National Centre of Excellence in Intellectual Disability Health

Assessment and Accreditation Committee
The Australian Psychology Accreditation Council (APAC)
PO Box 20
Collins Street
West Vic 8007 Australia

Sent via email: apacstandards@apac.au

13 June 2025

Dear Assessment and Accreditation Committee

Round 2 - Public Consultation on the 2025 Alignment Accreditation Standards Review

We write on behalf of the National Centre of Excellence in Intellectual Disability Health to provide input on Round 2 - Public Consultation on the 2025 Alignment Accreditation Standards Review.

In our submission attached, we provide evidence on the health and mental health inequities faced by people with intellectual disability and nine recommendations for amendments to the proposed Accreditation Standards ('the Standards') to promote better mental health outcomes and improved health equity for people with intellectual disability.

We appreciate the opportunity to provide comment on the proposed Standards and trust you will find our submission invaluable in strengthening psychology education and training in Australia. We are happy for our submission be made public.

We would welcome the opportunity to discuss our comments further and should you require further information about this submission, please do not hesitate to contact me at +61 2 8358 5923 or at sophie@cid.org.au.

Sincerely;

Sophie Howlett
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National Centre of Excellence in Intellectual Disability Health

Contents

About us

The National Centre of Excellence in Intellectual Disability Health ('the Centre') is an important initiative supported by the Australian Government Department of Health, Disability and Ageing. The Centre is a consortium of nine organisations including:

1. Centre for Disability Studies (University of Sydney),
2. Council for Intellectual Disability,
3. Down Syndrome Australia,
4. First Peoples Disability Network,
5. Queensland Centre of Excellence in Autism and Intellectual Disability Health,
6. Queenslanders with Disability Network,
7. The Kids Institute,
8. University of Melbourne, and
9. UNSW Sydney.

The Centre also includes another 56 health and disability organisations as partners and collaborators. The vision of the Centre is to ensure that the 500,000 people with intellectual disability in Australia receive the highest attainable level of healthcare.

Executive Summary

People with intellectual disability face stark health and mental health inequalities compared to the general population and multiple barriers to accessing health care that meets their needs. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability ('The DRC') found that 'people with cognitive disability have been and continue to be subject to systemic neglect in the Australian health system'.[1] The DRC mentions 'witnesses proposed further education and training for health professionals to address the problems identified around communication and

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preconceptions about people with cognitive disability*[1]'. The DRC also made a specific recommendation, number 6.27, regarding how accreditation authorities should 'review and amend accreditation standards to address whether cognitive disability health is sufficiently covered. If it is not, they should amend their accreditation standards.[1]'

In this submission, we provide evidence of the poor health and mental health outcomes people with intellectual disability face in Australia and we make seven recommendations for how to integrate intellectual disability health content and capabilities in training standards for psychology professionals, drawing on evidence-based resources that have already been developed.

To prevent further harm to a population group that has experienced significant systemic neglect in the health care settings, we encourage The Australian Psychology Accreditation Council (APAC) to consider our recommendations in the Australian 2025 Alignment Accreditation Standards Review.

Background

In comparison to the general population, health outcomes for people with intellectual disability are characterised by:

- Premature mortality occurring 27 years earlier[2].
- More than double the proportion of potentially avoidable deaths[2].
- Four times the rate of potentially preventable hospitalisations[3].

Mental health disparities have also been well documented, including:

- The near-ubiquitous rates of mental health conditions in people with intellectual disability (76%), which is twice the rate experienced by the general population (38%)[4]
  - Across a wide range of conditions; anxiety disorders, depression, psychotic illness, substance use disorders and personality disorders.[4]
- Significantly higher rates of neurodevelopmental conditions, including autism and ADHD, highlighting the complexity and intersectional needs of this cohort.
- Mental health costs being grossly inflated, with the 1.1% of people in NSW with intellectual disability accounting for 14% of inpatient mental health expenditure in a given financial year.[5]

* We note that the DRC uses the term 'cognitive disability', which is an umbrella term to describe a number of disabilities that may be temporary or permanent. In contrast, throughout this submission we use the term intellectual disability to describe a lifelong condition, which affects a person's intellectual skills, memory, communication and behaviour in different situations.[11]

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Compared to people in the general population, health service interactions for people with intellectual disability are:

- Over-represented, with hospitalisations and emergency presentation rates being twice as high.[6]
- Costly, with:
  - Admissions being on average twice as long and twice as expensive.[6]
- Inefficient:
  - With higher rates of representation to emergency departments and inpatient units following discharge from mental health facilities, even for first-ever admission.[7]
  - Even with a clear clinical pathway for epilepsy and seizure admissions, there are significant disparities. Age-standardised admission rates per 100,000 people are 21 times higher, with longer admissions and higher readmission rates within 30 days.[8]

We propose that the 2025 Australian Psychology Standards Review is an opportunity for the Australian Psychology Accreditation Council to address these inequities in the mental health care and support of people with intellectual disability in Australia.

Integration with the Intellectual Disability Health Capability Framework

The Australian Government Department of Health and Aged Care (DoHAC) has, together with sector stakeholders, developed a National Roadmap for Improving the Health of Intellectual Disability ('The Roadmap') released in 2021. The Roadmap is a comprehensive plan with many goals to address the issues preventing people with intellectual disability from the highest standard of health care. The Government and its sector stakeholders, including us at the Centre, are committed to its implementation. One of the priorities of the Roadmap is Curriculum Development in Intellectual Disability Health. As part of this work, the Intellectual Disability Health Capability Framework ('The Framework') was developed.

Curriculum development in intellectual disability health is necessary to:

- Upskill students' knowledge and skills in intellectual disability health, co-occurring health conditions, effective and inclusive communication and identifying trauma among people with intellectual disability.
- Support students to build positive, human rights based, respectful and reflective attitudes towards people with intellectual disability and their families and carers and,

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- Improve the quality of care provided to people with intellectual disability by building the capacity of future and current health professionals to make reasonable adjustments for people with intellectual disability.[9]

The Framework sets out clear capabilities, learning outcomes and guides for universities and accreditation authorities to improve education and training for health students. The Framework's six Capability areas include:

a) Intellectual Disability Awareness
b) Communication
c) Quality Evidence-Informed Health Care
d) Coordination and Collaboration
e) Decision-Making and Consent
f) Responsible, Safe and Ethical Practice.[10]

Additional mapping work was completed by the Framework team across multiple disciplines with the view to identifying where overlaps and crossovers may occur between the Framework and accreditation standards to promote implementation of the Framework across disciplines. The 'Accreditation Standards mapping – Psychology report' (2023) is included at Appendix A and outlines the conceptual overlap between the Standards and the Framework. These overlaps are the common areas where the Standards could integrate intellectual disability health best practice content under already existing domains. The areas in the Standards with the most conceptual overlap are as follows:

- Across all stages of study in the competencies;
  - Appropriate assessment
  - Intersectionality of care
  - Best practice approaches to management.
- Across the specialist areas of practice programs;
  - Appropriate assessment
  - Best practice approaches to management
  - Intersectionality of care

The Report also highlights gaps in areas such as communication, dignity and respect, structure and function of the disability support system and its workers, supported decision-making, and safeguards against exploitation, violence, abuse and neglect and are areas we recommend are included in the proposed Standards.

We make the following seven recommendations for the APAC to consider in the development of the Standards.

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Recommendations

1. Acknowledge, endorse and promote the Intellectual Disability Health Capability Framework as good practice in the standards or guidance notes. The Framework's six Capability areas could be built into the Accreditation Standards by reviewing the report at Appendix A 'Accreditation Standards mapping – Psychology report' (2023) and table at Appendix B 'Accreditation Standards – Suggested Amendments.'

   There are presently no references to intellectual disability in the Standards. There are references to related concepts including mention of 'learning difficulties and other developmental problems, developmental difficulties, disability in sport, and diversity'.

   The Framework outlines the importance of intersectionality of care within the Capability area of Intellectual Disability Awareness. It details that health professionals can '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.[10]' The Standards require review with a diverse and intersectional lens. The inclusion of priority populations like people with intellectual disability and Aboriginal and Torres Strait Islander people can be woven into the fabric of all of the standards, as opposed to being a separate addition. APAC could amend the Standards to specify 'people with intellectual disability' when diverse groups are referenced, as has been done with Aboriginal and Torres Strait Islander peoples, and rightfully so. Where the Standards note the Australian Indigenous Psychology Education Project and endorse "its recently developed frameworks" (p. 4), similar acknowledgement could be provided endorsing the Intellectual Disability Health Capability Framework.

   Implementing the six Framework Capability areas within the Standards has the capacity to:
   - Drive inclusion of content in pre-registration education curricula.
   - Equip psychology students with the right knowledge, skills and attitudes to provide better care and personalised support for people with intellectual disability.
   - Lead to improvements in the quality of mental health care for people with intellectual disability.[10]

2. Developing a new standard to align with new Professional Competencies for Psychologists #7, 'Demonstrating a health equity and human rights approach when working with people with diverse groups' and in particular, Competency 7.9.

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The new Professional Competency for Psychologists 7.9, which will be effective as of 1 December 2025, is a new competency which calls for psychologists to:

- Understand neurodiversity, strengths-based, trauma-informed and positive approaches to supporting people with developmental disability.
- Demonstrate the ability to adapt psychological practice and make reasonable adjustments for people with disability, including understanding of alternative and augmentative communication.[12]

A new standard should be developed in the Standards to not only align the Standards with the Framework (as discussed in Recommendation 1 above) but serve to also build alignment with Professional Competency for Psychologists #7 and 7.9 specifically. This will help build consistency in the sector and help improve the mental health care for people with intellectual disability. See new standard suggested and proposed number 3.10 at Appendix b 'Accreditation Standards – Suggested Amendments.'

3. Develop a new standard that articulates how students will receive exposure to the population groups they serve, for example people with intellectual disability. It is recommended that co-design and co-delivery of education with diverse people with intellectual disability is included in the Standards.

   It is key that students receive exposure to people with intellectual disability as part of their training if we are to improve equity in mental health outcomes for this population group. This aligns with the Framework (as mentioned above) and the National Roadmap to Improve the Health and Mental Health of Autistic People (NRIHMAP).

   The Australian Government released the NRIHMAP on 25 February 2025. The Roadmap aims to address the breadth of issues faced by Autistic people in the Australian healthcare system. It outlines the path to improve the physical and mental health of Australia's growing Autistic population. A guiding principle in the NRIHMAP is 'ensure that Autistic people are included and considered in the design and delivery of health and mental health services that affect them, including through co-design and co-production.'[13] We note that both the Framework and NRIHMAP emphasise the importance of co-design and co-delivery of education which are currently absent from the Standards.

4. Develop a new standard to support psychology students who have a lived experience of intellectual disability.

   Human rights of people with disability are highlighted in the Framework, within the Capability area of Intellectual Disability Awareness[10]. APAC could introduce a new

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standard to include students with intellectual disability. People with intellectual disabilities have a 'human right to participate fully in society, including access to education and training.' This right is protected in international agreements like the United Nations Convention on the Rights of Persons with Disabilities[14] and national legislation such as the Disability Discrimination Act 1992 within Division 22 Education[15].

5. Amendments to encourage person-centred and supportive quality care.

   APAC could make amendments to encourage person-centred and supportive quality care. The Framework encourages person-centred care under both the Capability areas of 'Intellectual Disability Awareness' and 'Quality Evidence-Informed Health Care'.[10]

   Person-centred language in the Accreditation Standards could encourage:
   a) Attention to the person's unique needs and preferences.
   b) Focus on the many contributing factors that impact a person's health.
   c) Collaboration with the person in choosing their own goals, type of treatment and measurement of progress.[16]

6. Amendments to reflect strengths-based language.

   Strength-based language in psychology is important because it prioritises a person's capabilities, power, talents, resources, family, networks, community connections, optimism and independence when facing hardship.[17] Strengths-based approaches foster 'empowerment, healing and self-determination, which are seen as central to Aboriginal and Torres Strait Islander conceptions of health and wellbeing'.[17] Specific incidences where the language in the Standards can be flipped to strengths-based can be found in Appendix B.

7. Additionally, we make recommendations on specific criteria amendments where APAC can further add content to ensure that providing safe and quality mental health care to people with intellectual disability is considered a priority in the Standards.

   These can be found in the table below at Appendix B: 'Accreditation Standards – Suggested Amendments'.

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Australian Government
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Appendix A.

Implementation of the Intellectual Disability Health Capability Framework

Accreditation standards mapping - Psychology

Contents

Authors

This report was prepared by the Framework resource development team at UNSW Sydney, with the following members contributing to the mapping and report:

- Dr Janelle Weise - Senior Research Fellow, Department of Developmental Disability Neuropsychiatry
- Dr Jenna Zhao - Project Officer, Department of Developmental Disability Neuropsychiatry
- Claire Eagleson - Project Officer, Department of Developmental Disability Neuropsychiatry
- Dr Seeta Durvasula - Senior Research Fellow, Department of Developmental Disability Neuropsychiatry
- Marianne Gibney-Quinteros - Project Officer, Department of Developmental Disability Neuropsychiatry

Date of report: 27 October 2023

Aim of this report

This report outlines findings from a mapping exercise comparing the **Australian Psychology Accreditation Council Accreditation Standards for Psychology Programs** (1 January 2019) to the Intellectual Disability Health Core Capabilities (the Capabilities; see Appendix 1 for a list). This exercise will help to inform the next steps of this project which includes strategic engagement with the accreditation sector around integration of the Intellectual Disability Health Capability Framework (the Framework) within accreditation standards and the development of a guidance plan.

Key points

- We mapped the i) Foundational competencies, ii) Pre-professional competencies, iii) Professional competencies (Practice placements) and iv) Professional competencies for specialised areas of practice
- There are no references to intellectual disability in the Accreditation Standards. There are references to related concepts including mentions of learning difficulties and other developmental problems, developmental difficulties, disability in sport, and diversity.
- Across all stages of study, there is most conceptual overlap between the competencies and Capabilities in the areas of appropriate assessment, intersectionality of care, and best practice approaches to management. Conceptual overlap identifies common areas of conceptual overlap where intellectual disability content could potentially be integrated.
- Across the specialist areas of practice programs, there is most conceptual overlap in the areas of appropriate assessment, best practice approaches to management, and intersectionality of care. Gaps were identified in areas such as communication, dignity and respect, structure and function of the disability support system and its workers, supported decision-making, and safeguards against exploitation, violence, abuse and neglect.

Background

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[1]
- experience double the percentage of deaths from potentially avoidable causes[1]
- experience a higher prevalence of physical conditions, including epilepsy, sensory impairments, diabetes, dental disease and osteoporosis[2,3-7], and mental health conditions such as depression and anxiety[8-10].

Along with a high prevalence of mental health conditions, people with intellectual disability have higher rates of behaviours of concern (such as aggression, self-harm, and socially inappropriate behaviours); reported prevalence rates vary from e.g., 18.1%[11] to 45%[12]. It is

also well recognised that this population experience high levels of trauma, abuse and neglect, as highlighted in the recent report of the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*[13]. One meta-analysis found the prevalence of sexual abuse for people with intellectual disability was 32.9%[14]. Thus, people with intellectual disability have considerable need for psychological assessment, cognitive assessments, and therapy.

The high morbidity within this population has contributed to high health service use[1, 15-16]. Analysis of linked data has found that mental health admissions are twice as long and cost twice as much for people with intellectual disability compared to the general population[17].

People with intellectual disability often experience significant barriers to quality health care including:

- 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' insufficient skills and knowledge about the health needs of people with intellectual disability[18,21-23], and
- stigmatising attitudes[24].

In response, the Department of Health and Aged Care (the Department) is leading the Intellectual Disability Health Curriculum Development Project, a short-term action under the *National Roadmap for Improving the Health of People with Intellectual Disability*. A key component of the project is the development of an Intellectual Disability Health Capability Framework in collaboration with people with intellectual disability, their families, carers and support workers, accreditation authorities, universities, health professionals and academic experts.

The Framework sets out clear core capabilities and learning outcomes regarding health care for people with intellectual disability. The Framework also includes implementation guidelines, tools, and resources to support:

- Accreditation authorities to integrate the Framework within health professional accreditation standards, and
- universities to integrate intellectual disability health care principles into their current pre-registration education curricula.

The need for such a Framework is reinforced by findings from the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* which found people with cognitive disability (including people with intellectual disability) are subject to systemic neglect in the Australian Health System. The Commission identified education and training for health professionals and the review and amendment of accreditation standards to ensure that cognitive disability health is sufficiently covered to address these barriers[13].

The ultimate aim is to prepare graduates with the required capabilities to provide the highest quality care to people with intellectual disability throughout their future health professional careers.

Implementation of the Framework

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

The Framework is due for release in early 2024. The next stage of the project aims to support accreditation authorities and education providers to implement the Framework. The Department engaged UNSW Sydney to undertake mapping of accreditation standards to the Capabilities and the curation and development of intellectual disability health resources to support the integration of the Framework.

Mapping standards to core capabilities

Purpose of this mapping exercise

The purpose of this mapping exercise was to identify areas the accreditation standards currently map onto the Capabilities. This can help accreditation authorities and education providers to gain a better understanding of i) areas they currently include content, ii) areas of conceptual overlap where intellectual disability content could potentially be integrated into existing accreditation standards and/or curriculum content, and iii) where new content may need to be added to ensure that key capabilities are covered.

Methodology

A review of relevant grey literature and consultation with accreditation authority representatives was conducted to identify best practice mapping techniques. The mapping template was piloted with the Australian Medical Council.

The mapping process:

i) identified any mentions of intellectual disability; developmental disability; disability; cognitive disability or impairment, groups with diverse needs or similar; human rights; or equity throughout the standards
ii) mapped conceptual areas in common across the accreditation standards and Capabilities (where intellectual disability content could potentially be integrated),
iii) identified gaps where there was no mention of capability concepts, and
iv) identified where ‘intellectual disability’ could be included in other sections of the standards document or has potential relevance (e.g. when specifying groups with health inequities, mentioning groups to consult or co-design content with, or mentions of simulation activities or experiential learning).

We mapped the following sections of the **Australian Psychology Accreditation Council Accreditation Standards for Psychology Programs** (1 January 2019):

1. Foundational competencies
2. Pre-professional competencies
3. Professional competencies (Practice placements)
4. Professional competencies for specialised areas of practice

To note, the foundational and pre-professional stages do not lead directly to registration as a psychologist without attaining the professional competencies.

Findings

Please see a copy of the accompanying full mapping template (available from IntellectualDisability@Health.gov.au**).**

Specific mentions

There are no specific mentions of intellectual disability in the Accreditation Standards. There are mentions of learning difficulties and other developmental problems, developmental difficulties, disability in sport, 'diversity of clients', diversity, and individuals vulnerable to involvement in legal proceedings.

Conceptual overlap

Over all the stages of study, the main areas of conceptual overlap are between the competencies and the following Capabilities (in descending order).

1. 3.6 Appropriate assessment
2. 1.9 Intersectionality of care
3. 3.10 Best practice approaches to management for people with intellectual disability
4. 1.4 Causes of intellectual disability, co-occurring conditions and variability across individuals
5. 3.2 Evidence-informed practice
6. 3.13 Lifespan approach to health care
7. 3.7 Diagnostic overshadowing and other reasons for misdiagnosis
8. 4.4 Collaborate with other professionals
9. 3.11 Responsible management of medications
10. 6.4 Legislation and other frameworks

For the **Foundational stage**, the main conceptual overlap is between the competencies and Capabilities in the areas of evidence-informed practice, causes of intellectual disability, co-occurring conditions and variability across individuals, and intersectionality of care. Thirteen Capabilities mapped to content in the competencies (out of 46).

There is little overlap for the **Pre-professional stage** given this year predominantly involves an Honours project. Six Capabilities mapped to content in the competencies.

For the **Professional competencies (Practice placements)**, the main areas of conceptual overlap are appropriate assessment, evidence-informed practice and intersectionality of care. Fifteen Capabilities mapped to content in the competencies.

For the **Specialist areas of practice**, there is greatest conceptual overlap between the competencies and Capabilities for the clinical psychology, counselling psychology, educational and developmental psychology, and clinical neuropsychology programs. The

number of Capabilities that mapped to competencies content ranged from 18 Capabilities (clinical psychology) to eight Capabilities (sport and exercise psychology). Across the specialist programs, there is most conceptual overlap in the areas of appropriate assessment, best practice approaches to management, and intersectionality of care. Gaps were identified in areas such as communication, dignity and respect, structure and function of the disability support system and its workers, supported decision-making, capacity to consent, and safeguards against exploitation, violence, abuse and neglect.

Please see a copy of the accompanying full mapping template for more details (available from IntellectualDisability@Health.gov.au).

It is recognised that some topics and practice areas not specified in accreditation or professional standards will still be part of program curricula.

Other sections of the standards with potential relevance to intellectual disability

There is potential relevance for people with intellectual disability in Academic governance and quality assurance Standard 2 statement, *Academic governance and quality assurance processes are effective*, regarding relevant external input into the design and management of programs. People with intellectual disability have a key role to play in the design, development, and delivery of program content.

Next steps

The next stage of this project involves strategic engagement with the accreditation sector to identify key barriers and facilitators related to integration of the Framework. This includes an online survey and focus groups. We will use information gathered to identify practical solutions to integrate the Framework and develop a guidance plan that addresses concerns raised by the sector, defines the benefits of integrating or linking the Framework in accreditation standards, and includes examples of implementable steps for accreditation authorities.

Work is also underway to curate a list of existing educational and teaching resources that can support education providers and students to develop knowledge and skills in intellectual disability health. We will undertake strategic engagement with the pre-registration education sector to identify priority resources that need to be developed to support integration of the Framework.

Contact

If you have any questions or feedback, please contact IntellectualDisability@Health.gov.au.

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Appendix 1: Intellectual Disability Health Capabilities

Core capability areas

The core capabilities are divided into six broad capability areas, which are presented below along with a description of each capability area.

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

Intellectual Disability Awareness

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

Capability	Description
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 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.

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
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.

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
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.

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
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.

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
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.

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
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 B. Accreditation Standards – Suggested Amendments

#	Proposed criteria	Suggested criteria amendment	Rationale for changes
1.5	Where students provide psychological services to clients and organisations, clients' informed consent is obtained prior to provision of the service.	Where students provide psychological services to clients and organisations, clients' informed consent is obtained prior to provision of the service. "Informed consent for people with intellectual disability involves using inclusive communication, duty of care, dignity of risk, supported decision-making, reasonable adjustments and trauma informed principles."	Inclusion of people with intellectual disability and important safety principles.
New 3.10	*No proposed criteria. We are suggesting this as a new Standard. We suggest this can be integrated as 3.10.*	"Neurodiversity and disability awareness, including adapting psychological practice for people with intellectual disability, is appropriately integrated within the program and clearly articulated as a required learning outcome, with education content co-designed and ideally co-delivered with people with lived experience."	Inclusion of people with intellectual disability.
New 6.4	The program provider ensures students are provided with access to appropriate resources and to staff with specialist knowledge, expertise and cultural capabilities, to facilitate learning about Aboriginal and Torres Strait Islander health and wellbeing.	The program provider ensures students are provided with access to appropriate resources and to staff with specialist knowledge, expertise and cultural capabilities, to facilitate learning about Aboriginal and Torres Strait Islander health and wellbeing, "including Aboriginal and Torres Strait Islander people with intellectual disability."	Inclusion of Aboriginal and Torres Strait Islander people with intellectual disability.
New 4.8	*No proposed criteria. We are suggesting this as a new*	"Students with intellectual disability who are studying psychology, should be provided individualised support and reasonable adjustments."	New standard to include students with intellectual disability.

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#	Proposed criteria	Suggested criteria amendment	Rationale for changes
	Standard. We suggest this can be integrated as 4.8.		

Foundational competencies

#	Proposed criteria	Suggested criteria amendment	Rationale for changes
1.1 ix.	Lifespan developmental psychology.	Lifespan developmental psychology "including intellectual disability, developmental disability and neurodiversity."	Inclusion of people with intellectual disability.

Pre-Professional competencies

#	Proposed criteria	Suggested criteria amendment	Rationale for changes
2.2	Demonstrate appropriate interpersonal communication and interview skills in situations appropriate to psychological practice and research. This includes active listening, clarifying and reflecting, effective questioning, summarising and paraphrasing, developing rapport, appropriate cultural responsiveness and empathic responding.	Demonstrate appropriate interpersonal communication and interview skills in situations appropriate to psychological practice and research. This includes active listening, clarifying and reflecting, effective questioning, summarising and paraphrasing, developing rapport, appropriate cultural responsiveness, empathic responding, "the teach back method, and adapting communication as needed for people with intellectual disability or cognitive disability or who use alternative or augmentative communication."	Inclusion of people with intellectual disability.

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#	Proposed criteria	Suggested criteria amendment	Rationale for changes

Professional competencies

#	Proposed criteria	Suggested criteria amendment	Rationale for changes
3.2	Apply evidence-based and scientific methods to professional practice across the lifespan in empirically valid and culturally responsive ways.	Apply evidence-based and scientific methods to professional practice across the lifespan in empirically valid, culturally responsive ways and "adapted to a client's cognitive capacity as needed"/ "adapted to a person's support needs using reasonable adjustments."	Encouragement of person-centred and supportive quality care.
3.3	Employ professional communication skills, in a culturally responsive manner, with a range of socially and culturally diverse clients.	Employ professional communication skills, "adapt to the client's cognitive capacity as needed" / "adapt to the person's support needs using reasonable adjustments," in a culturally responsive manner, with a range of socially and culturally diverse clients.	Encouragement of person-centred and supportive quality care.
3.4	Perform appropriate standardised psychological testing, as part of broader assessment, to assess and interpret aspects of functioning.	Perform appropriate standardised psychological testing, as part of broader assessment, to assess and interpret aspects of functioning "or support needs."	Encouragement of person-centred and supportive quality care.
3.6	Conduct professional interviews and assessments and synthesise information from multiple sources, including assessment of risk, to formulate a conceptualisation of the	Conduct professional interviews and assessments and synthesise information from multiple sources, including assessment of risk, to formulate a conceptualisation of the presenting issues to determine the most appropriate interventions, including management of risk "while utilising supported decision-making principles and adapting to	Encouragement of person-centred and supportive quality care.

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#	Proposed criteria	Suggested criteria amendment	Rationale for changes
	presenting issues to determine the most appropriate interventions, including management of risk.	a client's cognitive capacity as needed / adapting to the person's support needs using reasonable adjustments."	
New 3.25	Communicate the psychologist's role and purpose.	Communicate the psychologist's role and purpose "clearly and adapt to a client's cognitive capacity as needed / adapt to a person's support needs using reasonable adjustments."	Encouragement of person-centred and supportive quality care.

Professional competencies for specialised areas of practice

#	Proposed criteria	Suggested criteria amendment	Rationale for changes
4.1 - 4.9.3	Across all competencies.	"adapted to the client's cognitive capacity or intellectual disability/ adapted to a person's support needs using reasonable adjustments" is added as applicable.	Encouragement of person-centred and supportive quality care.
4.2.3 i	Selection, tailoring and implementation of appropriate evidence-based interventions on the basis of an initial case formulation, whether individuals, dyads or carers/dependents.	Selection, tailoring "adapting to a client's cognitive capacity as needed"/ "adapting to a person's support needs using reasonable adjustments" and implementation of appropriate evidence-based interventions on the basis of an initial case formulation, whether individuals, dyads or carers/dependents.	Encouragement of person-centred and supportive quality care.
4.2.3 ii.	Monitoring of outcomes and modifications based on evolving case formulation and intra- and interpersonal processes, with	Monitoring of outcomes and modifications based on evolving case formulation and intra- and interpersonal processes, with care given to the appropriateness of interventions for the client or clients within their wider context and "adapting to a client's cognitive capacity as	Encouragement of person-centred and supportive quality care.

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#	Proposed criteria	Suggested criteria amendment	Rationale for changes
	care given to the appropriateness of interventions for the client or clients within their wider context.	needed"/ "adapting to a person's support needs using reasonable adjustments."	
4.2.3 iv.	Evidence-based practice in the understanding and management of psychological disorders, including across the age range and across modalities such as e-health approaches.	Evidence-based practice in the understanding and management of psychological disorders, including across the age range, "cognitive capacity, support needs, reasonable adjustments" and across modalities such as e-health approaches.	Encouragement of person-centred and supportive quality care.
4.5.1. ii.	Principles and models for the learning process, how to identify barriers to learning and means of addressing "impediments."	Principles and models for the learning process, how to identify barriers to learning and means of addressing "barriers."	Strengths-based language
4.5.3. i.	Design and management of programs for individuals with learning difficulties and other developmental problems, including setting goals, monitoring progress and	Design and management of programs for "individuals with intellectual; learning or developmental disability or other developmental differences," including setting goals, monitoring progress and making evidence-based recommendations.	Strengths-based language

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#	Proposed criteria	Suggested criteria amendment	Rationale for changes
	making evidence- based recommendations.		
4.5.3 iii.	Development and implementation of behavioural interventions appropriate for those with behavioural and emotional problems, including setting goals and monitoring progress.	Development and implementation of “positive behaviour supports” appropriate for those with behavioural and “emotional differences”, including setting goals and monitoring progress.	Strengths-based language

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