Australian Government
Department of Health and Aged Care

Intellectual Disability Health Capability Framework

Contents

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.

[Artwork by First Nations artist to be inserted with description]

Executive summary

- To be drafted once content of the Intellectual Disability Health Capability Framework finalised.

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: Prof Nigel Robb, Prof Julian Trollor, Prof Stephen Trumble and Dr Janelle Weise

Lived experience researcher: Ms Katrina Sneath

Disability Support Officer: Ms Michaela Kobor

The drafting group would like to thank all individuals and organisations who have taken part in consultations and contributed feedback toward the Intellectual Disability Health Capability 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 Tahney, Larry Simpson and Naomi Lake, and the Education and Training Expert Advisory Group (see Appendix 1 for membership).

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 Intellectual Disability Health Capability 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 below.

To note - we plan to add quotes and artwork from people with lived experience of intellectual disability throughout the Framework.

Glossary

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

- **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 problem[1].

- **dignity of risk** – promotes each person's autonomy and self-determination to make their own choices, including the choice to take some risks in life[2].

- **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.

- **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 people, 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.

- **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)[3].

- **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.

- **intersectoral** – collaboration of health professionals from different sectors.

- **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 diploma leading to registration as a health professional).

- **support networks** – includes carers, families, support workers, advocates, and friends.

Introduction

The Intellectual Disability Health Capability Framework (the Framework) articulates a national benchmark for the level of capability 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*. The Commission identified 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[4]. A key recommendation was the development of a capability framework that specifies the core knowledge, skills and attributes required to provide quality health care for people with cognitive disability.

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 (the 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
- Pre-registration health education providers including:
    - Deans, managers, and leaders
    - Curriculum coordinators and educators

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

Section One: Background

The context for the development of the Framework

The *National Roadmap for Improving the Health of People with Intellectual Disability* (the Roadmap) was released in August 2021. 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[5].
- 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[5]. Compared with the general population, people with intellectual disability also experience high morbidity[6]. They have a higher prevalence of both physical conditions, including epilepsy, sensory impairments, diabetes, dental disease and osteoporosis[6,7-11], and mental health conditions[12-13].

The high morbidity within this population has contributed to high health service use[5, 14-15]. For example, Srasuebkul and colleagues[16] 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[17]. 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[18-20], a lack of reasonable adjustments being made to communication or practice[21-22], health professionals' inadequate skills and knowledge about the health needs of people with intellectual disability[18,21-23], stigmatising attitudes[24] and diagnostic overshadowing[23,25]. Diagnostic overshadowing refers to the misattribution of symptoms to the person's disability rather than to a health or mental health problem[1].

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[26]. However, the Disability Royal Commission's 2022 hearing[4] into the education and training of health professionals found that there is no requirement to deliver education or training about intellectual disability health. The Commission also found no consistent approach used by health education providers to teach intellectual disability content and recommended the development of the Capabilities.

Systematic audits conducted in Australia found that there is minimal content related specifically to intellectual disability health in medical and nursing education[27-29]. Trollor and colleagues[30] also found little overall improvement in the amount and nature of intellectual disability health education for medical students in the last 20 years, with Trollor and colleagues[28] reporting a median of less than three hours of compulsory intellectual disability content in Australian medical curricula across 12 universities. Similarly, intellectual disability content is scarce in nursing curricula, with over half of the schools audited offering no intellectual disability content[29]. 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[31-36]. A considerable percentage (38%) of General Practitioners said that they would not be confident in treating people with intellectual disability[31]. 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[32]. Mental health professionals also reported a lack of confidence to provide mental health care to people with intellectual disability[33] and have expressed support for increased specialised training[34-35]. Allied health and medical staff within child and adolescent services in NSW also reported a strong desire for training and skill development[36]. 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 and 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 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 to 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	n
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 on-line 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.

Consultation involved:

1. Interviews and focus groups with XX First Nations people (August – XX 2023)
2. A focus group with XX people with intellectual disability (September 2023)
3. Public open consultation (XX responses; October 2023)

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

Section Two: The Intellectual Disability Health Capabilities and Learning Outcomes

The Intellectual Disability Health Core Capabilities (the 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 including:

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[37]. 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[38]. 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.

[A graphic representation of the capability model will be inserted]

1. Intellectual Disability Awareness

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

*Note – we plan to cross-reference learning 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.	1.1.1 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
		1.1.2 Examine how the human rights of people with intellectual disability can be promoted within practice.	2
		1.1.3 Critique the challenges of upholding human rights within practice and strategies that would maintain and promote the human rights of people with intellectual disability.	3
1.2 Attitudes, values and beliefs about people with intellectual disability	Practise in a manner that recognises, respects and values the lived experience and lives of people with intellectual disability.	1.2.1 Discuss the stigma and discrimination experienced by people with intellectual disability and their support networks when accessing and receiving health care.	1
		1.2.2 Discuss how attitudes, beliefs, and values about people with intellectual disability shape health care provision and health outcomes.	1
		1.2.3 Compare and contrast strength and deficit-based approaches when working with people	2

			with an intellectual disability and the value of lived experience.	
		1.2.4	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.	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.	1
		1.3.2	Identify how autonomy over health care decisions can be maintained for people with intellectual disability.	1
		1.3.3	Examine strategies to reduce power differentials in health care interactions with people with intellectual disability and their support networks.	2
		1.3.4	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
		1.3.5	Design a treatment or care plan that supports the self-determination of a person with an intellectual disability.	3
1.4 Causes of intellectual disability, co-	Apply knowledge of the causes of intellectual disability and associated	1.4.1	Identify the different causes of intellectual disability, common co-occurring health conditions and the evidence that underpins their management.	1

occurring conditions and variability across individuals	conditions to provide comprehensive individualised care.	1.4.2	Examine how co-occurring conditions may affect care provision and contribute to complex care needs for people with intellectual disability.	2
		1.4.3	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.	1.5.1	Discuss historical models of disability and how they shaped practice and perceptions of intellectual disability.	1
		1.5.2	Identify and reflect upon instances where best practice models of disability and health care have been used.	1
		1.5.3	Compare and contrast current best practice models of disability, including social models of disability, and health care, and consider how they apply to best health care practice.	2
		1.5.4	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.	1.6.1	Discuss the social determinants of health and their effect on health outcomes for people with intellectual disability.	1
		1.6.2	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
		1.6.3	Propose examples of potential pathways that support individual strengths, positive behaviours and empowers 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.	1.7.1	Discuss why people with intellectual disability have increased prevalence of chronic, multiple, and complex health conditions.	1
		1.7.2	Develop person-centred and recovery focused care plans to address the needs of people with intellectual disability within your professional scope of practice.	3
		1.7.3	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.	1.8.1	Identify health care access barriers and enablers that people with intellectual disability may experience.	1
		1.8.2	Describe how barriers and enablers influence health outcomes for people with intellectual disability.	2
		1.8.3	Identify practice adaptations that could be made to provide equitable access and care to people with intellectual disability.	3
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.	1.9.1	Discuss the principles of culturally safe care and how they apply to people with intellectual disability.	1
		1.9.2	Discuss how individuals and communities of people with intellectual disability can describe their identity and intersectionality.	1
		1.9.3	Identify specific health and community services and supports that exist for First Nations people with intellectual disability.	1
		1.9.4	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

		1.9.5 Critique examples of culturally safe and unsafe care for people with intellectual disability and demonstrate best 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.	1.10.1 Describe the key role of support networks in the lives of people with intellectual disability and how to identify support networks.	1
		1.10.2 Discuss how to apply the knowledge provided by the support networks of people with intellectual disability to their care.	2
		1.10.3 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

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.	2.1.1 Discuss effective and ineffective communication when interacting with people with intellectual disability.	1
		2.1.2 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.	2.2.1 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
		2.2.2 Develop strategies on how to include support networks in communication as appropriate.	3
		2.2.3 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.	2.3.1 Discuss why it is important to recognise behaviour as a form of communication.	1
		2.3.2 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
		2.3.3 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.	2.4.1 Describe what you may need to communicate to a person with intellectual disability regarding what will happen during a health care interaction.	1
		2.4.2 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
		2.4.3 Evaluate the person's understanding throughout the health care interaction and respond with appropriate information.	3
		2.4.4 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

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.	3.1.1 Use current best practice, person-centred language and terminology when discussing and working with people with intellectual disability.	1
		3.1.2 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.	3.2.1 Identify research and areas of evidence-informed practice for people with intellectual disability.	1
		3.2.2 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.	3.3.1 Summarise the principles of person-centred care and their importance to the provision of health care for people with intellectual disability.	1
		3.3.2 Apply the principles of person-centred care to work in partnership with people with intellectual disability to identify their goals, motivations, preferences, and priorities.	3

		3.3.3 Work in partnership with people with intellectual disability 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.	3.4.1 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
		3.4.2 Identify which reasonable adjustments are appropriate for an individual with intellectual disability and explain when they are needed.	2
		3.4.3 Develop a plan to implement reasonable adjustments to meet the individual needs of the person with intellectual disability.	3
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.	3.5.1 Develop a plan for the inclusion of people with intellectual disability and their support networks during the assessment and management stage.	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.	3.6.1 Identify modifications to diagnostic criteria and reasonable adjustments that may be required when conducting an assessment for people with intellectual disability.	1
		3.6.2 Describe the role of a multidisciplinary team and the person's support network in providing an accurate diagnosis for people with intellectual disability.	1
		3.6.3 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.	3.7.1 Explain the concept of diagnostic overshadowing as it applies to people with intellectual disability.	1
		3.7.2 Give examples of atypical clinical presentations in people with intellectual disability and how they can lead to misdiagnosis.	1
		3.7.3 Formulate strategies to recognise atypical presentations and minimise diagnostic overshadowing.	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.	3.8.1 Analyse the inter-relationship of clinical, social, and contextual factors that contribute to complexity in health care for people with intellectual disability.	2
		3.8.2 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.	3.9.1 Name the factors that may impede recognition of deterioration of function in people with intellectual disability.	1
		3.9.2 Formulate a plan for early recognition and management of a deterioration in function of people with intellectual disability.	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.	3.10.1 Discuss the elements of best practice approaches to manage health conditions for people with intellectual disability.	1
		3.10.2 Identify relevant best-practice non-pharmacological interventions to manage health-related issues for people with intellectual disability.	2
		3.10.3 Identify relevant best-practice pharmacological considerations to manage health-related issues for people with intellectual disability.	2

		3.10.4 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.	3.11.1 List the factors to be considered when prescribing or monitoring medications for people with intellectual disability.	1
		3.11.2 Develop a plan for medication monitoring and review in people with intellectual disability.	2
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.	3.12.1 Define behaviours of concern and identify their main causes.	1
		3.12.2 Describe non-restrictive techniques to work safely with people who display behaviours of concern.	1
		3.12.3 Identify the roles of health and disability professionals in the multidisciplinary assessment and management of behaviours of concern in people with intellectual disability.	1
		3.12.4 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.	3.13.1 Name the key transition points for people with intellectual disability across the lifespan and associated health and support needs.	1
		3.13.2 Develop an example health care plan for: (i) an adolescent with intellectual disability who is leaving school; (ii) for 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.	3.14.1 List the main health enablers and health risks for people with intellectual disability.	1
		3.14.2 Identify the screening and health promotion activities relevant for people with intellectual disability.	2
		3.14.3 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.	3.15.1 Explain the ways that traumatic health care experiences can influence health seeking behaviour and engagement with health care providers.	1
		3.15.2 Identify resources and services available to support people with intellectual disability who have experienced trauma.	1
		3.15.3 Describe how to apply the principles of trauma-informed care to the care of people with intellectual disability.	2
		3.15.4 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.	3.16.1 Discuss strategies to contribute to health literacy for people with intellectual disability and their support networks.	1
		3.16.2 Provide accessible and relevant health information to people with intellectual disability and their support networks.	3
		3.16.3 Work collaboratively with people with intellectual disability and their support networks to foster health literacy.	3

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, 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.	4.1.1 Discuss common challenges and gaps in the navigation between health, mental health, and community services for people with intellectual disability.	1
		4.1.2 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
		4.1.3 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.	4.2.1 Describe the importance of trust and positive health care interactions for people with intellectual disability.	1
		4.2.2 Create strategies to build positive relationships with people with intellectual disability and their support networks and manage information sharing and conflict.	3
		4.2.3 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.	4.3.1	Describe the concept of collaborative partnerships and who and what they entail when providing care for people with intellectual disability.	1
		4.3.2	Compare the roles, skills, and resources that different groups (e.g., community services, specialist services, language services, positive behaviour support) bring to the collaborative partnership for people with intellectual disability and their support networks.	2
		4.3.3	Demonstrate an example of 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.	4.4.1	Identify ways that professionals can effectively collaborate and share information at each stage of a care pathway including assessment, care planning and management.	1
		4.4.2	Interpret and integrate information from other professionals into care planning, delivery and practice when caring for people with intellectual disability.	2
		4.4.3	Demonstrate skills in working with interprofessional teams to benefit the health outcomes of people with intellectual disability.	3
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.	4.5.1	Identify enablers and barriers to continuity of care and the effective transfer of care for people with intellectual disability.	1
		4.5.2	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
		4.5.3	Critique different models of care and how they address integration of care and support	3

			transitions through care for people with intellectual disability.	
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.	4.6.1	Outline key State, Territory and National disability support services and what they provide to assist people with intellectual disability.	1
		4.6.2	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
		4.6.3	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

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.	5.1.1 Summarise the key principles of supported decision-making for people with intellectual disability.	1
		5.1.2 Identify resources to support people with intellectual disability, their families and caregivers, and health professionals with decision-making and consent.	1
		5.1.3 Compare the types of supported decision-making arrangements that may exist.	2
		5.1.4 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.	5.2.1 Discuss the relevant legislation and potential benefits, risks, and ethical implications of supported decision-making.	1
		5.2.2 Compare supported decision-making to substitute decision-making.	2
		5.2.3 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.	5.3.1	Summarise the relevant legislation that relates to capacity to consent in a health care context.	1
		5.3.2	Summarise how reasonable adjustments could be made to assess a person with intellectual disability's capacity to consent.	1
		5.3.3	Recognise how and when to assess capacity to consent, including an understanding of presuming capacity and how to review existing arrangements for consent.	2
		5.3.4	Differentiate between when a person with intellectual disability does and does not have capacity to consent to a decision.	3
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.	5.4.1	Summarise the elements of consent, and how reasonable adjustments can be made to support a person with intellectual disability's capacity to consent.	2
		5.4.2	Demonstrate how to involve guardians or appointed decision-makers in health care decision-making where required.	3
		5.4.3	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.	5.5.1	Discuss the concept and importance of dignity of risk and how it relates to capacity to consent and supported decision-making.	1
		5.5.2	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

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.	6.1.1 Explain the principles of health advocacy, including altruism, social justice, autonomy, integrity, and idealism.	1
		6.1.2 Identify key resources to support people with intellectual disability to self-advocate or choose a suitable advocate.	1
		6.1.3 Design a health advocacy plan with a person with intellectual disability and/or their family, caregiver, support worker, 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.	6.2.1 Discuss the principles of quality and safety regarding the care of people with intellectual disability.	2
		6.2.2 Apply ethical principles to health care decisions involving people with intellectual disability.	3
		6.2.3 Demonstrate how to create a safe health care environment for people with intellectual disability and report risks.	3
		6.2.4 Evaluate and effectively communicate the risks of accessing health care to a person with intellectual disability.	3
6.3 Safeguards against potential	Identify and know how to act on signs of exploitation, violence, abuse and neglect	6.3.1 Describe the different forms of exploitation, violence, abuse, and neglect that people with intellectual disability may experience.	1

exploitation, violence, abuse and neglect	against people with intellectual disability, and practise in a manner that safeguards people with intellectual disability against potential harms.	6.3.2	Explain mandatory legal and professional reporting obligations for when exploitation, violence, abuse, and neglect against people with intellectual disability is suspected.	1
		6.3.3	Recognise signs of exploitation, violence, abuse, and neglect against people with intellectual disability.	2
		6.3.4	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.	6.4.1	Explain the implications of applicable legislation, policy, frameworks, and practice guidelines for the care of people with intellectual disability.	1
		6.4.2	Apply applicable legislation, policy, frameworks, and practice guidelines when working with people with intellectual disability.	3
		6.4.3	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.	6.5.1	Analyse personal practice and professional development needs with regards to working with people with intellectual disability.	3

Section Three: Implementation guidelines

This section provides advice and guidance for accreditation authorities and pre-registration education providers to implement the Framework within their standards and curricula. Accreditation authorities and pre-registration education providers are encouraged to 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; 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, 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 workforce, and providing sufficient resources to facilitate implementation.
- Curriculum coordinators and educators will likely find much of the Framework content is already covered in some capacity in existing curricula, 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; 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*.
- **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 centers 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** – 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.

* A toolkit providing advice to support the inclusion of people with intellectual disability and their support networks in the development and delivery of intellectual disability content will be developed as part of the next stage of this Project.

- **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

This section contains tailored guidance for accreditation authorities and pre-registration education provider leaders and educators around implementing the Framework into accreditation standards and curricula, with suggestions to overcome identified barriers.

Flexible options are provided to accommodate the varying needs of institutions across a variety of health disciplines.

Accreditation authorities

This section is for accreditation authorities.

It aims to assist accreditation authorities to assess where and how they can implement the Capabilities in accreditation standards.

Key points

- Implementing the Capabilities within accreditation standards advocates for the necessity 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. Accreditation authorities and standards for programs of study contribute by stating the requirements programs and their education providers must meet and requiring education providers to demonstrate how they meet the standards.

The purpose of the Framework is to set out clear core capabilities and learning outcomes regarding health care for people with intellectual disability. 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 proposed new or revised accreditation 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[39]. The nationally agreed 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.

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.

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.

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 the Appendix.

Pre-registration education providers

Deans, managers, and leaders

This section is for deans, managers, and leaders 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.

We know that it is intellectual disability champions who advance research and clinical practice in this area, and thus we also 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, managers and leaders can take to commence the Framework implementation process.

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

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, 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. • Consider employing 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: 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, managers, and leaders

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.

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 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, such as Trollor et al. (2017)[5], Liao et al. (2021)[6] and Cooper et al. (2015)[40].

- 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 and educators

This section is for curriculum 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.

Table 3: Steps for implementing the Framework: Curriculum 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: i) Integration of intellectual disability health content within existing curriculum areas (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 adaptive practices, person-centred care, and capacity to consent is also applicable for other groups with diverse needs. ii) 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. iii) Creation of an interprofessional course • Interprofessional education is foundational for interprofessional and intersectoral practice[41] and can help prepare students to practice collaboratively, improving multidisciplinary care for people with intellectual disability. • Consider creating 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. iv) Creation of discipline specific course • There is scope for discipline-specific education, particularly at the advanced level following an interprofessional foundational course.
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[42]. • 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 consider 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[41,43-45]. • However, it is recognised that there are few intellectual disability specific services that can offer placements. • Where there is a shortage of opportunities or they are not feasible for certain health disciplines, community-based placements are an option such as National Disability Insurance Scheme (NDIS) services. They can provide students with i) real world experience, ii) allow for interprofessional collaboration, iii) increase awareness of the broad range of supports and services that people with intellectual disability utilise, and iv) make a positive contribution to the community. • 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 and students. Similarly, placements in this practice may be best completed towards the end of a program.
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 with education and training. Seek out continuing professional development opportunities with allocated time for staff to

* Plans are underway to curate and develop additional resources to support the ongoing implementation of the Framework.

	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 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 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.

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 within content teaching effective communication with people
    - specific focus on adaptations to care for people with intellectual disability when teaching clinical skills
    - facilitating supported decision-making to assist people with intellectual disability to make decisions 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 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 course, 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.

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 placements, for example NDIS providers or visits to day programs and centres.
- 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[46].

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 such as Trollor et al. (2017)[5], Liao et al. (2021)[6] and Cooper et al. (2015)[40].
- 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[16-17,47].

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.

Appendices

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

Intellectual Disability Health Capability Framework – Program content mapping tool

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 Capability		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	Is there a specific teaching method used for this curriculum content? Is the content assessed?	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.	Potential teaching and assessment method for *a* or *b*.	
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 and values 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	Apply knowledge of the determinants of health of people with							

people with intellectual disability	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.							
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.							
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.							
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.							

Intellectual Disability Health Capability Framework – Accreditation standards development tool

Accreditation standards: .....Year……..

Lead: .....Role: ..... Date: .....

Current accreditation standards with mention of:

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

Integration of intellectual disability content could be considered for these standards.

Standard	**Notes**

Potential new standards

For example, covering the six core capability areas.

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 standards	**Notes**

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

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	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

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.*

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	Practise in a manner that recognises, respects and values the lived experience and lives of people with intellectual disability.					

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.

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.
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.

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
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://www.pandda.net/cpd-program.html
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
Providing Healthcare for Clients with an Intellectual Disability (PDC57028)	Central Queensland University	Nursing (but may be suitable for all disciplines)	An online, self-paced course to improve knowledge about the complexities of accessing quality health care for people with intellectual disability.	https://www.cqu.edu.au/courses/824898/providing-healthcare-for-clients-with-an-intellectual-disability

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:* 1. Define the concept of "power differentials" in health care. 2. 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.
Concept mapping, brain storming 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]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.

[2]Department of Social Services (2013) *National Standards for Disability Services*, Department of Social Services, Australian Government, accessed 1 May 2023.

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

[4]Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2022) *Public hearing report: Public hearing 10 – Education and training of health professionals in relation to people with cognitive disability*, accessed 5 May 2023.

[5]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.

[6] 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.

[7]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.

[8] 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.

[9]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.

[10]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.

[11]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.

[12]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.

[13]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.

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

[15]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.

[16] 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.

[17]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.

[18]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.

[19]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.

[20]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.

[21]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.

[22]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.

[23]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.

[24]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.

[25]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.

[26]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.

[27]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.

[28]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.

[29]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.

[30]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.

[31]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.

[32]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.

[33]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.

[34]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.

[35]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.

[36]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.

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

[38]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.

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

[40]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.

[41]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.

[42]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.

[43]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.

[44]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.

[45]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.

[46]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.

[47]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.