and their support networks.	**Essay:** Outline and critique two specific strategies that could be used in your practice to reduce inequity and power differentials when providing care for people with intellectual disability.
Group discussions & case-based learning	**1.4.2** Examine how co-occurring conditions may affect care provision and contribute to complex care needs for people with intellectual disability.	**Case review:** Provide lived experience cases for students to discuss in small groups, for example, personal stories from the Disability Royal Commission, video stories by people with intellectual disability and their support networks, composite case studies, or coroners' cases. Obtain evidence of discussion that can be graded e.g., photos of discussion (e.g., butchers' paper / white board key points), submission of summaries/notes.
Quizzes	**5.1.1** Summarise the key principles of supported decision-making for people with intellectual disability.	**Quiz:** A series of quizzes that explore the key principles of supported decision-making for people with intellectual disability.
Simulation, role plays, and video assignments	**2.1.2** Demonstrate strategies to engage and directly communicate with people with intellectual disability, using their support networks as appropriate.	**Video skills assessment:** Develop a short video in small groups that demonstrates the use of two key strategies to engage and directly communicate with people with intellectual disability (e.g., active listening, use of visual aids, targeted information sharing).
	3.1.1 Use current best practice, person-centred language and terminology when discussing and working with people with intellectual disability.	**Clinical scenario:** Co-design a simulation/role play that assesses the student's use of current best practice, person-centred language and terminology in a clinical situation that represents people with intellectual disability's lived experience (tailored to the profession and scope of practice); include actors/community members with intellectual disability in the simulation/role play where possible.

Category	Example learning outcomes	Example assessment
Concept mapping, brainstorming activities, development of infographic material	**6.3.1** Describe the different forms of exploitation, violence, abuse, and neglect that people with intellectual disability may experience.	**Mapping exercise:** Design and present a concept map of the different forms of exploitation, violence, abuse, and neglect that people with intellectual disability may experience. Ask what resources and strategies students might utilise and their reporting responsibilities (within scope of practice) if they encounter these circumstances.
	3.16.2 Provide accessible and relevant health information to people with intellectual disability and their support networks.	**Preventative health initiative infographic:** Develop an infographic on a specific preventative health measure that is targeted to people with intellectual disability, families and their support networks, and its associated resources.
Placements, log books, reflective case review	**4.4.3** Demonstrate skills in working within interprofessional teams to benefit the health outcomes of people with intellectual disability.	**Supervision feedback related to interprofessional practice skills:** Case presentations that reflect on the benefits of working in interprofessional teams for people with intellectual disability. Provision of reports and reflective case reviews from placements demonstrating application of interprofessional practice.

Appendix 5: References

[1]Trollor J, Srasuebkul P, Xu H and Howlett S (2017) 'Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data', *BMJ Open*, doi:7**:**e013489, doi:10.1136/bmjopen-2016-013489.

[2]Liao P, Vajdic C, Trollor J and Reppermund S (2021) 'Prevalence and incidence of physical health conditions in people with intellectual disability – a systematic review', *PLoS ONE*,16(8):e0256294, doi:10.1371/journal.pone.0256294.

[3]Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023), ***Final report – Volume 6, Enabling autonomy and access***, accessed 29 September 2023.

[4]Australian Government Department of Health (2021) ***National Roadmap for Improving the Health of People with Intellectual Disability***, Department of health, Australian Government, accessed 14 March 2023.

[5]Ahpra Board Accreditation Committee (2023) ***Glossary of accreditation terms***, Ahpra & National Boards, accessed 27 November 2023.

[6]NSW Health (2020) ***Consent to Medical and Healthcare Treatment Manual***, NSW Ministry of Health, accessed 12 December 2023.

[7]Mason J and Scior K (2004) 'Diagnostic overshadowing amongst clinicians working with people with intellectual disabilities in the UK', *Journal of Applied Research in Intellectual Disabilities*, 17(2):85-90, doi:10.1111/j.1360-2322.2004.00184.x.

[8]NDIS (2023) ***Participant Safeguarding Policy***, National Disability Insurance Scheme, accessed 27 November 2023.

[9]American Psychiatric Association (2013) *Diagnostic and statistical manual of mental disorders : DSM-5*, American Psychiatric Association, Arlington, VA.

[10]Australian Government Tertiary Education Quality and Standards Agency (2023) ***TEQSA Glossary of Terms***, TEQSA, Australian Government, accessed 20 November 2023.

[11]Australian Commission on Safety and Quality in Health Care (2023) *Reasonable adjustments,* ACSQHC*,* accessed 6 December 2023.

[12]Healy K (2016) '2015 Norma Parker Address: Being a Self-regulating Profession in the 21st Century: Problems and Prospects', *Australian Social Work*, 69(1): 1-10, doi: 10.1080/0312407X.2016.1103391.

[13]Anders PL and Davis EL (2010) 'Oral health of patients with intellectual disabilities: A systematic review', *Special Care in Dentistry*, 33(3):110-117, doi:10.1111/j.1754-4505.2010.00136.x.

[14]Beange H, McElduff A and Baker W (1995) 'Medical disorders of adults with mental retardation: A population study', *American Journal of Mental Retardation*, 99(6):595-604.

[15]Capone GT, Chicoine B, Bulova P, Stephens M, Hart S, Crissman B, Videlefsky A, Myers K, Roizen N, Esbensen A, Peterson M, Santoro S, Woodward J, Martin B, Smith D; Down Syndrome Medical Interest Group DSMIG-USA Adult Health Care Workgroup (2018) 'Co-occurring medical conditions in adults with Down syndrome: A systematic review toward the development of health care guidelines', *American Journal of Medical Genetics*, 176(1):116-133, doi:10.1002/ajmg.a.38512.

[16]Robertson J, Hatton C, Emerson E and Baines S (2015) 'Prevalence of epilepsy among people with intellectual disabilities: A systematic review' *Seizure*, 29:46-62, doi:10.1016/j.seizure.2015.03.016.

[17]Srikanth R, Cassidy G, Joiner C and Teeluckdharry S (2011) 'Osteoporosis in people with intellectual disabilities: A review and a brief study of risk factors for osteoporosis in a community sample of people with intellectual disabilities', *Journal of Intellectual Disability Research*, 55(1):53-62, doi:10.1111/j.1365-2788.2010.01346.x.

[18]Einfeld SL, Ellise LA and Emerson E (2011) 'Comorbidity of intellectual disability and mental disorder in children and adolescents: A systematic review', *Journal of Intellectual & Developmental Disability*, 36(2):137-143, doi:10.1080/13668250.2011.572548.

[19]Hughes-McCormack L, Rydzewska E, Henderson A, MacIntyre C, Rintoul J and Cooper S (2018) 'Prevalence of mental health conditions and relationship with general health in a whole-country population of people with intellectual disabilities compared with the general population', *BJPsych Open*, 3(5):243-248, doi:10.1192/bjpo.bp.117.005462.

[20]AIHW (1997) ***The definition and prevalence of intellectual disability in Australia***, Australian Institute of Health and Welfare, Australian Government, accessed 15 May 2023.

[21]White P, Chant D, Edwards N, Townsend C and Waghorn G (2005) 'Prevalence of intellectual disability and comorbid mental illness in an Australian community sample' *Australian & New Zealand Journal of Psychiatry*, 39(5):395-400, doi:10.1080/j.1440-1614.2005.01587.x.

[22]Srasuebkul P, Cvejic R, Heintze T, Reppermund S and Trollor JN (2021) 'Public mental health service use by people with intellectual disability in New South Wales and its costs', *Medical Journal of Australia*, 215(7):289-296, doi:10.5694/mja2.51166.

[23]Weise JC, Srasuebkul P and Trollor JN (2021) 'Potentially preventable hospitalisations of people with intellectual disability in New South Wales', *Medical Journal of Australia*, 215(1):31-36, doi:10.5694/mja2.51088.

[24]Ali A, Scior K, Ratti V, Strydom A, King M and Hassiotis A (2013) 'Discrimination and other barriers to accessing health care: Perspectives of patients with mild and moderate intellectual disability and their carers', *PloS One*, 8(8):e70855, doi:10.1371/journal.pone.0070855.

[25]Webber R, Bowers B and Bigby C (2010) 'Hospital experiences of older people with intellectual disability: Responses of group home staff and family members', *Journal of Intellectual & Developmental Disability*, 35(3):155-164, doi:10.3109/13668250.2010.491071.

[26]Ziviani J, Lennox N, Allison H, Lyons M and Del Mar C (2004) 'Meeting in the middle: Improving communication in primary health care consultations with people with an intellectual disability', *Journal of Intellectual & Developmental Disability*, 29(3):211-225, doi:10.1080/13668250412331285163.

[27]Doherty AJ, Atherton H, Boland P, Hastings R, Hives L, Hood K, James-Jenkinson L, Leavey R, Randell E, Reed J, Taggart L, Wilson N and Chauhan U (2020) 'Barriers and facilitators to primary health care for people with intellectual disabilities and/or autism: An integrative review', *BJGP Open*, 4(3):bjgpopen20X101030, doi:10.3399/bjgpopen20X101030.

[28]Moloney M, Hennessy T and Doody O (2023) 'Parents' perspectives on reasonable adjustments in acute healthcare for people with intellectual disability: A qualitative descriptive study', *Journal of Advanced Nursing*, doi:10.1111/jan.15772.

[29]Whittle EL, Fisher KR, Reppermund S, Lenroot R and Trollor J (2018) 'Barriers and enablers to accessing mental health services for people with intellectual disability: A scoping review', *Journal of Mental Health Research in Intellectual Disabilities*, 11(1):69-102, doi:10.1080/19315864.2017.1408724.

[30]Pelleboer-Gunnink HA, Van Oorsouw WMWJ, Van Weeghel J and Embregts PJCM (2017) 'Mainstream health professionals' stigmatising attitudes towards people with intellectual disabilities: A systematic review', *Journal of Intellectual Disability Research*, 61(5):411-434, doi:10.1111/jir.12353.

[31]Minnes P and Steiner K (2009) 'Parent views on enhancing the quality of health care for their children with fragile X syndrome, autism or Down syndrome', *Child: care, health and development*, 35(2):250-256, doi:10.1111/j.1365-2214.2008.00931.x.

[32]Tracy J and McDonald R (2015) 'Health and disability: Partnerships in health care', *Journal of Applied Research in Intellectual Disabilities*, 28(1):22-32, doi:10.1111/jar.12135.

[33]Furst MAC and Salvador-Carulla L (2019) 'Intellectual disability in Australian nursing education: Experiences in NSW and Tasmania', *Journal of Intellectual & Developmental Disability*, 44(3):357-366, doi:10.3109/13668250.2017.1386288.

[34]Trollor JN, Ruffell B, Tracy J, Torr JJ, Durvasula S, Iacono T, Eagleson C and Lennox N (2016) 'Intellectual disability health content within medical curriculum: An audit of what our future doctors are taught', *BMC Medical Education*, 16(105), doi:10.1186/s12909-016-0625-1.

[35]Trollor JN, Eagleson C, Turner B, Salomon C, Cashin A, Iacono T, Goddard L and Lennox N (2016) 'Intellectual disability health content within nursing curriculum: An audit of what our future nurses are taught', *Nurse Education Today*, 45:72-79, doi:10.1016/j.nedt.2016.06.011.

[36]Trollor JN, Eagleson C, Ruffell B, Tracy J, Torr JJ, Durvasula S, Iacono T, Cvejic RC and Lennox N (2020) 'Has teaching about intellectual disability healthcare in Australian medical schools improved? A 20-year comparison of curricula audits', *BMC Medical Education*, 20(321), doi:10.1186/s12909-020-02235-w.

[37]Lennox N, Diggens J and Ugoni A (1997) 'The general practice care of people with intellectual disability: barriers and solutions', *Journal of Intellectual Disability Research*, 41(5):380-390, doi:10.1111/j.1365-2788.1997.tb00725.x.

[38]Phillips A, Morrison J and Davis RW (2004) 'General practitioners' educational needs in intellectual disability health', *Journal of Intellectual Disability Research*, 48(2):142-149, doi:10.1111/j.1365-2788.2004.00503.x.

[39]Weise J and Trollor JN (2018) 'Preparedness and training needs of an Australian public mental health workforce in intellectual disability mental health', *Journal of Intellectual & Developmental Disability*, 43(4):431-440, doi:10.3109/13668250.2017.1310825.

[40]Eagleson C, Cvejic RC, Weise J, Davies K and Trollor JN (2019) 'Subspecialty training pathways in intellectual and developmental disability psychiatry in Australia and New Zealand: Current status and future opportunities', *Australasian Psychiatry*, 27(5):513-518, doi:10.1177/1039856219839468.

[41]Man J, Kangas M, Trollor J and Sweller N (2017) 'Clinical competencies and training needs of psychologists working with adults with intellectual disability and comorbid mental ill health', *Clinical Psychologist*, 21(3):206-214, doi:10.1111/cp.12092.

[42]Ong N, McCleod E, Nicholls LE, Fairbairn N, Tomsic G, Lord B and Eapen V (2017) 'Attitudes of healthcare staff in the treatment of children and adolescents with intellectual

disability: A brief report', *Journal of Intellectual & Developmental Disability*, 42(3):295-300, doi: 10.3109/13668250.2016.1236368.

[43]Institute for Social Science Research (2022) ***Final Report: Scoping and gap analysis of undergraduate resources in intellectual disability health – Prepared for the Department of Health***, The University of Queensland, accessed 24 August 2023.

[44]Miller GE (1990) 'The assessment of clinical skills/competence/performance', *Academic Medicine*, 65(9 Suppl):S63-67, doi:10.1097/00001888-199009000-00045.

[45]Anderson LW, Krathwohl DR and Bloom BS (2001) *A taxonomy for learning, teaching, and assessing: A revision of Bloom's Taxonomy of educational objectives*, Complete ed, Longman, New York.

[46]Australian Health Practitioner Regulation Authority (2023) ***Ahpra Procedures for the Development of Accreditation Standards***, Ahpra and National Boards website, accessed 18 September 2023.

[47]Cooper SA, McLean G, Guthrie B, McConnachie A, Mercer S, Sullivan F and Morrison J (2015) 'Multiple physical and mental health comorbidity in adults with intellectual disabilities: population-based cross-sectional analysis', *BMC Family Practice*, 16(110), doi:10.1186/s12875-015-0329-3.

[48]Jones J, McQueen M, Lowe S, Minnes P and Rischke A (2015). 'Interprofessional education in Canada: addressing knowledge, skills, and attitudes concerning intellectual disability for future healthcare professionals', *Journal of Policy and Practice Intellectual Disabilities*, 12(3):172-180, doi:10.1111/jppi.12112.

[49]Rotenberg S, Rodríguez Gatta D, Wahedi A, Lo R, McFadden E and Ryan S (2022) 'Disability training for health workers: A global evidence synthesis', *Disability and Health Journal*, 15(2):101260, doi:10.1016/j.dhjo.2021.101260.

[50]Boyd K, Bridge E, McConnell M, Kates N and Stobbe K (2019) 'A curriculum of caring for people with developmental disabilities in medical education', *Journal on Developmental Disabilities*, 24(2):10-18.

[51]Coret A, Boyd K, Hobbs K, Zazulak J and McConnell M (2018) 'Patient narratives as a teaching tool: a pilot study of first-year medical students and patient educators affected by intellectual/developmental disabilities', *Teaching and Learning in Medicine*, 30(3):317-327, doi :10.1080/10401334.2017.1398653.

[52]Jiwa MI, Armstrong S, Shao Y and Lunsky Y (2020) 'Development of educational modules for MRTs to better support patients with intellectual and developmental disabilities undergoing imaging procedures: A collaborative patient-oriented initiative', *Journal of Medical Imaging and Radiation Sciences*, 51(4):S26-S30, doi:10.1016/j.jmir.2020.08.017.

[53]Kahtan S, Inman C, Haines A and Holland P (1994) 'Teaching disability and rehabilitation to medical students', *Medical Educ*ation, 28(5):386–93, doi:10.1111/j.1365-2923.1994.tb02549.x.

[54]Howlett S, Florio T, Xu H and Trollor J (2015) 'Ambulatory mental health data demonstrates the high needs of people with an intellectual disability: Results from the New South Wales intellectual disability and mental health data linkage project', *Australian and New Zealand Journal of Psychiatry*, 49(2):137-144, doi:10.1177/0004867414536933.

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