National Centre of Excellence in Intellectual Disability Health

Accreditation Manager
The Optometry Council of Australia and New Zealand (OCANZ)
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Sent via email: accreditation.manager@ocanz.org

30 October 2026

Dear Optometry Council of Australia and New Zealand,

Consultation on the 2026 Proposed Revised OCANZ Accreditation Standards and Evidence Guide for Entry-Level Optometry Programs

We write on behalf of the National Centre of Excellence in Intellectual Disability Health to provide input on the proposed draft OCANZ Accreditation Standards. Our submission focuses on one significant gap: the draft Standards do not ensure that optometry graduates are prepared to provide safe, quality eye care for people with intellectual disability.

In our submission below we provide evidence on the health inequities faced by people with intellectual disability in Australia, and we make recommendations about integrating intellectual disability health capabilities into the OCANZ Accreditation Standards and Evidence Guide for Entry-Level Optometry Programs to promote better health outcomes and quality of care for people with intellectual disability. We draw on evidence-based resources that have already been developed.

The Centre would be pleased to support OCANZ and optometry education providers to implement these recommendations, including through resources

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that support the Intellectual Disability Health Capability Framework and assistance with curriculum mapping.

We trust you will find this submission useful in the development of the revised OCANZ Accreditation Standards. 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 Julian Trollor at J.Trollor@unsw.edu.au or Jenna Zhao at jenna.zhao@unsw.edu.au or +61 2 90651742.

Sincerely,



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

The Centre is also supported by a network of 58 partner and collaborator organisations across the health and disability sectors. The vision of the Centre is to ensure that the 560,000 people with intellectual disability in Australia receive the highest attainable level of health care.

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National Centre of Excellence in Intellectual Disability Health

Executive summary

People with intellectual disability are a population group that experiences some of the most substantial health disadvantages of any group in Australia. This health gap has been framed as 'systemic neglect' by the Disability Royal Commission. At least 40% of people with intellectual disability have visual impairment, much of it undetected and readily treatable. Standard eye examinations rely heavily on verbal communication and cooperation, requiring optometrists to have specific skills and make reasonable adjustments to care for people with intellectual disability. Relevant content is limited in current university curricula and is not explicitly or comprehensively addressed within the OCANZ accreditation standards, limiting its formal emphasis in optometry education. The Disability Royal Commission, in Recommendation 6.27, calls on accreditation authorities to address cognitive disability in their accreditation standards.*

OCANZ's draft Standards refer to cognitive disability only once, in guidance that is not formally part of the Standards. Intellectual disability is not mentioned at all. Our strong experience is that general commitments to person-centred care and diversity will not change what students learn unless intellectual disability is named explicitly.

We make ten recommendations, with wording OCANZ can adopt directly. Our four priority recommendations are to:

1. name intellectual disability and other cognitive disability in Criterion 1.1
2. require clinical training to include people with intellectual disability
3. reference the Intellectual Disability Health Capability Framework and include curriculum mapping against it as evidence

* We note that the Disability Royal Commission uses the term 'cognitive disability', an umbrella term that includes intellectual disability, as well as a number of other disabilities that may be temporary or permanent. 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.

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4. add guidance on supported decision-making, consent and reasonable adjustments to Standard 1.

Recommendations 5 to 10 cover involving people with intellectual disability in program design, assessment, supervisor skills, Glossary definitions, the entry-level competency standards, and reporting on Recommendation 6.27.

As the Intellectual Disability Health Capability Framework already provides the capabilities and mapping tools, these changes add little regulatory burden. We would be pleased to support their implementation.

Why the standards should include a substantial focus on people with intellectual disability

We emphasise these sources:

- The research evidence on health inequalities experienced by people with intellectual disability.
- Findings of the Australian Commission on Safety and Quality in Health Care (ACSQHC).
- Findings and recommendations of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.
- Anti-Racism and Discrimination Prevention in Health Practitioner Education and Assessment – Commitment Statement of the Health Professions Accreditation Collaborative (HPAC) Forum

<u>The research evidence</u>

The approximately 560,000 people with intellectual disability in Australia face glaring health inequalities. For example, compared to the general population, people with intellectual disability:

- have a life expectancy that is, on average, 27 years less than the general population[1]

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- experience double the percentage of deaths from potentially avoidable causes[1]
- experience a higher prevalence of physical conditions, including visual and hearing impairments, epilepsy, diabetes, dental disease and osteoporosis, and mental health conditions[2].

Eye and vision problems are among the most common health conditions affecting people with intellectual disability[2]. UK estimates suggest adults with intellectual disability are ten times more likely than the general population to be blind or partially sighted[3], and visual impairment has been estimated to affect at least 40% of people with intellectual disability, rising to almost all people with severe or profound intellectual disability[4]. Importantly, correctable refractive error accounts for a significant proportion of these eye and vision problems, which can directly be addressed by optometrists. A Dutch study that screened 1,539 adults with intellectual disability found that 60.6% had refractive errors, followed by 44.1% with strabismus and 18.1% with lens opacities, with keratoconus and lens opacities strongly associated with Down syndrome[5]. Yet, much of this goes undetected. 40.6% of adults with intellectual disability who were found to be visually impaired had not previously been diagnosed[6].

Despite these inequalities, entry-to-practice health curriculums include minimal focus on the health needs of this group. In Australian medical schools, there is only a median of 2.55 hours of compulsory intellectual disability content[7], and more than half of nursing schools offer no intellectual disability content at all[8]. We are not aware of any equivalent audit of Australian optometry curricula. While some universities have begun to recognise the need to prepare graduates to provide inclusive eye examinations, coverage is likely to vary between programs. Neither the current nor proposed OCANZ Accreditation Standards require programs to teach about intellectual disability. Explicitly addressing intellectual disability in the OCANZ accreditation standards would set consistent expectations for all optometry programs and better prepare the future optometry workforce to meet the eye care needs of this under-served population.

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People with intellectual disability face several barriers to inclusion in mainstream healthcare services. Surveys of health professionals suggest a lack of confidence and skills in working with people with intellectual disability. A systematic review found evidence of stigmatising attitudes towards people with intellectual disability among mainstream health professionals[9].

For optometrists, confidence in working with people with intellectual disability is strongly related to how many patients from this population group they have seen[10,11]. However, a 2025 survey of 198 optometrists and ophthalmologists (most of whom were from Australia) found that only 14% had received formal training in autism[11], which can often co-occur with intellectual disability.

Training that includes supervised clinical contact with people with intellectual disability improves the knowledge, confidence and attitudes of optometrists and optometry students more than lectures alone[10]. Implementing formal clinical placements with patients with intellectual disability could therefore be an important step towards addressing these challenges.

ACSQHC User guide for the Health Care of People with Intellectual Disability

The ACSQHC User guide for the Health Care of People with Intellectual Disability (the ID User Guide)[12] identifies (at page 7):

- Barriers to appropriate healthcare for people with intellectual disability include direct and indirect discrimination and negative attitudes leading to misdiagnosis or delayed diagnosis, with the person's symptoms being attributed to their intellectual disability, and in turn leading to preventable hospitalisations, chronic disease and early mortality.
- Common "cognitive biases towards people with intellectual disability include assumptions about a person's quality of life, their ability to gain new skills and their capacity to participate in health care planning. Cognitive bias may

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> influence decisions about providing proactive treatment, rehabilitation, preventative health care and end-of-life care."

We acknowledge and in no way downplay the disadvantage experienced by people with other disabilities. However, as the ACSQHC User Guide states, people with intellectual disability have poorer health outcomes compared to people with other disabilities (Page 6 of User Guide)[12].

The Disability Royal Commission

Based predominantly on research, clinical and lived experience evidence in relation to people with intellectual disability, the Disability Royal Commission found that 'people with cognitive disability have been and continue to be subject to systemic neglect in the Australian health system'[13].

The Royal Commission made numerous recommendations to address this situation including Recommendation 6.27[14]:

> **Recommendation 6.27 Establish regular progress reporting by accreditation authorities**
>
> Accreditation authorities for registered health professions and the peak professional bodies for non-registered health professions should:
>
> a) review and amend accreditation standards and evidence requirements where necessary to address whether cognitive disability health is sufficiently covered. If it is not, they should amend their accreditation standards or evidence requirements (as the case may be) accordingly
>
> b) encourage or mandate education providers to develop specific cognitive disability health curriculum content and deliver such content using inclusive teaching practices, involving people with cognitive disability where possible

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c) report annually to the Australian Government Department of Health and Aged Care on their progress in implementing this recommendation. Where accreditation authorities have only recently undertaken their five-yearly review, annual reporting should include progress on implementation planning to address this recommendation pending the next scheduled review.

The Royal Commission's report on Public Hearing 10 also focused specifically on the education and training of health professionals in relation to people with cognitive disability. OCANZ itself identifies this report as informing the current review. The Royal Commission found that health professional education lacked consistent curricula and specific requirements for teaching safe, high-quality care for people with cognitive disability, and that clinical placements did not consistently prepare students to provide this care[15]. Accreditation standards are the mechanism that can address this, and the current review is OCANZ's opportunity to act.

Commitment Statement of the Health Professions Accreditation Collaborative (HPAC) Forum

OCANZ is a member of the HPAC Forum. The Forum's *Commitment Statement on Anti-Racism and Discrimination Prevention in Health Practitioner Education and Assessment* states[16]:

> As stewards of accreditation and assessment for Australia's regulated health professions, HPAC Forum members play a critical upstream role in shaping the capability, behaviour, and values of the future health workforce. This responsibility extends beyond clinical competence. It includes embedding cultural safety, ethical practice, and inclusive care as core professional expectations. HPAC Forum accreditation authorities have undertaken significant work to embed Aboriginal and Torres Strait

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Islander cultural safety within accreditation standards, graduate capabilities and assessment processes…

HPAC Forum accreditation authorities recognise that anti-racism and discrimination prevention extends beyond Aboriginal and Torres Strait Islander cultural safety. HPAC Forum members are working individually and collectively to strengthen a sector-wide approach to anti-racism and discrimination prevention. This includes addressing bias, supporting respectful learning environments, and strengthening expectations relating to ethical practice and inclusive communication for diverse and multicultural communities. Across all professions, accreditation authorities are already incorporating elements relevant to anti-racism and discrimination prevention within accreditation standards, graduate capabilities and assessment approaches.

Building on this foundation, HPAC Forum accreditation authorities collectively commit to strengthening approaches that support anti-racism and discrimination prevention across all regulated health professions.

HPAC Forum members commit to… promoting the development of graduate capabilities that support inclusive communication, critical reflection, recognition of bias, and the delivery of respectful and equitable care for diverse communities

Discrimination prevention for people with intellectual disability falls squarely within this commitment. The ACSQHC identifies direct and indirect discrimination, negative attitudes, cognitive bias and limited training in the healthcare needs of people with intellectual disability as key barriers in their care[12].

In view of these robust sources, we now look to you to include a substantial focus on people with intellectual disability in your updated accreditation standards.

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Key challenges for people with intellectual disability in accessing optometry services

Eye examinations rely heavily on verbal communication, on the person's ability to respond to subjective tests, and on their ability to sit at fixed equipment. Each of these can be difficult for people with intellectual disability. Without the right skills and adjustments, optometrists may be unable to complete an examination, may obtain unreliable results, or may wrongly conclude that vision problems are untreatable or unimportant[4]. In the Dutch screening study described previously, a reliable refraction could be obtained for only 56% of adults with intellectual disability[17]. This shows how important skills in objective assessment techniques are.

We submit that the Standards need to address challenges including:

- Impaired communication experienced by people with intellectual disability, the alternative communication methods they may use, and optometrists' need for skills in maximising communication[4,18].
- Taking an accurate history when the person may be unable to describe their symptoms and relies on carers or support workers, whose knowledge of the person's health may be incomplete and whose records may be fragmented[4].
- Adaptations to eye examination techniques to consider varying levels of impaired literacy and communication skills. For example, adjustments away from standard letter charts for the measurement of visual acuity, towards the use of shape-based visual acuity charts, matching cards and preferential looking[4,18].
- Challenges people with intellectual disability may face in understanding and cooperating with eye testing processes. These include subjective tests, automated perimetry, and procedures involving touch, eye drops or bright lights[4].
- Diagnostic overshadowing which refers to attributing changes in behaviour, function or skills to the person's intellectual disability rather

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than to a treatable vision problem. Behavioural indications that a person has impaired vision may be falsely assumed to instead be just part of their intellectual disability. A related misconception is that people with intellectual disability have low visual needs, so refraction, spectacles or referral are not worthwhile[4,12].

- The high prevalence of co-occurring conditions that affect the eyes and vision, together with the frequency of undetected visual impairment[5,6]. Examples include Down syndrome, which is associated with refractive error, strabismus, keratoconus and lens opacities[5,19], as well as cerebral palsy and cerebral visual impairment.
- Supporting decision-making and obtaining valid consent, including working with guardians and supporters while engaging the person directly to the fullest extent possible[4,18].
- Sensory sensitivities, anxiety and distress in unfamiliar clinical environments, which may be misread as "behaviours of concern"[4].
- Difficulty adapting to and tolerating spectacles, and lower rates of spectacle prescribing, particularly for people living in supported accommodation[4].
- Practical barriers, including the need for longer appointments, physical access, transport and out-of-pocket costs[4].

Optometrists may be able to minimise these challenges by:

- Making reasonable adjustments to their service models such as longer or double appointments, quieter appointment times, splitting the examination over several visits, pre-visit familiarisation with the practice, and home or outreach services where attending a practice is too difficult[18,20].
- Recognising and challenging their own assumptions about the person's visual needs, quality of life and capacity to benefit from treatment[12].
- Gathering information before the appointment (e.g., through a questionnaire about the person's communication, sensitivities and everyday vision), and by asking to see any health summaries or communication passports[4,18].

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- Communicating directly with the person rather than only with their carer. This includes using plain language, short questions, pictures, symbols or signs, explaining and showing each step before touching the person, and allowing time to respond[4,18].
- Adjusting to more objective assessment techniques that do not depend on literacy or detailed verbal responses. Examples include picture or symbol acuity tests, preferential looking tests, retinoscopy, and cycloplegia where appropriate[4,18].
- Supporting decision-making and consent in line with the person's capacity and applicable guardianship law[4,18].
- Providing results and recommendations in accessible formats, such as Easy Read, to the person and their supporters, and sharing them with the person's GP with consent. This includes practical advice on wearing and adapting to spectacles[18,20].
- Knowing when and how to refer, and working collaboratively with GPs, ophthalmologists, disability support workers and other health professionals[4].
- Seeking regular feedback from the person, their supporters and other professionals involved in their care, and reflecting on which approaches worked well and which did not, to continually improve their practice.

These adjustments are learnable skills that can be developed through teaching and supervised clinical contact with people with intellectual disability. Specialised services, such as the Australian College of Optometry's disability service, show that this care can be delivered in Australia[4]. However, specialised services cannot meet the needs of every person with intellectual disability, most of whom rely on mainstream optometry services. Entry-level programs therefore need explicit curriculum content and, wherever possible, supervised clinical experience with people with intellectual disability. This will happen consistently only if the Accreditation Standards and Evidence Guide specifically require it.

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The Intellectual Disability Health Capability Framework (the Framework)

The Framework is a practical guide for accreditation authorities (Ahpra and self-regulating professions) and tertiary institutions. It sets out the core capabilities required by health graduates with guidance on how to incorporate the capabilities into accreditation standards and entry-to-practice education[21].

With wide ranging inputs, we developed the Framework for the Australian Government's Department of Health, Disability and Ageing (then Department of Health and Aged Care). The Framework is a key output from the Australian Government's National Roadmap for Improving the Health of People with Intellectual Disability[22].

Review of the OCANZ Accreditation Standards and Evidence Guide for Entry- Level Optometry Programs

We welcome the opportunity to input to this review.

We welcome that cultural safety features heavily in the draft revised Standards both as a standard itself and as a consideration throughout the document.

We welcome that the Proposed Changes to the existing standards include "strengthening expectations in several areas, including:...

- Stronger emphasis on person-centred care, anti-racism and equity.
- Care for diverse populations, including people with cognitive disability...".

However, we do not yet see any significant provision in the proposed standards to address the needs of people with intellectual or other cognitive disability.

The only reference is in the Guidance for Standard 4, which states that clinical training "should address the delivery of care to a diverse range of patients, including those with specific healthcare needs. This may include people with physical and/or cognitive disabilities...". Under section 1.7 of the draft, guidance

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"is not formally part of the Standards", and "may include" sets no expectation. Intellectual disability is not explicitly mentioned anywhere in the draft Standards, Criteria, evidence lists or Glossary. This is despite the Public Consultation Document identifying care for people with cognitive disability, as informed by the Disability Royal Commission, as one of the "emergent matters" considered in this review.

Mention of intellectual disability is also absent from Optometry Australia's Entry-level Competency Standards for Optometry 2022[23], to which programs must map their learning outcomes.

Our recommended amendments to the proposed standards

General commitments to "safe person-centred care", "diversity" and "reduction in disparities in healthcare" are welcome. On their own, however, they are unlikely to change what optometry students learn about caring for people with intellectual disability. In an outcomes-based framework, education providers respond to what the Standards and Evidence Guide specifically name. Evidence from medicine and nursing shows that when intellectual disability is not explicitly included within accreditation standards, it is commonly overlooked in curriculum design[7,8].

Intellectual disability also needs to be named explicitly, rather than assumed under the "cognitive disability" umbrella, as clinicians and educators may not recognise intellectual disability as a specific area of need. We therefore recommend that the Standards and Guidance use the phrase "people with intellectual disability and other cognitive disability" or, at a minimum, "people with cognitive disability, including intellectual disability, acquired brain injury and dementia".

We recognise that OCANZ is unlikely to add a large volume of new material. Our recommendations are therefore targeted, work within the existing structure of the draft, and provide wording that can be adopted directly. Proposed new

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wording is shown in **bold**. Recommendations 1 to 4 are priority amendments that we consider essential. Recommendations 5 to 10 would further strengthen the Standards at little cost.

Priority amendments

Recommendation 1: Name intellectual disability in Criterion 1.1

Criterion 1.1 sets out the guiding principles of the program. We recommend:

> 1.1 Protection of the public; safe person-centred care, **including for people with intellectual disability and other cognitive disability**; culturally safe practice that is free of racism and discrimination and promotes anti-racism; and a commitment to diversity, inclusion and reduction in disparities in healthcare are prominent amongst the guiding principles of the educational program, its clinical education components and learning outcomes.

Recommendation 2: Require, wherever possible, clinical experience in caring for people with intellectual disability (Standard 4)

Supervised clinical contact is particularly effective in building students' skills and confidence in caring for people with intellectual disability[10,11]. We recommend amending Criterion 4.3:

> 4.3 The quality, quantity and diversity of clinical training are sufficient to produce a graduate competent to practice person-centred and culturally safe care across a range of settings and patient presentations, **including for people with intellectual disability and other cognitive disability**.

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We also recommend amending the Guidance for Standard 4 (Clinical training) as follows. This replaces "may include people with physical and/or cognitive disabilities":

> Clinical training should address the delivery of care to a diverse range of patients, including those with specific healthcare needs. This **should** include people with **intellectual disability and may include other groups such as people with other cognitive disability (such as acquired brain injury and dementia), people with** physical **and sensory** disabilities, marginalised members of the community, older people in aged care, children with special needs, those experiencing family or gendered violence, and people vulnerable to health disparities for other social and economic reasons. …**Education providers should ensure that students have meaningful contact with people with intellectual disability. This can occur through clinical placements (where possible), outreach to schools or disability services, or simulation with people with intellectual disability as standardised patients.**

Consistent with this, we recommend amending the evidence for Standard 4:

- Possible evidence: "Reporting on student experience of psycho-social and cultural diversity of patient presentations, **including people with intellectual disability and other cognitive disability,** (as an adjunct to the mandatory clinical data)".
- Required Documentary Evidence, item 8: "… the expected diversity of patient presentations, **including people with intellectual disability**, as outlined in the Table on page 17 and the corresponding evidence for same".

Many disability advocacy organisations suggest avoiding the use of the term "special needs". Though we acknowledge that terminology preferences differ between individuals, we suggest that the Guidance for Standard 4 revises "children with special needs" to **"children with additional needs"**.

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Recommendation 3: Reference the Intellectual Disability Health Capability Framework (Standard 4)

The Framework already sets out the capabilities health graduates need and provides tools for mapping curricula against them[21]. Referencing it gives education providers practical direction without OCANZ needing to add detailed content. We recommend adding the following to the Guidance for Standard 4, after "Cross-cultural competence":

> **Care for people with intellectual disability and other cognitive disability**
> **People with intellectual disability experience significantly poorer health outcomes than the general population, including a high prevalence of visual impairment and eye disease that often goes undetected. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability recommended that accreditation authorities ensure that cognitive disability health is sufficiently covered in accreditation standards (Recommendation 6.27). Education providers are expected to demonstrate how the program prepares graduates to provide safe, quality eye care for people with intellectual disability and other cognitive disability. The Intellectual Disability Health Capability Framework (2024) sets out the core capabilities required by health graduates and includes a tool for mapping curricula against it. Capabilities particularly relevant to optometry include adapting communication, making reasonable adjustments, appropriate assessment, avoiding diagnostic overshadowing, supported decision-making and consent, and collaboration with the person's support network and other health professionals. The Australian Commission on Safety and Quality in Health Care's National Safety and Quality Health Service Standards User Guide for the Health Care of People with Intellectual Disability (2024) is also a useful reference.**

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We also recommend adding to the possible evidence for Standard 4:

- **Mapping of program learning outcomes and assessment against the Intellectual Disability Health Capability Framework.**

A stronger and preferable option, consistent with Recommendation 6.27(b) of the Royal Commission, would be to include this mapping in the Required Documentary Evidence in the Appendix to the Standards.

Recommendation 4: Address consent, communication and reasonable adjustments (Standard 1)

Criterion 1.5 requires that patients consent to care by students. For people with intellectual disability, valid consent depends on accessible communication and, where needed, supported or substitute decision-making. We recommend adding the following to the Guidance for Standard 1, under "Student clinical placements":

> **Students and supervisors should understand how to support people with intellectual disability and other cognitive disability to make decisions about their own care, including consent to care by students. They should also understand how to involve substitute decision-makers where required while keeping the person involved. Reasonable adjustments, as required under the Disability Discrimination Act 1992 (Cth) and equivalent legislation in Aotearoa New Zealand, should be made so that people with disability can access and participate in care. Examples include adapting communication, providing information in accessible formats, and allowing additional time.**

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Further recommended amendments

Recommendation 5: Involve people with intellectual disability in program design and delivery (Standards 3 and 4)

Recommendation 6.27(b) of the Royal Commission calls for cognitive disability health content to be delivered using inclusive teaching practices, involving people with lived experience where possible. We recommend amending Criterion 3.2:

> 3.2 Input is obtained periodically from internal and external stakeholders to the design, review and improvement of the program, including feedback from students, consumers **with diverse experiences**, academics and representatives of the optometry profession to ensure the program remains fit for purpose.

We also recommend adding to the possible evidence for Standard 3:

- **Evidence of the involvement of people with intellectual disability in the design, delivery or evaluation of the program, for example as co-educators or standardised patients.**

In addition, we recommend amending Criterion 4.4:

> 4.4 Learning and teaching methods are intentionally designed and used to enable students to achieve the required learning outcomes, **including, where possible, involving people with lived experience in teaching about their health care.**

We also recommend adding the following to the Guidance for Standard 4, at the end of "Learning and teaching approaches":

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Involving people with lived experience in teaching can deepen students' understanding of the health care experiences of groups who face health inequities, and build their communication skills and confidence. For example, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability recommended that cognitive disability health content be delivered using inclusive teaching practices, involving people with cognitive disability where possible (Recommendation 6.27(b)). People with cognitive disability, such as people with intellectual disability, can contribute to curriculum design, and take part in teaching as co-educators. Education providers should make sure this involvement is accessible, safe, and appropriately supported and paid.

Recommendation 6: Assess students' capability to care for diverse patients, including people with intellectual disability (Standard 6)

We recommend adding the following to the list of clinical assessment strategies in the Guidance for Standard 6:

- **Assessment of students' ability to adapt their communication, examination techniques and management to the needs of diverse patients (for example, children, people who are deaf, and people with intellectual disability and other cognitive disability), with relevant scenarios included in OSCE stations (using simulated patient encounters) or observed clinical encounters.**

Recommendation 7: Clinical supervisor skills (Standard 1)

We recognise that skills in providing eye care for people with intellectual disability are currently considered advanced, and it would not be practical to expect every clinical supervisor to have specialist expertise.

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We recommend adding the following point to the Guidance for Standard 1 (Student clinical placements):

- **All clinical supervisors support students to provide inclusive, person-centred care and to recognise when additional expertise or support is needed. Supervisors who teach or assess students in the care of people with intellectual disability and other cognitive disability have relevant skills and experience. Where available, placements in services that specialise in eye care for people with intellectual disability can give students access to appropriately experienced supervisors.**

Recommendation 8: Add definitions to the Glossary

We recommend adding the following terms to the Glossary:

- **Intellectual disability**: a disability characterised by an impairment of general mental abilities and adaptive functioning, originating during the developmental period (before 18 years of age).
- **Cognitive disability**: an umbrella term for disabilities that affect cognitive functioning, including intellectual disability, acquired brain injury and dementia.
- **Reasonable adjustments**: changes to the way a service is provided so that a person with disability can access and fully participate in it.
- **Supported decision-making**: approaches that enable a person to make their own decisions, with support where needed, rather than having decisions made for them.
- **Diagnostic overshadowing:** attributing a person's symptoms, or changes in their behaviour or function, to their disability rather than investigating a possible underlying health condition.

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Recommendation 9: Competency standards

Optometry programs map their learning outcomes to Optometry Australia's Entry-level Competency Standards for Optometry 2022[23], which do not mention intellectual disability, disability or reasonable adjustments. Including competencies relating to the provision of health care to people with intellectual disability in registration and practice standards is identified in Part C of the *National Roadmap for Improving the Health of People with Intellectual Disability* as a key short-term action for professional associations, regulating bodies and other partners[22]. We encourage OCANZ to raise this gap with Optometry Australia and the Optometrists and Dispensing Opticians Board for consideration at their next review of the competency standards.

Recommendation 10: Report on the response to Recommendation 6.27

We recommend that OCANZ's report on this consultation, and any reporting to the Australian Government Department of Health, Disability and Ageing on the Disability Royal Commission's Recommendation 6.27, describe how the revised Standards address the health of people with intellectual disability and other cognitive disability.

The Centre would be pleased to support OCANZ and optometry education providers to implement these recommendations, including through resources that support the Framework and assistance with curriculum mapping.

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