

Appendices to accompany the PCEP Trainers’ Guide

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Appendix A - Background to the PCEP and the training materials

# Development of a Primary Care Enhancement Program

In 2019, a Roundtable identified the key elements of a National Roadmap for Improving the Health of People with Intellectual Disability. These included:

* improved models of care for people with intellectual disability and their families;
* better support for health professionals to provide improved care for people with intellectual disability; and
* research, data and measurement to support continuing improvement.

A short-term priority under the Roadmap was a Primary Care Enhancement Program or PCEP focusing on the needs of people with intellectual disability. The PCEP sought to build upon existing infrastructure. Four lead Primary Health Networks (PHNs) were identified to contribute to the development and evaluation of the PCEP, with a view to national rollout across all 31 PHNs in Australia.

# How the materials were developed

As part of the PCEP, the Council for Intellectual Disability led the development of a suite of national resources with input from people with intellectual disability and their families, four lead PHNs, clinical and academic experts, disability service providers, and the Department of Health.

The lead Primary Health Networks were:

* Central and Eastern Sydney PHN
* Tasmania PHN
* QLD Wide Bay and Sunshine Coast PHN
* Western Victoria PHN

The training resources, which include this trainers guide, comprise a part of those national resources. These are available for download at [www.cid.org.au/health/PCEP](http://www.cid.org.au/health/PCEP) .

Accompanying health promotion resources, suitable for distribution to health professionals, can be found at [www.cid.org.au/health/resources-health-professionals](http://www.cid.org.au/health/resources-health-professionals) .

## Training and resources were underpinned by a needs assessment

The content of the PCEP training was based upon a comprehensive needs assessment.

The aims of the needs assessment were to:

1. understand the perspectives of people with intellectual disability and those who support them regarding their health care and to identify currently unmet needs; and
2. identify health professionals learning needs and review what training and resources professionals currently access.

People with intellectual disability were involved in both the consultation process and the analysis of data.

Information was gathered from the following sources.

* Community consultation using a combination of focus groups, semi-structured interviews and online meetings. Cohorts included:
* people with intellectual disability;
* family members and support people of people with intellectual disability;
* First Peoples Disability Network members;
* elders and community members of First Nations People; and
* health professionals working in specialised intellectual disability health services.
* Review of existing resources and training;
* Review of the outcomes and recommendations of the Royal Commission into Health care and services for people with a cognitive disability;
* Peer-reviewed literature on Australian health professionals’ training needs; and
* A survey capturing professionals’ views regarding their confidence and training needs in responding to people with intellectual disability. This has been distributed to health and allied health professionals, medical and allied health students, First Nations People disability networks. Over 120 responses were received from medical and allied health professionals across a broad range of disciplines, as well as from staff within disability service providers.

All data were analysed using content analysis to identify themes.

Themes emerging from this process centred on:

* Issues of clinical relevance which impact the health care of some people with intellectual disability;
* Improving communication between health professionals and people with intellectual disability;
* Reasonable adjustments which can improve interactions during health appointments;
* Existing resources which could helpfully be promoted to health professionals and to people with intellectual disability; and
* Gaps in existing resources where there is a need to create new resources.

# Ongoing input came from lead Primary Health Networks and the Department of Health

The style of the training and the resources developed were informed through ongoing collaboration with the four lead Primary Health Networks involved in the PCEPs and the Department of Health.

Further refinement of content and style occurred through ongoing consultation with people with intellectual disability, health professionals and the Department of Health.

Appendix B Tips for recruiting a co-facilitator with intellectual disability

To recruit a co-facilitator with intellectual disability, start by contacting a local disability advocacy organisation. Peak advocacy groups focused on intellectual disability can help connect you with members who may be local to you.

## National

* Inclusion Australia [www.inclusionaustralia.org.au](http://www.inclusionaustralia.org.au)
* First Peoples Disability Network [www.fpdn.org.au](http://www.fpdn.org.au)
* Down Syndrome Australia – [www.dsa.org.au](http://www.dsa.org.au)

You can also use the search function on this site to find someone local. It is not specific to intellectual disability but keyword searches can be added. <https://disabilityadvocacyfinder.dss.gov.au/disability/ndap/>

## State based organisations

* NSW - Council for Intellectual Disability [www.cid.org.au](http://www.cid.org.au)
* WA - Developmental Disability WA [www.ddwa.org.au](http://www.ddwa.org.au)
* Tasmania – Speak Out Advocacy [www.speakoutadvocacy](http://www.speakoutadvocacy).org
* Victoria – VALID – [www.valid.org.au](http://www.valid.org.au)
* South Australia – SACID [www.sacid.org.au](http://www.sacid.org.au)
* QLD – P2PQLD – [www.p2pqld.org.au](http://www.p2pqld.org.au)

Local disability service providers may be another option. Tell the organisation a bit about the training (e.g. it was co-designed with people with intellectual disability) and what the person’s role will be (e.g. paid speaking role in training sessions) and what supports are available (e.g. PHN staff time and/or funding for external supports).

Ideally, try to speak with a few people with intellectual disability and be upfront that you are doing this. Not only will this allow you to choose the best candidate, it will also build a ‘talent’ pool so you avoid relying on only one person. If you plan to run training multiples times over several months, you may find you need more than one co-facilitator with intellectual disability anyway.

### The first contact

First, speak to each candidate over the phone about what is involved. Check their availability at this point, if possible.

Keep your first meeting casual – offer to buy them a coffee (or hot chocolate!) somewhere they know. Tell them they can bring someone with them if they like. At the meeting, try to strike a balance between showing interest in them as a person and also talking about the training. Ask them why they are interested in being involved. Check if they have questions. Ask them if they’ve done anything like this before.

Casual conversation prompt questions that can reveal a lot:

* What do you do during a normal week?
* Who is important to you?
* What things to do you with [organisation that connected you]?

### Important things to discuss

Either over the phone, or in your first meeting with them, make sure you cover these points:

* Tell them:
  + what is involved, how long you expect it to go for and how often they will present training;
  + what they will be paid if they end up being a co-facilitator; and
  + what support is available for them.
* Ask them:
  + why they are interested;
  + their availability and how much flexibility they have; and
  + supports that work for them.

### Discussing supports

Be matter-of-fact about asking the person what supports they think they would need to be able to prepare for, and deliver training. You need to work out whether what you’re able to offer matches their needs. Ask them who usually supports them and in what activities? What works for them, and what doesn’t?

They may already have a support person who regularly works with them. If so, then one option is to pay that person as their support for this work. Another may be arranging support from an advocacy organisation, paid for by the PHN.

If their work will be supported by someone working for the PHN who is not you, then arrange for them to meet and discuss supports before offering the person the role.

### Do a task together

If you feel you have good rapport with someone and they seem likely to be a good co-facilitator and availability and supports are compatible, then invite them to complete a task *with support*. It needs to be brief. However, this helps you understand how much support they need and so they can have a clearer idea of the work they’ll be doing.

Example tasks (choose one):

Provide dot-point answers for a few questions written in Easy Read text. The questions could be about why they would be a good co-facilitator. Then do a more formal job interview.

or

Have a brief Q&A session with you, focused on a specific health care experience and things that made it good or not so good. Then, working together, identify the parts that could be included in a talk about what health professionals might be able to offer support to a person with intellectual disability, and order them in a logical sequence. Allow the person to practice and then deliver a 30- 60 second summary of those points.

### Using a formal recruitment process

If you wish to use a formal recruitment process, then the JobAccess website may assist you. [www.jobaccess.gov.au/employers/employer-toolkit/recruiting-people-with-disability/](http://www.jobaccess.gov.au/employers/employer-toolkit/recruiting-people-with-disability/)

### Paying people

People with intellectual disability should be paid for their time, including the time spent preparing for the training and any meetings they attend. This includes paying someone to be an expert on a panel discussion. It is especially important to do this (even if others are volunteering their time) because historically, people with disability were underpaid or unpaid, including in situations where they had little choice over the work they performed.

The person supporting them needs to be paid too. The easiest way is for the PHN to pay them as a contractor or via their agency.

Job Access has some information about financial support for supporting people with disability in the workplace through the disability employment strategy. See <https://www.jobaccess.gov.au/employers> .

Some people may also have employment support already in their NDIS plan. However, most won’t. Requesting a change to their NDIS plan to support them to work as a co-facilitator may take longer than your time frame allows.

### How income impacts the Disability Support Pension

People on the Disability Support Pension can earn up to a threshold before their pension is impacted. The current thresholds are available on the Services Australia website.

The process of declaring income can be difficult for someone with intellectual disability. This is one reason to space their work out and have them work the same number of hours each fortnight.

It is a good idea to give the person an idea of what they are likely to be paid each fortnight (or for each training session). They can then ask their supporters to help them to work out if it will impact their pension - especially if they already have a job.

### Completing employment forms

The Tax File Declaration form and most employment forms, are not written in accessible language. A person will need support to go through them. Given they involve personal information, it is best if this support comes from someone who regularly assists them with paperwork. However, if no such person is available, then the PHN co-facilitator or another staff member may provide some assistance.

# Checklist for recruitment

## Things for PHN co-facilitator to cover when recruiting a co-facilitator:

* How well do they communicate?
* Are they engaging?
* Do they use email? Phone? Zoom or Teams?
* What is their level of interest in health? Self-advocacy? Health?
* How much availability do they have? Does it match yours?
* Who will support them to go through the co-facilitator guide and prepare for training?
  + Options might be the PHN co-facilitator
  + another PHN staff member
  + or a person working in a local advocacy or disability agency.

## Things to encourage the person with intellectual disability to consider:

* What is their level of interest in health? Self-advocacy? Health?
* Do they enjoy public speaking?
* How will payment for the work impact their pension? For current information, see:

<https://www.servicesaustralia.gov.au/income-test-for-pensions?context=22276>

* Who do they want to support them to go through the co-facilitator guide?
* What do they hope to get from it?

Appendix C - One page profile

Do this together with the co-facilitator with intellectual disability in order to understand each other’s working style.

Your co-facilitator may need some assistance to read and complete the form.

Don’t forget to do it for yourself too.

|  |  |
| --- | --- |
| What people appreciate about me | |
|  | |
| What’s important to me | How best to support me |
|  |  |

Appendix D – Suggested learning outcomes and session outlines for the recommended slide sets

**Delivery mode:** In person / live online

**Timing:** not including pre and post-workshop reading, reflection, and survey questions

* 1.5 hours, which can include question time and/or additional video content.
* 2 hours, which can include video content and a panel discussion.
* 1 hour “express”.

**Target audience:** Primary health practitioners, with the option of separate workshops for different professions or groups. For example:

* GPs and practice nurses;
* speech therapists, psychologists, behaviour support practitioners;
* occupational therapists, physiotherapists;
* pharmacists; and
* dentists.

If you wish to present to combined groups, or all disciplines together, this will require a carefully chosen case study that touches on all disciplines. Do this in consultation with expert clinicians who can co-facilitate with you or sit on a panel discussion.

**Facilitators:** Flexible but ideally it could include:

* Primary Health Network team and specialist educators;
* a clinician with experience in this area (preferably local) and/ or
* co-facilitator with intellectual disability.

**Resources for facilitators:**

* Training manual.
* slides set with brief notes and more detailed notes.

**Resources for participants:**

* Copy of case studies used in full.
* Copy of slides.
* Pre-workshop activity and reflection.
* Links to key resources:
  + To use with people with intellectual disability – focused on communication, reasonable adjustments and personal health records.
  + For health professionals - Therapeutic Guidelines, *HealthPathways*, NDIS information and resources and other available training.
  + *What not to miss* by Nick Lennox.
* Post-workshop activity and reflection questions.

# Goals and learning outcomes:

These apply to the entire training package, i.e. including the pre-and post-workshop activities.

## Goal – GPs

Increase the confidence of health practitioners to promote the best possible health care of clients with intellectual disability through accessing appropriate resources, undertaking care coordination, including liaising with other health and disability professionals and by identifying whole-of-practice reasonable adjustments which are feasible.

**Learning outcomes – GPs and practice nurses:**

At the conclusion of the workshop, participants will be able to:

1. Identify relevant clinical resources to guide best practice when providing primary health care for people with intellectual disability.
2. Discuss appropriate accessible consumer resources to promote best practice when providing health care for people with intellectual disability.
3. Describe adjustments to standard practice that help to overcome barriers to health care commonly experienced by people with intellectual disabilities.

## Goal – other professionals

Increase the confidence of health practitioners to promote the best possible health care of clients with intellectual disability through accessing appropriate resources, liaising with other health and disability professionals and by identifying whole-of-practice reasonable adjustments which are feasible.

## 

**Learning outcomes – allied health:**

At the conclusion of the workshop, participants will be able to:

1. Identify resources available to promote best practice when providing health care for people with intellectual disability.
2. List adjustments to standard practice that help to overcome barriers to health care commonly experienced by people with intellectual disabilities.

# Session outline – General

|  |  |  |
| --- | --- | --- |
| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 – 10 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care  2-4 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief intro through slides or video.    Personal story - in person or via video. |
| Case examples  30 - 40 minutes | Up to 3 cases – tailored to the profession targeted.  Each involves group discussion and sharing.  For each, summarise:   * common clinical challenges * clinical resources * practical challenges * Adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group, followed by facilitator summary.  Resources:   * Therapeutic Guidelines * ‘Commonly missed health conditions’ sheet * Links to communication tools * Links to other practical resources * Case studies sent ahead of time |
| Break  0 – 10 minutes | Break | Coffee |
| Reasonable adjustments  10-13 minutes  + / - videos:  3-9 minutes | Reasonable adjustments throughout an appointment and follow-up  Communication | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources * Other resources, e.g. Books beyond words. |
| Question time  5 min  OR  Panel discussion  15 min | Question time  Or Panel discussion | Q&A;  Or  Panel with at least one person with lived experience (supported) and at least one health professional of each type, targeted for that session. |
| Wrap up  3 - 4 minutes | * Summary of Key messages * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – GPs and Practice Nurses – 1.5 hour workshop

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| --- | --- | --- |
| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care  2 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief introduction through slides or video.    Personal story - in person or via video. |
| Case examples  45 minutes | 3 cases:   * Kit * Amelia * Amir   Each involves group discussion and sharing.  For each, summarise:   * common clinical challenges; * clinical resources; * practical challenges and * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group; followed by facilitator summary  Resources:   * Therapeutic guidelines * ‘Commonly missed health conditions’ sheet * Links to communication tools * Links to other practical resources * Case studies sent ahead of time |
| Break  5 minutes | Break | Coffee |
| Reasonable adjustments  10 minutes  + / - videos:  3-9 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources * Other resources e.g. Books beyond words. |
| Question time  5 min | Question time | Q&A |
| Wrap up  3 minutes | * Summary of Key messages. * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – GPs and Practice Nurses – 2 hour workshop

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| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 – 10 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care  2-4 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief intro through slides or video    Personal story - in person or via video. |
| Case examples  45 - 52 minutes | 3 cases:   * Kit * Amelia * Amir   Each involves group discussion and sharing.  For each, summarise:   * common clinical challenges * clinical resources * practical challenges * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group, followed by facilitator summary.  Resources:   * Therapeutic Guidelines * ‘Commonly missed health conditions’ sheet * Links to communication tools * Links to other practical resources * Case studies sent ahead of time |
| Break  10 minutes | Break | Coffee |
| Reasonable adjustments  10-13 minutes  + / - videos:  3-9 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication. | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources. * Other resources, e.g. ‘Books beyond words.’ |
| Panel discussion  15 min | Or Panel discussion. | Panel with at least one person with lived experience (supported) and at least one health professional of each type targeted for that session. |
| Wrap up  2-4 minutes | * Summary of Key messages. * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – GPs and Practice nurses – 1 hour express

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| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care.  2-4 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability | Brief introduction through slides or video.    Personal story - in person or via video. |
| Case examples  35 minutes | 2 cases:   * Amelia * Amir   Each involves group discussion and sharing.  For each, summarise:   * common clinical challenges * clinical resources * practical challenges * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group, followed by facilitator summary.  Resources:   * Therapeutic Guidelines * ‘Commonly missed health conditions’ sheet * Links to communication tools * Links to other practical resources * Case studies sent ahead of time |
| Reasonable adjustments  8 - 12 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication. | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources. * Other resources, e.g. ‘Books beyond words.’ |
| Question time  5 min | Question time. | Q&A |
| Wrap up  2-4 minutes | * Summary of Key messages. * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – Allied/mental health – 1.5 hour workshop

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| --- | --- | --- |
| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care  2 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief introduction through slides or video.    Personal story - in person or via video. |
| Case examples part 1  25 - 30 minutes | 2 cases:   * Kit * Amelia   Each involves group discussion and sharing.  For each, discuss and summarise:   * common clinical challenges * clinical resources * practical challenges * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group, followed by facilitator summary.  Resources:   * Therapeutic Guidelines * ‘Commonly missed health conditions’ sheet * Links to communication tools * Links to other practical resources * Case studies sent ahead of time |
| Break  10 minutes |  |  |
| Case examples part 2  15 - 20 minutes | 1 remaining case: Amir  Discuss and summarise:   * common clinical challenges * clinical resources * practical challenges   Adjustments to practice to ensure optimal health care. | Resources:   * Therapeutic Guidelines * ‘Commonly missed health conditions’ sheet * Links to communication tools * Links to other practical resources   Case studies sent ahead of time. |
| Reasonable adjustments  14 - 16 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication.  Includes videos. | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources. * Other resources, e.g. ‘Books beyond words.’ |
| Question time  10 min | Question time | Q&A; |
| Wrap up  2-4 minutes | * Summary of Key Messages * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – Allied/mental health – 2 hour workshop with panel discussion

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| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 – 10 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care.  2-4 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief introduction through slides or video.    Personal story - in person or via video. |
| Case examples  50 - 60 minutes | 3 cases:   * Kit * Amelia * Amir   Each involves group discussion and sharing.  For each, discuss and summarise:   * common clinical challenges * clinical resources * practical challenges * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group, followed by facilitator summary.  Resources:   * Therapeutic Guidelines * Commonly missed health conditions sheet * Links to communication tools * Links to other practical resources * Case studies sent ahead of time |
| Break  15 minutes, depending on timing | Break | Coffee |
| Reasonable adjustments  14-18 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication.  Includes videos. | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources. * Other resources, e.g. ‘Books beyond words.’ |
| Panel discussion  20 min | Panel discussion | Panel with at least one person with lived experience (supported) and at least one health professional of each type targeted for that session. |
| Wrap up  2-4 minutes | * Summary of Key messages. * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – Pharmacists 1 hour

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| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care.  2-3 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief introduction through slides or video.    Personal story - in person or via video. |
| Case examples  30-35 minutes | 2 cases:   * Joe * Daryan   Each involves group discussion and sharing.  For each, summarise:   * common clinical challenges * clinical resources * practical challenges * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group, followed by facilitator summary.  Resources:   * Therapeutic Guidelines; POMPIDA resources; STOMP website. * ‘Commonly missed health conditions’ sheet. * Links to communication tools. * Links to other practical resources. * Case studies sent ahead of time. |
| Reasonable adjustments  8-9 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication. | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources. * Other resources e.g. ‘Books beyond words.’ |
| Question time  5 min | Question time | Q&A |
| Wrap up  2-3 minutes | * Summary of Key Messages. * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – Pharmacists 1.5 hours with panel discussion

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| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 – 10 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts |
| The impact of supportive, effective care.  2-4 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief intro through slides or video.    Personal story - in person or via video. |
| Case examples  35 - 40 minutes | 2 cases:   * Joe * Daryan   Each involves group discussion and sharing.  For each, summarise:   * common clinical challenges * clinical resources * practical challenges * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group, followed by facilitator summary.  Resources:   * Therapeutic Guidelines; POMPIDA resources; STOMP website. * ‘Commonly missed health conditions’ sheet. * Links to communication tools. * Links to other practical resources. * Case studies sent ahead of time. |
| Break  5 - 10 minutes depending on timing | Break | Coffee |
| Reasonable adjustments  10-16 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication.  Includes a video. | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources. * Other resources e.g. ‘Books beyond words.’ |
| Panel discussion  15 min | Or Panel discussion. | Panel with at least one person with lived experience (supported) and at least one health professional of each type targeted for that session. |
| Wrap up  2-4 minutes | * Summary of Key messages. * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – Dentists 1 hour

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| --- | --- | --- |
| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care.  3 - 4 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief intro through slides or video.    Personal story - in person or via video. |
| Case examples  30 - 35 minutes | 2 cases:   * Stacey * Leon   Each involves group discussion and sharing  For each, summarise:   * Clinical issues * clinical resources * practical challenges * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group, followed by facilitator summary.  Resources:   * Therapeutic Guidelines; NIH guidance * Commonly missed health conditions sheet * Links to communication tools * Links to other practical resources * Case studies sent ahead of time. |
| Reasonable adjustments  8 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication. | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources. * Other resources e.g. ‘Books beyond words.’ |
| Question time  5 min | Question time. | Q&A |
| Wrap up  2-4 minutes | * Summary of Key messages. * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

# Session outline – Dentists 1.5 hours with a panel discussion

|  |  |  |
| --- | --- | --- |
| **Topic**  **Approximate timing** | **Content and key points** | **Delivery format and resources** |
| Introduction  8 – 10 minutes | Welcome and Acknowledgment of Country.  Introductions, housekeeping.  Outline of workshop and its plan and purpose. | Facilitator led slides and handouts. |
| The impact of supportive, effective care.  2-4 minutes | Barriers to good health outcomes for people with intellectual disability.  Good health care is possible for people with intellectual disability. | Brief intro through slides or video.    Personal story - in person or via video. |
| Case examples  30 - 35 minutes | 2 cases:   * Stacey * Leon     Each involves group discussion and sharing.  For each, summarise:   * clinical issues * clinical resources * practical challenges * adjustments to practice to ensure optimal health care. | Interactive discussion amongst participants with sharing with wider group; followed by facilitator summary  Resources:   * Therapeutic Guidelines * ‘Commonly missed health conditions’ sheet * Links to communication tools * Links to other practical resources * Case studies sent ahead of time |
| Break  10 minutes | Break | Coffee |
| Reasonable adjustments  10-13 minutes | Reasonable adjustments throughout an appointment and follow-up.  Communication. | Presented by co-facilitator with intellectual disability  OR presented by a facilitator without intellectual disability but including videos of a person with intellectual disability and/or a panel discussion which includes people with intellectual disability.  Resources:   * CID Easy Read resources. * Other resources e.g. ‘Books beyond words.’ |
| Panel discussion  15 min | Or Panel discussion | Panel with at least one person with lived experience (supported) and at least one health professional of each type targeted for that session. |
| Wrap up  2-4 minutes | * Summary of Key messages. * Evaluation, reference handouts and evaluation and thanks. | Post-workshop pack.  Evaluation form or link. |

Appendix E - Summary of all slides

The table below shows all the slides in the order they appear in the master slide set.

Key to the Symbols:

O – Options to change/choose; VID – Video; VERB – read verbatim; SG – group discussion; A – slide has animations; T – slide needs to be tailored.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Slide number | Slide name | Suggested use | | | | | | | Who presents | | | Symbols | Time | |
| GPs and Practice Nurses Longer/Shorter | Dentists | Allied Health 1 MH | Allied Health 2 PH | Pharmacists | Aboriginal Health | Other training | Co-facilitator with intellectual disability | PHN co-facilitator | Health Professional | Min time | Max time |
| S1C | Explanatory slide – How to use these slides and the speaker notes |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S2C | Welcome to workshop |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S3C | Acknowledgement of Country |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S4C | Co-facilitators introduce themselves (with 2) |  |  |  |  |  |  |  |  |  |  | T | 3 | 5 |
| S5C | Co-facilitators introduce themselves (with 3) |  |  |  |  |  |  |  |  |  |  | T | 3 | 6 |
| S6C | Housekeeping - webinar |  |  |  |  |  |  |  |  |  |  | O | 2 | 2 |
| S7C | Housekeeping – Face to face |  |  |  |  |  |  |  |  |  |  | O | 2 | 2 |
| S8C | What do you hope to learn? |  |  |  |  |  |  |  |  |  |  | O | 0 | 2 |
| S9C | Workshop outline |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S10C | Health care for people with intellectual disability |  |  |  |  |  |  |  |  |  |  | O; VID | 1 | 2 |
| S11V | Health care for people with intellectual disability - Video placeholder |  |  |  |  |  |  |  |  |  |  | O; VID | 1 | 2 |
| S12C | Good health care |  |  |  |  |  |  |  |  |  |  | O, VID | 1 | 2 |
| S13C | Intro to case examples |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S14C | Reasonable adjustments definition - share |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S15C | Reasonable adjustments definition |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S16C | Before I see you |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S17C | After I see you |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S18C | When I see you |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S19C | Talk to ME |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S20C | Visual aids |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S21C | Communication aids |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S22V | Video – communication - longer |  |  |  |  |  |  |  |  |  |  | VID | 3 | 3 |
| S23V | Video – Non-verbal and augmentative communication |  |  |  |  |  |  |  |  |  |  | VID | 3 | 3 |
| S24V | Video – Annual health assessment |  |  |  |  |  |  |  |  |  |  | VID | 1 | 3 |
| S25C | Panel discussion |  |  |  |  |  |  |  |  |  |  | SG | 15 | 15 |
| S26C | Question time |  |  |  |  |  |  |  |  |  |  | SG | 5 | 10 |
| S27C | 6 key points |  |  |  |  |  |  |  |  |  |  | O | 1 | 1 |
| S28C | 2 key messages |  |  |  |  |  |  |  |  |  |  | O | 1 | 1 |
| S29C | Thank you and wrap-up |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S30O | Divider slide – other training |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S31O | Slides to use in other training – “What if…” |  |  |  |  |  |  |  |  |  |  | SG, T | 4 | 4 |
| S32O | Slides to use in other training – “What has changed? What is the same?” |  |  |  |  |  |  |  |  |  |  | SG | 2 | 5 |
| S33O | Use as extra to other training - further reflections |  |  |  |  |  |  |  |  |  |  |  | 3 | 3 |
| S34O | Use as extra to other training – clinical resources |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S35O | Use as extra to other training – Easy Read resources |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S36O | Resources – Medicare Item numbers |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S37O | Use with other training – Polypharmacy |  |  |  |  |  |  |  |  |  |  | SG, A | 2 | 2 |
| S38V | Slides to use in other training – Video Placeholder |  |  |  |  |  |  |  |  |  |  | VID, T | 3 | 3 |
| S39V | Video – Annual health assessment |  |  |  |  |  |  |  |  |  |  | VID | 1 | 3 |
| S40P | Divider slide – Case study slides |  |  |  |  |  |  |  |  |  |  | VERB | 1 | 1 |
| S41P | Divider slide – Case examples – GPs longer |  |  |  |  |  |  |  |  |  |  | VERB | 1 | 1 |
| S42P | Kit divider slide |  |  |  |  |  |  |  |  |  |  |  | 0 | 0 |
| S43P | Case example 1: Kit Longer GP workshop |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S44P | Kit – Longer GP workshop - Small group discussion |  |  |  |  |  |  |  |  |  |  | SG | 10 | 12 |
| S45P | Kit – Longer GP workshop – Further reflections? Blank |  |  |  |  |  |  |  |  |  |  | SG | 4 | 4 |
| S46P | Kit – Longer GP workshop – Further reflections? Animated |  |  |  |  |  |  |  |  |  |  | SG, A | 4 | 4 |
| S47P | Diagnostic overshadowing |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S48P | Kit – Longer GP workshop - Highlight resources |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S49P | Your HealthPathways |  |  |  |  |  |  |  |  |  |  | T | 1 | 1 |
| S50P | Amelia divider slide |  |  |  |  |  |  |  |  |  |  |  | 0 | 0 |
| S51P | Amelia – Longer GP workshop |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S52P | Amelia – Longer GP - Group discussion |  |  |  |  |  |  |  |  |  |  | SG | 6 | 8 |
| S53P | Amelia – Longer GP - Comprehensive assessment? |  |  |  |  |  |  |  |  |  |  | SG | 2 | 2 |
| S54P | Amelia – Longer GP workshop – Further reflections |  |  |  |  |  |  |  |  |  |  |  | 2 | 2 |
| S55P | Amir divider slide |  |  |  |  |  |  |  |  |  |  |  | 0 | 0 |
| S56P | Amir - Longer GP or GP Express workshop |  |  |  |  |  |  |  |  |  |  | VERB | 2 | 2 |
| S57P | Amir – Longer GP or GP Express workshop - First steps |  |  |  |  |  |  |  |  |  |  | SG | 10 | 10 |
| S58P | Amir – Longer GP or GP Express workshop also for pharmacists and mental health workers – Polypharmacy |  |  |  |  |  |  |  |  |  |  | SG, A | 2 | 2 |
| S59P | Amir – Longer GP or GP Express workshop – Further reflections |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S60P | Resources – Medicare item numbers |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S61P | Divider slide – case examples – GP Express |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S62P | Amelia divider slide |  |  |  |  |  |  |  |  |  |  |  | 0 | 0 |
| S63P | Amelia – GP express workshop |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S64P | Amelia – GP express workshop – group discussion |  |  |  |  |  |  |  |  |  |  | SG | 6 | 8 |
| S65P | Amelia – GP express workshop – Comprehensive assessment? |  |  |  |  |  |  |  |  |  |  | SG | 2 | 2 |
| S66P | Amelia – GP express workshop – Further reflections 1 |  |  |  |  |  |  |  |  |  |  |  | 2 | 2 |
| S67P | Diagnostic overshadowing |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S68P | Amelia – GP express - Further reflections 2 |  |  |  |  |  |  |  |  |  |  | SG, A | 2 | 2 |
| S69P | Amelia – GP express – Highlight resources |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S70P | GP express - Your *HealthPathways* |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S71P | Amir divider slide |  |  |  |  |  |  |  |  |  |  |  | 0 | 0 |
| S72P | Amir - GP express workshop |  |  |  |  |  |  |  |  |  |  | VERB | 2 | 2 |
| S73P | Amir – GP Express workshop - First steps and beyond |  |  |  |  |  |  |  |  |  |  | SG | 10 | 10 |
| S74P | Amir – Longer GP or GP Express workshop – Further reflections |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S75P | Amir – Longer GP or GP Express workshop– Polypharmacy |  |  |  |  |  |  |  |  |  |  | SG, A | 2 | 2 |
| S76P | Divider Slide - Case examples – Allied health (MH) |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S77P | Kit divider slide |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S78P | Kit - Allied health professionals |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S79P | Kit – Small group discussion – Allied health care |  |  |  |  |  |  |  |  |  |  | SG | 8 | 8 |
| S80P | Kit – Further reflections? – Allied health workers |  |  |  |  |  |  |  |  |  |  |  | 2 | 2 |
| S81P | Kit – Some key points – Allied health workers |  |  |  |  |  |  |  |  |  |  |  | 2 | 2 |
| S82P | Amelia divider slide |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S83P | Amelia – Allied Health Professionals |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S84P | Amelia – Allied Health Professionals – your turn |  |  |  |  |  |  |  |  |  |  | SG | 8 | 8 |
| S85P | Amelia – Longer term |  |  |  |  |  |  |  |  |  |  |  | 4 | 4 |
| S86P | Amelia – Allied health - Further reflections |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S87P | Amir divider slide |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S88P | Amir – Allied health workers |  |  |  |  |  |  |  |  |  |  | VERB | 2 | 2 |
| S89P | Amir – Allied Health workers - Your turn |  |  |  |  |  |  |  |  |  |  | SG | 10 | 10 |
| S90P | Amir – Allied health - Highlight resources |  |  |  |  |  |  |  |  |  |  |  | 1 | 2 |
| S91P | Divider Slide - Case examples – Dentists |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S92P | Stacey divider slide |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S93P | Stacey - Dentists |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S94P | Stacey – Dentists- your turn |  |  |  |  |  |  |  |  |  |  | SG | 8 | 8 |
| S95P | Stacey – Dentists – Further reflections |  |  |  |  |  |  |  |  |  |  | SG | 6 | 6 |
| S96P | Leon divider slide |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S97P | Leon - Dentists |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S98P | Leon – Dentists – Your turn |  |  |  |  |  |  |  |  |  |  | SG | 6 | 7 |
| S99P | Leon – Dentists – Pragmatics |  |  |  |  |  |  |  |  |  |  |  | 4 | 4 |
| S100P | Dentists – Resources Special Care |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S101P | Dentists – Other resources |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S102P | Divider Slide – Aids – Dentists |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S103P | Visual aids - Dentists |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S104P | Communication aids - Dentists |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S105P | Divider Slide – Ending slides – Dentists |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S106P | 6 key points - Dentists |  |  |  |  |  |  |  |  |  |  | O | 1 | 1 |
| S107P | Thank you and wrap-up - Dentists |  |  |  |  |  |  |  |  |  |  | O | 1 | 1 |
| S108P | Divider slide – Case examples - Pharmacists |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S109P | Divider slide - Joe |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S110P | Joe - Pharmacists |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S111P | Joe – Pharmacists – Your turn |  |  |  |  |  |  |  |  |  |  | SG | 10 | 12 |
| S112P | Joe – Pharmacists – Further considerations |  |  |  |  |  |  |  |  |  |  | A | 6 | 6 |
| S113P | Joe – Further considerations – No animations |  |  |  |  |  |  |  |  |  |  |  | 6 | 6 |
| S114P | Pharmacists – POMPIDA resources |  |  |  |  |  |  |  |  |  |  |  | 1 | 1 |
| S115P | Daryan divider slide |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S116P | Daryan - Pharmacists |  |  |  |  |  |  |  |  |  |  | VERB | 1.5 | 1.5 |
| S117P | Daryan – Your turn |  |  |  |  |  |  |  |  |  |  | SG | 10 | 12 |
| S118P | Daryan – Polypharmacy |  |  |  |  |  |  |  |  |  |  |  | 2 | 2 |
| S119P | Divider Slide – Ending slides – Dentists |  |  |  |  |  |  |  | n/a | n/a | n/a |  | 0 | 0 |
| S120P | 6 key points - Dentists |  |  |  |  |  |  |  |  |  |  | O | 1 | 1 |
| S121P | Thank you and wrap-up - Dentists |  |  |  |  |  |  |  |  |  |  | O | 1 | 1 |

Appendix F - Detailed description of the slides

A brief description of all the slides appears in Appendix E. This includes:

* which professional groups the slide is intended for;
* which co-facilitator is recommended to present it; and
* the recommended timing for the slide.

The aim of this Appendix is to provide sufficient detail about the slides to allow a PHN co-facilitator to understand the material. Where several slides relate to the same topic, they have been clustered together.

# Description of slides in the common set:

### S1C Explanatory slide

This describes how to use the slides and slide notes. Delete this slide*.*

### S2C Welcome to workshop

If the co-facilitator with intellectual disability feels comfortable commencing the session, we suggest you encourage them to welcome people to the training.

### S3C Acknowledgement of Country

There are detailed notes in the Easy Read co-facilitator guide explaining this.

### S4C Co-facilitators introduce themselves

### S5C Co-facilitators introduce themselves

Tailor the slides. Unhide only 1.

The Easy Read co-facilitator guide includes a sheet on what to include in an introduction.

### S6C Housekeeping – webinar

### S7C Housekeeping - Face to face

Choose one, hide or delete the other.

There is a sheet in the Easy Read co-facilitator guide explaining this content.

### S8C What do you hope to learn?

Optional slide. Only useful if you are able to modify the content based on the answers.

Using this slide requires the PHN co-facilitator to moderate the group. It is not recommended for the people with intellectual disability to present.

### S9C Workshop outline

Either co-facilitator can present this. There is a sheet in the Easy Read co-facilitator guide to explain the purpose of the outline.

### S10C Health care for people with intellectual disability: Introductory information

Ideally the co-facilitator with intellectual disability presents this. There is a sheet in the Easy Read co-facilitator guide to further explain the slide content.

**Key points:**

* 1 – 2 % of people have intellectual disability.
* Health outcomes are not equal.
* Barriers in health care access.

### S11V Health care for people with intellectual disability: Video placeholder

This a video if wishing to substitute for the content of S10. See [www.cid.org.au/health/PCEP-videos](http://www.cid.org.au/health/PCEP-videos) .

Key points are as per S10.

### S12C Good health care

**Key point:**

* Despite the barriers described in the last slide, good health care is possible.

The co-facilitator with intellectual disability can share their own health care story here, if they like. There is a sheet in the Easy Read co-facilitator guide to assist someone to consider if they want to share their story and, if so, how.

### S13C Case examples

This leads into the case study discussion.

**Key points:**

* Before they leave, thank the co-facilitator with intellectual disability for their introduction to the topic. Tell participants that they will be back later, before they leave the room.
* Encourage participants to contribute, emphasise that there is no one correct answer.

Slides S14C – 21C are all covered in detail in the reasonable adjustments section of the Easy Read co-facilitator guide.

### S14C Reasonable adjustments definition – share

**Key points:**

* Welcome back co-facilitator.
* This is an opportunity for the group to share their thoughts.

The co-facilitator with intellectual disability can present the slide but the PHN co-facilitator needs to assist with facilitating the conversation.

### S15C Reasonable adjustments definition

**Key points:**

* Reasonable adjustments are small adaptations to practice that can have a large impact on the quality of a person’s health care.

### S16C Before I see you

### S17C After I see you

### S18C When I see you

**Key points:**

* Reasonable adjustments may be required during, before or after an appointment.
* Adopt an all-of-practice approach and consider wait times and accessible information.
* Encourage other practices to do so too e.g. when referring patients with disability.

### S19C Talk to ME

**Key points:**

* Talk to the person with intellectual disability first.
* Establish rapport with them.
* Even if a person is non-verbal, still greet them.
* Ask permission to speak to their supporter.
* Check understanding in both directions.

### S20C Visual aids

**Key point:**

* Having visual aids such as body maps handy helps a person communicate.

### S21C Communication aids

**Key point:**

* Accessible information like Easy Read is available – link to resources.

### S22V Video – communication – longer – Video placeholder

**Key point:**

* People may communicate in different ways. Challenge assumptions about how much someone can understand.

### S23V Video – Non-verbal and augmentative communication – Video placeholder

**Key point:**

* The importance of promoting communication.

### S24V Video – Annual health assessment – Video placeholder

**Key point:**

* A health story of a good health outcome following use of the Comprehensive Health Assessment Program.

### S25C Panel discussion

Either use this or the Question time slide.

You may need to remind people to speak accessibly. Rephrase questions that are not spoken accessibly.

### S26C Question time

Either use this or the panel discussion slide. Rephrase questions that are not spoken accessibly.

### S27C 6 Key points

Ideally the co-facilitator with intellectual disability presents this slide.

### S28C 2 Key messages

Optional slide. A good option if the co-facilitator with intellectual disability struggles with S28. The PHN co-facilitator can present S28 in an adapted form and the co-facilitator with intellectual disability S29.

There is a section of the Easy Read co-facilitator guide about question time.

### S29C Thank you and wrap-up

A co-facilitator to prompt participants about the survey.

The co-facilitator with intellectual disability to thank the PHN co-facilitator for their efforts, and vice versa.

# Description of slides tailored for each profession

## Case studies:

Each case study is described in detail in the next chapter.

When running the workshop, you will read the case study out to participants and ask them to discuss prompt questions - firstly in small groups then sharing with the broader group. The PHN co-facilitator needs to moderate these discussions but the health professional involved in the training should give feedback and input on the responses shared.

There are several slides for each case study, directing participants to focus on different elements of the case. The notes sections of the slides give ideas of what to encourage at each point in the discussion. However, it is very possible that some points will be raised by participants across each of the slides. For this reason, it’s best to read the case descriptions in full and understand the content before you run a workshop.

## Slides focused on broader issues and resources

In the recommended slide sets, the same resource may be showcased in slightly different ways for different professionals. The same applies to the way things are assembled for GPs depending on the workshop length.

### S30O Divider slide – Slides to use in other training

The following slides can be used as a part of other training. That is, where the focus is not specific to intellectual disability.

### S31O Slides to use in other training – “What if…”

You need to tailor this slide with the name of the case study already being presented in the other training.

**Key point:**

* Group discussion. To get health professionals to consider what would change or stay the same if a patient has an intellectual disability.

### S32O Slides to use in other training – “What has changed? What is the same?”

Workshop participants who are not expecting this question may recognise that they don’t feel confident to provide health care for people with intellectual disability. If they share this, thank them for their honesty and reassure them they aren’t alone and that there is training and resources to improve their confidence.

Summarise what has arisen from the discussion.

**Key points:**

* What stays the same is providing person-centred, proactive health care.
* What is different is the need for reasonable adjustments.

### S33O Use as extra to other training - further reflections

**Key points:**

* Missed health conditions are common.
* Showcase the Comprehensive Health Assessment Program as a tool to ensure a methodical way approach to annual health checks.

### S34O Use as extra to other training – clinical resources

**Key points:**

* Excellent clinical resources are available.
* Showcase:
  + What not to miss – included in the Resources for Health Professionals document.
  + The Therapeutic Guidelines (subscription service) – link is provided and is in the handouts.

### S35O Use as extra to other training – Easy Read resources

**Key point:**

* Briefly showcase the availability of Easy read resources.

### S36O Resources – Medicare Item numbers

* Only use this slide if you are conducting a workshop for GPs. It is not pertinent to allied health workers.
* Tailor according to the case study’s name and presenting issues.

**Key points:**

* Refer GPs to the resource in the handouts.
* They can make this work financially viable.

### S37O Use with other training – Polypharmacy

This slide will only be relevant to your training if the case study you have featured in your workshop involves polypharmacy. Otherwise, if you choose to use it, you will need to include some introduction to give context as to why it is included.

**Key points:**

* Polypharmacy is common in people with intellectual disability and is of major concern due to:
  + cumulative and compounding side effects and long term health risks &
  + anticholinergics are of particular concern.
* Polypharmacy can be a restrictive practice.
* STOMP protocol is a resource from UK about de-prescribing.
  + For complex cases, seek a pharmacist’s advice first.

### S38V Video – Use as extra to other training – Optional video

This is an optional slide which can be used for a video at the end of other training. Choose a video from: [www.cid.org.au/health/PCEP-videos](http://www.cid.org.au/health/PCEP-videos) or you can use your own.

If this is being shown at or near the end of training, try to choose a positive health story to motivate and inspire health professionals.

If your workshop is for GPs and practice nurses, we suggest using slide S103V instead.

**Key point:**

* Include the story of someone with intellectual disability.

### S39V Video – Annual health assessment – Video placeholder

This is an optional slide which can be used for a video when presenting a longer workshop for GPs. It can also be added to the end of other training for GPs and practice nurses. Choose a video from: [www.cid.org.au/health/PCEP-videos](http://www.cid.org.au/health/PCEP-videos) or you can use your own.

**Key point:**

* Annual health assessments yield benefits.

### S40P Divider Slide - Case Study slides

The following slides are for case based learning.

Each case study lists the suggested professional audience.

### S41P Case Examples

This leads into the case study discussion.

### S42P Kit – Divider slide

This slide can be removed.

### S43P Case example 1: Kit Longer GP workshop

Read the description verbatim.

### S44P Kit – Longer GP workshop – Small group discussion

### S45P Kit – Longer GP workshop – Further reflections? Blank

These slides prompt small group discussion. Read the case study notes to understand the content.

### S46P Kit – Longer GP workshop – Further reflections? Animated

In this slide, the PHN co-facilitator or the health professional presents a summary of the more general points which have likely come out from the case discussion.

**Key points:**

* Missed conditions are common – Showcase the ‘Comprehensive Health Assessment Program’ as a tool to ensure a methodical way approach to annual health checks.
* Visual aids can assist communication – have some handy.
* Health professionals can support families to plan for smoother life transitions.

### S47P Diagnostic overshadowing

**Key point:**

* Define diagnostic overshadowing – to emphasise the importance of proactive and methodical health checks.

### S48P Kit – Longer GP workshop - Highlight resources

**Key point:**

* Showcase:
  + Therapeutic Guidelines – requires subscription but excellent. It is Australian, comprehensive and recently updated.
  + What not to miss– a list of commonly missed or mismanaged health issues in people with intellectual disability. Included in the Resources for Health Professionals document.

### S49P Your HealthPathways

**Key point:**

* Showcase what is on your own local *HealthPathways* for intellectual disability.

### S50P Amelia – Divider slide

This slide can be removed.

### S51P Amelia – Longer GP workshop

Read the case study out verbatim.

### S52P Amelia – Longer GP - Group discussion

### S53P Amelia – Longer GP - Comprehensive assessment?

These slides prompt small group discussion. Read the case study notes to understand the content.

This case study can be used for both medical and allied health professionals but the focus of the conversation may be different for each. For medical practitioners the key message is to follow a methodical approach to investigate possible causes of behaviour change.

Be sure to validate participants’ input and answers and emphasise to them that the value here is to talk about the *process* to identify the cause rather than the specific answer. It is unlikely anyone will identify the underlying medical cause (thrush). Expect it to surprise people. However, revealing the outcome at the end adds a bit of shock value because it is such an easily treated condition and the real Amelia waited some time for that treatment.

### S54P Amelia – Longer GP workshop – Further reflections

Summarise the general principles underpinning what has come from the discussion.

**Key points:**

* Any change in behaviour should be assessed in the following order: physical, mental health, social/environment and behaviour.
* Importance of being trauma-aware before doing invasive tests.
* Sometimes sedation is needed to assess – if so arrange other needed tests.

### S55P Amir – Divider slide

This slide can be removed.

### S56P Amir - Longer GP or GP Express workshop

Read the case study out verbatim.

### S57P Amir – Longer GP or GP Express workshop - First steps and beyond

This slide prompts small group discussion. Read the case study notes to understand the content.

### S58P Amir – Longer GP or GP Express workshop – Polypharmacy

**Key points:**

* Polypharmacy is common in people with intellectual disability and is of major concern due to:
  + cumulative and compounding side effects and long term health risks &
  + anticholinergics are of particular concern.
* Polypharmacy can be a restrictive practice.
* STOMP protocol is a resource from UK about de-prescribing.
  + For complex cases, seek a pharmacist’s advice first.

### S59P Amir – Longer GP or GP Express workshop – Further reflections

This slide prompts small group discussion. Read the case study notes to understand the content.

### S60P Resources – Medicare Item numbers

* Only use this slide if you are conducting a workshop for GPs. It is not pertinent to allied health workers.
* Tailor according to the case study’s name and presenting issues.

**Key point:**

* Refer GPs to the resource in the handouts.
* They can make this work financially viable.

### S61P Divider slide – case examples – GP Express

Whereas the longer GP workshop has 3 case studies, the express version has only 2 – Amelia and Amir. The case study descriptions and the notes provided for presenters in the next chapter are broadly consistent between the two versions. However, the clinical and practical content of the case study on Kit has been shifted to Amelia and Amir’s cases. This means resources are highlighted at different points.

### S62P Amelia – Divider slide

This slide can be removed.

### S63P Amelia – GP express workshop

Read the case study out verbatim

### S64P Amelia – GP express workshop – group discussion

### S65P Amelia – GP express workshop – Comprehensive assessment?

These slides prompt small group discussions. Read the case study notes to understand the content.

This case study can be used for both medical and allied health professionals but the focus of the conversation may be different for each. For medical practitioners, the key message is to follow a methodical approach to investigate possible causes of behaviour change.

Be sure to validate participants’ input and answers and emphasise to them that the value here is to talk about the *process* to identify the cause rather than the specific answer. It is unlikely anyone will identify the underlying medical cause (thrush).

Expect it to surprise people. However, revealing the outcome at the end adds a bit of shock value because it is such an easily treated condition and the real Amelia waited some time for that treatment.

### S66P Amelia – GP express workshop – Further reflections 1

**Key points:**

* Importance of being trauma-aware before doing invasive tests.
* Showcase *What not to miss* – a list of commonly missed or mismanaged health issues in people with intellectual disability. Included in the Resources for Health Professionals document.

### S67P Diagnostic overshadowing

**Key points:**

* Define diagnostic overshadowing – to emphasise the importance of proactive and methodical health checks.
* A methodical approach overcomes this.
  + Any change in behaviour should be assessed in the following order: physical, mental health, social/environment and behaviour

### S68P Amelia – GP express - Further reflections 2

**Key points:**

* Showcase the Comprehensive Health Assessment Program as a tool to ensure a methodical way approach to annual health checks.
* Adjustments at the whole of practice level can improve health care.
* Sometimes sedation is needed to assess – if so arrange other needed tests.

### S69P Amelia – GP express – Highlight resources

**Key point:**

* Showcase the Therapeutic Guidelines – requires subscription but excellent. It is Australian, comprehensive and recently updated.

### S70P GP express - Your *HealthPathways*

**Key point:**

* Showcase what is on your own local *HealthPathways* for intellectual disability.

### S71P Amir – Divider slide

This slide can be removed.

### S72P Amir - GP express workshop

Read the case study out verbatim.

### S73P Amir – GP Express workshop - First steps and beyond

### S74P Amir – Longer GP or GP Express workshop – Further reflections

These slides prompt small group discussions. Read the case study notes to understand the content.

### S75P Amir – Longer GP or GP Express workshop– Polypharmacy

**Key points:**

* Polypharmacy is common in people with intellectual disability and is of major concern due to:
  + cumulative and compounding side effects and long term health risks &
  + anticholinergics are of particular concern.
* Polypharmacy can be a restrictive practice.
* STOMP protocol is a resource from UK about de-prescribing.
  + for complex cases, seek a pharmacist’s advice first.

### S76P Divider Slide - Case examples – Allied health (MH)

### S77P Kit divider slide (can be removed)

### S78P Kit - Allied health professionals

Read the case study out verbatim.

### S79P Kit – Small group discussion – Allied health care

This slide prompts small group discussion. Read the case study notes to understand the content.

### S80P Kit – Further reflections? – Allied health workers

Use either S64P (if also using the Amelia case study) or S65P (if not using Amelia).

**Key points:**

* Reliance on supporters for health care.
* Role of allied health workers to encourage families to plan future care needs.
* Value of annual health checks.
* Missed health conditions common.

### S81P Kit – Some key points – Allied health workers

Use either S64P (if also using the Amelia case study) or S65P (if not using Amelia).

**Key points:**

* Reliance on supporters for health care.
* Role of allied health workers to encourage families to plan future care needs.
* Value of annual health checks.
* Missed health conditions common.
  + Any change in behaviour should be assessed in the following order: physical, mental health, social/environment and behaviour.

### S82P Amelia divider cover slide (can be removed)

### S83P Amelia – Allied Health Professionals

Read the case study out verbatim

### S84P Amelia – Allied Health Professionals – your turn

### S85P Amelia – Longer term

These slides prompt small group discussions. Read the case study notes to understand the content.

This case study can be used for both medical and allied health professionals but the focus of the conversation may be different for each. For allied health professionals, the key message is to check if the person has seen a medical practitioner and liaise with the GP if there is any doubt that appropriate investigations have occurred. This requires allied health professionals to be assertive and not simply assume that such checks have been done. Allied health answers will also vary, based on their profession – Amelia could benefit from a broad range of allied health care. Work with the health professionals involved in your training to understand what they think is important to highlight for their specific profession. They can make minor adjustments to the slides and notes.

Be sure to validate participants’ input and answers and emphasise to them that the value here is to talk about the *process* to identify the cause, rather than the specific answer. It is unlikely anyone will identify the underlying medical cause (thrush). Expect it to surprise people. However, revealing the outcome at the end adds a bit of shock value because it is such an easily treated condition and the real Amelia waited some time for that treatment.

### S86P Amelia – Allied health - Further reflections

**Key points:**

* Any change in behaviour should be assessed in the following order: physical, mental health, social/environment and behaviour.
* Allied health professionals should be vigilant in checking if a person has seen a medical professional about a change in behaviour and assertive in suggesting that medical causes be ruled out first.

### S87P Amir divider slide (can be removed)

### S88P Amir – Allied health workers

Read the case study out verbatim.

### S89P Amir – Allied Health workers – Your turn

This slide prompts small group discussion. Read the case study notes to understand the content.

**Key points:**

Allied health workers need to send Amir back to his GP promptly. Beyond that, answers will vary based on their profession. Work with the health professional involved in your training to understand what they think is important to highlight for their specific profession. They can make minor adjustments to the slide and notes.

Speech therapists in particular should be able to identify the risk that Amir has dysphagia and the need to work longer term to improve his communication.

### S90P Amir – Allied health - Highlight resources

**Key points:**

* Showcase:
  + Therapeutic Guidelines – requires subscription. It is excellent, Australian, comprehensive and recently updated.
  + *What not to miss* – a list of commonly missed or mismanaged health issues in people with intellectual disability. Included in the Resources for Health Professionals.

### S91P Divider Slide - Case examples – Dentists

### S92P Stacey divider slide (can be removed)

### S93P Stacey – Dentists

Read the case study out verbatim.

### S94P Stacey – Dentists, your turn

### S95P Stacey – Dentists – Further reflections

These slides prompt small group discussions. Read the case study notes to understand the content.

**Key points:**

* Regular appointments to do small amounts of work with lots of breaks.
* Use relaxation techniques together, tell her what you are going to do and check that she is OK.
* Manage the risk of vomiting through scheduling.
* Pay attention to communication and reasonable adjustments:
  + Speak to Stacey.
  + Quiet space.
  + One thing at a time, simple words.
  + Give time to think.
  + Scheduling – let her mum know the date and time too.

### S96P Leon divider slide (can be removed)

### S97P Leon – Dentists

Read the case study out verbatim.

### S98P Leon – Dentists – Your turn

### S99P Leon – Dentists – Pragmatics

These slides prompt small group discussions. Read the case study notes to understand the content.

**Key points:**

* Focus on what Leon can tolerate – a toothbrush examination.
* Demonstrate, check in, give breaks.
* Consider scheduling to suit the person and minimise waiting.
* For work under GA – liaise with GP early – maximise opportunity.
* If referring – include info on adjustments that help.
* Consent and payment may come from another person.

### S100P Dentists – Resources Special Care

**Key point:**

* The Association of Special Care Dentistry – source of information and referral options.

### S101P Dentists – Other Resources

**Key point:**

* Inclusion Australia has produced an excellent resource for dentists.
* The NIH paper shown here is one in a series of papers about oral health care and developmental disabilities. They are short and practical.
* NICE guidelines from the UK are also available but are specific to people living in residential care settings. The link is on the slide.

### S102P Divider slide – Aids – Dentists (can be removed)

### S103P Visual aids - Dentists

**Key point:**

* Having visual aids such as body maps handy helps a person communicate.

### S104P Communication aids – Dentists

**Key point:**

* Accessible information like Easy Read is available – link to resources.

### S105P Divider slide – Ending slides – Dentists (can be removed)

### S106P 6 key points – Dentists

Ideally the co-facilitator with intellectual disability presents this slide.

**Key points:**

1. Talk to **me.**
2. Ask me what I need.
3. Ask what helps me to cope.
4. Go slow.
5. Communicate with my GP.
6. Be aware of my complex health needs.

### S107P Dentists – Thank you and wrap-up

A co-facilitator to prompt participants about the survey. The co-facilitator with intellectual disability to thank their co-facilitator for their efforts, and vice versa.

### S108P Divider Slide - Case examples – Pharmacists

### S109P Divider slide – Joe (can be removed)

### S110P Joe – Pharmacists

Read the case study out verbatim

### S111P Joe – Pharmacists – Your turn

### S112P Joe – Pharmacists – Further considerations

These slides prompt small group discussions. Read the case study notes to understand the content.

**Key points:**

* Need to send Joe back to his doctor and also communicate your concerns with the doctor.
* People with intellectual disability can present with much complexity due to:
  + increased frailty risk and
  + missed conditions.
* Incomplete reports are common. To help:
  + keep scripts on file; check dates; and
  + touch base with the doctor.
* Home-based medication reviews are possible for people with intellectual disability. GP referral is needed.
* The Therapeutic Guidelines are an excellent resource - chapter on Developmental Disability and chapter on psychotropic prescribing (not specific to people with intellectual disability). They have recently been updated and are available online as a subscription service.

### S113P Joe – Pharmacists – Further considerations – No animations

Content is identical to S112P but without animations.

### S114P Pharmacists – POMPIDA resources

**Key point:**

* The POMPIDA (Pharmacists Optimising Medication for People with Intellectual Disability and Autism) is a source of information, including forms for Home medication review and information about how to charge for it.

### S115P Daryan divider slide (can be removed)

### S116P Daryan – Pharmacists

Read the case study out verbatim. The Daryan case study is different from all the others. Refer to the case study notes.

### S117P Daryan – Pharmacists – Your turn

### S118P Daryan – pharmacists – Polypharmacy

Daryan’s level of polypharmacy was extreme. However, the general points below apply in less extreme cases, too.

**Key points:**

* Polypharmacy is common in people with intellectual disability and is of major concern due to:
  + cumulative and compounding side effects and long term health risks &
  + anticholinergics are of particular concern.
* Polypharmacy can be a restrictive practice.
* STOMP protocol is a resource from UK about de-prescribing.
  + For complex cases, seek a pharmacist’s advice first

### S119P Divider slide – Ending slides – Pharmacists (can be removed)

### S120P 6 key points – Pharmacists

Ideally the co-facilitator with intellectual disability presents this slide.

**Key points:**

1. Talk to **me.**
2. Ask me what I need.
3. Ask what helps me to cope.
4. Go slow.
5. Communicate with my GP.
6. Be aware of my complex health needs.

### S121P Pharmacists – Thank you and wrap-up

A co-facilitator to prompt participants about the survey.

The co-facilitator with intellectual disability to thank their co-facilitator for their efforts, and vice versa.

Appendix G – Detailed description of the case studies

# Overlap of case studies

Several of the case studies (Kit, Amir and Amelia) are used for both medical and allied health professionals but slightly different clinical information is provided for medical vs allied health workers. Some elements of the group discussion will be the same across all groups, but some parts will be different for each profession.

Work with the health professional involved in your training to understand what they think is important to highlight for their specific profession. They can make adjustments to the slide and notes.

# GP Case study - Kit

Kit is a 51 year old man who enjoys gardening and Star Wars.

He lives with his mother Sherrie. His father David passed away last year. Kit also has a sister who lives interstate.

Kit’s father used to drive him to work where he restocked shelves at a small grocery store. Since his father’s passing, Kit left his job as it was too difficult to get there. His only NDIS supports cover his psychology services.

Kit has a history of anxiety, for which he takes an antidepressant (an SSRI). This was first prescribed by a psychiatrist over 10 years ago and the dose has remained stable for the past 8 years.

In the past year, Kit has become increasingly irritable and on two occasions he has become aggressive towards Sherrie. Sherrie, who is 76 and has a history of osteoporosis, is concerned for her own safety and for Kit’s wellbeing.

Kit has seen his psychologist 6 times so far this year to try to reduce his levels of agitation to discuss behaviour management. However, it is not working.

They have come to you for further assistance.

## Important things to know about Kit’s case

* SSRI stands for Selective Serotonin Reuptake Inhibitor, a commonly prescribed type of antidepressant. Prozac is an example.

## Tips for using this case study in training:

* For GPs and practice nurses, after the initial discussion read this extra information:

There is more information on Kit’s case.

When prompted with a visual aid of a body map, Kit indicates he has been experiencing pain in his upper and middle abdomen and his head. You are not able to get a reliable answer on the time frame though.

A week later they return for a comprehensive assessment. Your examination reveals a distended sigmoid colon. You ask Kit to have a plain X-ray which confirms constipation. You prescribe laxatives and exercise.

Kit and Sherrie together complete a survey as part of the comprehensive assessment. This reveals Kit has not seen a dentist in 18 months. Sherrie reports this is due to Kit’s anxiety over the dentist.

Then ask groups to discuss:

* What do you need to for Kit going forth?
* What else needs to happen in the short and the long term?
* For allied health professionals, instead read this:

As it turns out – the GP did investigate and Kit was extremely constipated. Laxatives and exercise were prescribed.

Then ask them to discuss whether this changes their plan.

## Kit’s case highlights some important points:

**Clinical points:**

* Possible causes of Kit’s symptoms include:
* Depression
* Thyroid disorder
* Constipation (especially as he is less active now than before, given he no longer works in a physical job)
* Grief response
* Medication reaction – even at 51 it is possible that Kit is experiencing early frailty, which can impact metabolism of medication.
* Ask about other recent symptoms; book a Comprehensive Health Assessment Program.
* Missed medical conditions are common in people with intellectual disability. Constipation is commonly missed.
* Refer to the ‘What not to miss resource.’
* Highlights the value of annual health checks
* Other ways to help Kit going forth:
  + To address the dental anxiety:
    - Suggest an Easy Read or video resource about dental care.
    - Liaise with his psychologist to see if they can address the dental anxiety.
    - Explain that if needed, dental care can be done under anaesthetic – however, he has tolerated dentistry before, so we want to try other methods to calm Kit first. A special care dentist could help a lot. Check health pathways for information on special care dentistry.
  + Review the SSRI dosage following blood test results.
  + Follow up to ensure constipation resolves.
  + Explore other allied health services that could be useful e.g. dietitian for nutrition, exercise physiologist.
  + Going forth, discuss preventative health care checks.

**Practical points:**

* Health professionals can support families to plan for smoother life transitions.
* Reliance on supporters for health care.
* Kit needs a physical exam – but schedule it when you can offer a long appointment (not today). Explain this to Kit.
* Suggest an NDIS plan review. Ask to include these services as well as supports to enhance his participation in work and the community and supports for Sherrie.
* Both GPs and allied health professionals can talk with Sherrie about her own wellbeing and safety. Ensure this conversation occurs without Kit present. If not already done, raise respite care and future care planning. An NDIS review is warranted to assess Kit’s eligibility for such services.

**Reasonable adjustments:**

* First step is talk to Kit – ask if he wants Sherrie to stay and if you can talk to Sherrie too.
* Visual aids can assist communication – have some handy. For example, a body map and visual pain scale.

# GP Case Study - Amelia

Amelia is a woman in her early 20’s who loves cats and enjoys watching cooking shows on TV.

She has an intellectual disability and cerebral palsy. She is able to vocalise and use some sign language. However, it is very difficult for people to understand her communication.

This is Amelia’s first visit with you. Her previous GP (whom she had seen since she was a child) recently retired. You see two other residents in Amelia’s group home.

Support staff inform you that Amelia has lived in their residential service for the past 3 years. She sees her Mum every weekend.

They tell you she has epilepsy for which she takes medication.

They also tell you that Amelia has a history of trauma – as a teenager she was sexually and physically abused by someone who was not a family member.

In recent years, she has had mental health problems, including a suspected suicide attempt. She has also exhibited behaviours of concern (including non-suicidal self-harm).

Support staff report that for the past month Amelia has exhibited 'sexualised' behaviours – this includes taking off her clothes, exposing her genitals to staff (male and female) and touching her genitals in public. Staff report that these behaviours are becoming more frequent.

They report that there were no changes in Amelia’s group home or day program close to when these behaviours began and also no other signs of any mental health crises emerged around then.

# Allied health case Study - Amelia



Amelia is a woman in her early 20’s who loves cats and enjoys watching cooking shows on TV.

She has an intellectual disability and cerebral palsy. She is able to vocalise and use some sign language. However, it is very difficult for people to understand her communication.

This is Amelia’s first visit with you. Support staff inform you that Amelia has lived in their residential service for the past 3 years. She sees her Mum every weekend. They tell you she has epilepsy for which she takes medication.

They also tell you that Amelia has a history of trauma – as a teenager she was sexually and physically abused by someone who was not a family member.

In recent years, she has had mental health problems, including a suspected suicide attempt. She has also exhibited behaviours of concern (including non-suicidal self-harm).

Support staff report that for the past month Amelia has exhibited 'sexualised' behaviours – this includes taking off her clothes, exposing her genitals to staff (male and female), and touching her genitals in public. Staff report that these behaviours are becoming more frequent.

They report that there were no changes in Amelia’s group home or day program close to when these behaviours began, and also no other signs of any mental health crises emerged around then.

**Follow-up information:**

A psychological interview reveals no other current concerns about Amelia’s mental health:

* During her prior mental health episodes, Amelia displayed signs of distress such as crying, withdrawing to her room, reduced signing or vocalisation and refusing to cooperate with any self-care. None of these things have occurred lately.
* Instead, when asked how she is, Amelia signs ‘good’ and ‘happy.’
* Staff and her mother report that she continues to engage with her regular activities with her typical level of enthusiasm.
* The group home manager investigates and confirms that no changes in staff or attendance occurred at either Amelia’s home or day program. Amelia’s mum confirms that during Amelia’s visits, no other visitors were present.

## Important things to know about Amelia’s case:

Amelia is based upon a real person who saw multiple allied health professionals to address the changes in her behaviour, before someone finally realised she had not yet had a medical check. The GP’s investigations revealed that Amelia had thrush. It was treated and behaviours settled.

## Tips for using this case study in training:

* This case study can be used for both medical and allied health professionals but the focus of the conversation may be different for each. For medical practitioners the key message is to follow a methodical approach to investigate possible causes of behaviour change.
* For allied health professionals, the key message is to check if the person has seen a medical practitioner, and liaise with the GP if there is any doubt that appropriate investigations have occurred. This requires allied health professionals to be assertive and not simply assume that such checks have been done. Other allied health answers will vary based on their profession – Amelia could benefit from a broad range of allied health care. Work with the health professional involved in your training to understand what they think is important to highlight for their specific profession. They can make minor adjustments to the slide and notes.
* Be sure to validate participants’ input and answers and emphasise to them that the value here is to talk about the process to identify the cause rather than the specific answer. It is unlikely anyone will identify the underlying medical cause (thrush). Expect it to surprise people. However, revealing the outcome at the end adds a bit of shock value because it is such an easily treated condition and the real Amelia waited some time for that treatment.

## Amelia’s case highlights some important points:

**Clinical points:**

* Complexities in a person’s medical and social history can make identifying the cause of change difficult.
* A methodical approach is the answer.
* Start with gathering additional information, from the person and/or their supporters as appropriate.
* Missed medical conditions is common in people with intellectual disability.
* Any change in behaviour should always trigger a physical health check in the first instance.
* Potential reasons for Amelia’s changes in behaviour include:
* It may be an attempt to communicate something.
* Further abuse, or a trauma response from prior abuse.
* Changes in medication or a hormonal contraceptive.
* Reaction to a lifestyle change.
* Seizure activity.
* Long-term ways to address Amelia’s health needs include:
* Referral to a speech therapist to improve communication.
* If the behaviours continue – a positive behaviour support plan.
* Engage with Amelia and her supporters to establish a good rapport and in the future, discuss options for health checks and other forms of preventative health care such as cancer screens.

**Practical points:**

* Amelia had a history of abuse.
* Abuse is more common in people with intellectual disability.
* People with intellectual disability may also be traumatised or re-traumatised by medical procedures.
* It is important that health practitioners are aware of this and respond in a trauma-informed way.

An example is arranging repeat visits *before* attempting an assessment, and ensuring a trusted person can attend with her

* Health practitioners need to be aware of how to establish if someone has capacity to consent and if not who can give proxy consent.
* This is a decision-by-decision matter.
* Health professionals may need to liaise with Group home staff.
* Establish a good working relationship early on.
* In Amelia’s case, it may be necessary to discuss staffing ratios with them during the time that you are investigating the cause. This is both for Amelia’s welfare and that of the staff.
* Amelia’s behaviour changes mean she currently requires additional supports. Health practitioners may be asked to support NDIS applications and it is helpful for them to know how to do this.
* There is a list of links for resources on this.

**Reasonable adjustments:**

* Repeat visits to build trust.
* Vigilantly checking Amelia is comfortable during appointments, stopping if she is not.
* Coordinating opportunistic investigations in the event a general anaesthetic is required.

# Man feeding a horseGP Case study – Amir

Amir is a 19 year old man who enjoys walks and spending time with his family. He moved to a group home 8 months ago. He visits his family’s farm one weekend a month.

He has an intellectual disability in the moderate range. He needs support in many areas, including for planning his activities, as well as some more complex self-care activities such as shaving. Amir has no speech - he communicates through basic sign language.

Amir attended a special education school where his parents report he received excellent support. The transition to post-school options was difficult and he often refused to go. This was a reason for his move into residential care. He still frequently refuses to attend the program and on these days he spends most of the day on his bed watching TV.

Most of Amir’s health care to date has been provided by a developmental paediatrician, who has liaised with a paediatric neurologist and more recently a child and adolescent psychiatrist. As a result, Amir has only seen you sporadically. He previously accessed some allied health services through the children’s hospital but now he has transitioned out of the children’s services. He still sees his psychiatrist 3 times a year and neurologist biannually.

Amir’s medical history includes Epilepsy, which appears to be well controlled using Tegretol. His parents made the appointment and asked group home staff to bring him to see you because he has been refusing to eat for 3 weeks.

Staff report Amir has always been a picky eater while in their care but this has gradually become worse. A few months back, Amir’s psychiatrist prescribed 3mg risperidone for behaviours of concern – it was hoped this would help his eating but it seems to be even worse since then. Amir stopped eating following a choking episode exactly 3 weeks ago – he appears ‘scared’ of food since this time. He refuses to go to the table for meals. He will eat small amounts of banana smoothie, only.

Amir appears very thin and underweight. By the time you see him, he has been in the waiting room for 40 minutes and he is agitated, though no one knows exactly why. He appears to be trying to communicate but the staff member who has come with Amir is not his key worker and does not know all of his signs.

# Man feeding a horseAllied Health Case Study – Amir

Amir is a 19 year old man who enjoys walks and spending time with his family.

He has an intellectual disability in the moderate range. He needs support in many areas, including for planning his activities, as well as some more complex self-care activities such as shaving. Amir has no speech - he communicates through basic sign language.

He moved to a group home 8 months ago. He visits his family’s farm one weekend a month.

Amir attended a special education school where his parents report he received excellent support. The transition to post-school options was difficult and he often refused to go. This was a reason for him to move to into residential care. He still frequently refuses to attend the program, and on these days he spends most of the day on his bed watching TV.

Amir’s parents made the appointment and asked group home staff to bring him to see you, because he has been refusing to eat for 3 weeks. Staff report Amir has always been a picky eater while in their care, but this has gradually become worse. A few months back, Amir’s psychiatrist prescribed a medication for behaviours of concern (risperidone, usually prescribed for psychosis). It was hoped this would help his eating, but it seems to be even worse since then.

Amir stopped eating following a choking episode exactly 3 weeks ago – he appears ‘scared’ of food since this time. He refuses to go to the table for meals and can become agitated if staff try to cajole him. He will eat small amounts of banana smoothie, only.

Amir appears very thin and underweight. He appears to be trying to communicate, but the staff member who has come with Amir is not his key worker and does not know all of his signs.

## Important information about Amir’s case

* The outcome of Amir’s case was as follows (you can share this at the end of the workshop if people ask for it):
* A swallowing assessment suggested oesophageal dysphagia. An urgent referral to a gastroenterologist was made for further assessment. The psychiatrist agreed to have Amir discontinue the risperidone under the GP’s supervision.
* Speech therapist recommended a thickened liquid diet whilst awaiting gastroenterology assessment and thereafter pending gastroenterology results and advice.
* Dietitian assisted with planning a very high nutrition liquid diet with review once Amir’s BMI reaches 18.5.
* The group home agreed to weigh Amir every week and will report any weight loss immediately.
* Risperidone is an anti-psychotic and when prescribed for behaviours of concern it is considered a restrictive practice. Appetite stimulation and weight gain is a major side effect. 3 mg is quite a high dose for someone who is underweight. It can – rarely - lead dysphagia (difficulty swallowing) and so it is *possible* it explains the worsening of his symptoms.
* Some drugs block on the action of acetylcholine, a neurotransmitter (that is, a chemical messenger in the body). These drugs are said to have an anticholinergic effect. They can also just be called anticholinergics. Many drugs have anticholinergic effects and some have a greater anticholinergic effects than others. The anticholinergic action can build up across different drugs. Drugs with a substantial anticholinergic burden can cause long-term side effects which impact a person’s health.
* People with intellectual disability are more likely than others to experience adverse reactions to psychotropic medications.
* In Amir’s case, he was already on Tegretol which has mild anticholinergic activity. Many drugs interact with Tegretol – include Risperidone, though this interaction is in the direction of Tegretol *reducing* the impact of the Risperidone. However, both of the drugs can cause gastrointestinal upsets.

## Tips for using Amir’s case in a workshop

* Amir’s case can be used for medical or allied health professionals. The notes below focus on medical issues. For allied health workers, major points are listed, but other topics raised in discussion will vary based on their profession. Work with the health professional involved in your training to understand what they think is important to highlight for their specific profession.

## Amir’s case highlights important points:

**Clinical points - For GPs and practice nurses:**

* Polypharmacy is common in people with intellectual disability and is of major concern due to cumulative and compounding side effects and long term health risks.
* Anticholinergics are of particular concern.
* Amir’s symptoms could have many causes: dysphagia, constipation, reflux, dental problems, ear infections, and any history of abuse and signs of mental health problems, including depression or PTSD. The file notes may provide a relevant history.
* It got worse with risperidone – medication reaction is possible. Speak with the prescribing psychiatrist, review any information they have sent about the reasons for prescription. Stop or reduce the dose.
* His weight is an issue, as is the risk of dehydration. A chemist can advise about a high-quality over the counter nutritional supplement. It should be started immediately.
  + However, if Amir does not like it, other options should be explored to meet his nutritional needs. Adding things to his smoothies without his consent may require the staff to seek necessary approvals. A health care worker can helpfully provide supporting documentation.
* Arrange a swallowing assessment urgently from a speech therapist. Privately via health pathways or call the hospital speech pathology department.
* In the longer term, Amir could benefit from:
* annual health assessments (which can detect problems sooner);
* a dietitian to build weight;
* any other allied health professionals he has lost when leaving child services.

**Clinical points - For allied health workers:**

* Send Amir back to his GP promptly for a physical check-up.
* Speech therapists in particular should be able to identify the risk that Amir has dysphagia and the need to work longer term to improve his communication.

**Practical points:**

* People arriving with a support person who is not the best person to be there happens. It’s not the health professional’s responsibility to sort out the group home’s scheduling. But confirming with the house manager that they can schedule a key worker when making an appointment will make everyone’s day smoother.
* No assessment is possible when Amir is distressed. He needs a long appointment (as soon as possible) at a time when he won’t need to wait.
* Health professionals can support families to plan for smoother life transitions.
* Some children with intellectual disability and complex conditions get most of their care through a paediatrician and/or multidisciplinary clinics within hospitals. This can be a problem once they leave paediatric services. GP needs to be copied into everything from age 11 on. Refer workshop participants to the hints in the sheet on supporting people through transitions, available within the booklet *Resources for Health Professionals working with People with Intellectual Disability*, available at: [www.cid.org.au/health/resources-health-professionals](http://www.cid.org.au/health/resources-health-professionals). Amir’s GP can encourage his supporters to bring him in regularly now to build a relationship.

**Reasonable adjustments:**

* Visual aids may assist communication. On another day, with someone present who understands Amir, it may be worth trying to use a visual scale for pain and a body map.
* Asking those who know him well about any other recent behavioural changes can give clues about pain, too.
* The first thing to do is engage with Amir – say hello even if he does not talk.
* Only attempt to weigh Amir if he assents to it.
* Allow Amir to wait in a separate room or outside.
* Offer him time slots when he won’t have to wait long.

# **Dentist Case study – Stacey**



Stacey is a young woman who lives with her family and has a companion dog. She works as a mail clerk and occasionally as an actor. She has an intellectual disability and needs support across several areas of life.

Stacey communicates using simple speech and can mostly be understood well. She is well supported by her mum, Anna, who attends all appointments with Stacey.

Stacey is a mouth breather and often gags. She also has bruxism but cannot wear a splint due to gagging. She has a phobia of needles and so won’t tolerate regular muscle relaxant injections, they make her extremely anxious.

Recently, she had a vertical root fracture of an unrestored premolar tooth.

## Stacey’s case highlights important points:

**Clinical:**

* Regular appointments to do small amounts of scaling; lots of breaks.
* Manage the risk of vomiting through scheduling 2 hours after food.
* A maxillary splint can help bruxing but she is unlikely to tolerate it due to gagging (the real life Stacey does not tolerate it).
* Refer to a psychologist for further assistance if bruxing increases.

**Practical:**

* Ask the GP for a care plan summary to appraise yourself of any relevant medical issues and medications.
* Salt on her tongue helped her tolerate scaling without gagging.

**Reasonable adjustments:**

* Use relaxation techniques together
* Give her time to settle in at the start of the appointment.
* Make conversation – ask about other things in her life (get to know her a bit).
* During scaling, relax shoulders (the dentist does it too).
* Have a way for her to communicate the need to stop (due to gagging or for any reason). Stacey raises her finger if she needs to stop for any reason.
* Count upwards or downwards to indicate when she will next get a break.
* Allow her to bring things from home that assist her to relax e.g. a weighted blanket or any sensory toys that help relax her.
* Ask her how it went at the end so you can adjust things next time if something could be better.
* Regular breaks focused on breathing and relaxation exercises, the dentist can do this along with her.
* Pay attention to communication.
* Speak to Stacey.
* Quiet space.
* One thing at a time, simple words.
* Give time to think.
* Tell and show her what you are going to do, use models, images and videos.
* Check understanding both ways. Use the teach-back method.
* Give Stacey time to think about what you have said and if she has questions.
* Be comfortable with silence, don’t feel the need to fill it.
* Especially important to give time if Stacey needs to make a decision.
* If recommending that Stacey does something, ask if she would like you to give the information to her mum too. You can provide it in writing or verbally.
* Scheduling – to minimise wait times; allow her to wait away from other patients where she may be more relaxed.
* Ask how she prefers to get reminders e.g. phone call, not text or letter.
* Ask if she wants her mum to be reminded, too.

# Dentist Case Study – Leon



Leon is a man in his late 30’s who enjoys watching home videos. He has a severe intellectual disability and requires support for most activities. Leon relies on non-verbal forms of communication. He also has a physical disability and uses a wheelchair.

He lives in a group home but stays with his father every second weekend.

Leon’s medical history includes dysphagia and epilepsy which is not well controlled. He tolerates having someone brush his teeth. His tolerance for dental work is lower – in the past he’s been able to manage small sections of scaling with good suctioning. However, he opens his mouth very wide making it hard to access the buccal surfaces.

His last comprehensive dental evaluation was 6 years ago, under general anaesthetic.

His GP has referred him to you for an assessment and possible extractions prior to commencing bisphosphonates.

## Important information about Leon’s case:

* Bisphosphonates are a type of drug used to treat osteoporosis. They can place a person at a higher risk of adverse effects following tooth extraction.
* An orthopantomagram is an x-ray of the whole jaw, upper and lower jaw in one go.
* Leon’s dysphagia (difficulty swallowing) places him at risk of choking.

## Tips for using Leon’s case in a workshop

This case came from a special care dentist and is based on a real case. People may find it challenging (in which case the small groups will be very quiet). If that happens you can use these secondary prompt questions:

* How would you assess Leon’s oral health?
* Would you go straight to general anaesthetic?
* Is there anything else you could try? How would you work out what to do?
* How would you address his dental needs?
* Are there risks you need to manage?
* Are there any adjustments you could make to your standard practice?
* How to do you about communicating with Leon?

## Leon’s case highlights important points:

**Clinical:**

* A toothbrush examination and an X-ray might help inform the need for GA.
* Work through small sections of scaling, with good suctioning.
* Leon’s dysphagia places him at risk of choking – limit his recline.
* General anaesthetic carries risks, especially for someone with multiple conditions. However, if extractions are needed it will be required.
* Liaise with GP early – maximise opportunity. Communicate that it would be good to get dental done IF Leon is having GA for any other reason. If extractions are needed under GA, give the GP sufficient notice to arrange other investigations he is due for. There is any number of preventative and routine checks that he could be due or overdue for.
* If you refer to a public hospital, ask if there is a process by which a generalist or a rehab physician can arrange these extra investigations.
* Referral options:
* Public hospital.
* Private dentist who is able to do this in a well-equipped hospital – Leon is at high risk from a GA so it needs to be in a hospital with sufficient equipment

**Practical:**

* Start with what Leon does tolerate – a toothbrush. Do a toothbrush examination.
* Consent and payment may come from another person – can call them on the day before doing X-ray for example.
* Leon stays in his wheelchair, with a strap to stay secure. The orthopantomagram can be done in a wheelchair but you might need a lifter.
* Some dentists won’t have this available – refer to another with this equipment.
* Organise pre-meds before a procedure. For someone with intellectual disability it can be really hard to sit in a waiting room. So if they are going to need pre-meds, consider whether it’s something they could take at home, to minimise the wait time.
* If referring to the hospital or another dentist:
* check their accessibility if it’s a practice;
* let them know adjustments that assist Leon to cope (see the tips sheet which can be shared along with referrals);
* for someone with few supports: ask your staff to make the appointment before they leave your service and to forward a copy of the referral directly to the practice – it all increases the likelihood that they will actually get there.

**Reasonable adjustments:**

* Suggest he bring distractions with him.
* Ask those supporters how Leon may indicate yes/no or any distress – actively check with them during the procedure and stop immediately if there is any distress.
* Show and tell him what you are going to do before you do it. Demonstrate on a model, your own hand, or on his hand so he has an idea of how the tool feels. Then do it to one tooth before doing the rest.
* Give regular breaks.
* Consider scheduling to suit the person and minimise waiting.
* Longer appointment = time to communicate, time to go slow.
* If referring – include info on adjustments that help.
* Communication:
  + Talk to Leon even though he can’t talk.
  + Tell him that you are going to ask his supporters for information and for them to help you understand him.

# Pharmacist case study – Joe

Joe is man in his late 50’s who lives alone in a public housing unit. He has a mild intellectual disability. He communicates through speech and can read some simple text. Joe has never mentioned having a family or supports. He has always attended the pharmacy alone.

Joe has epilepsy for which he takes 900 mg sodium valproate daily in 2 doses. The dose has remained the same for at least the past 10 years.

3 weeks ago, his GP prescribed 2 mg diazepam at night. Joe reports this was for an injury. There are 3 repeats on this script.

When questioned, Joe reports that the diazepam helps him sleep. His sleep was compromised recently due to shoulder pain which remained after a fall. It’s unclear from his report whether he fell or slipped. He can’t recall when the injury occurred. He does know that he tried a cream first but it did not help. He does not know what the cream was called. He already owned it before the injury, having used it for an injury some years ago. He reports the tube has now run out.

Today Joe is at his local pharmacy, asking for a repeat of the sodium valproate. The script is on file. He also asks if he can get another box of diazepam while he’s here, he is not sure how many pills are left. It’s not due to be refilled for another week.

Joe also asks if you can recommend a product to help with constipation. When asked, he says he has been feeling blocked up for a while but he is not sure how long.

You note that Joe is holding on to the counter and appears generally slower than typical for him.

When asked, Joe can’t remember the last time he went to the doctor. He thinks he has not been since the script for diazepam was issued (4 weeks ago).

## Important things to know for Joe’s case:

* Sodium valproate is commonly used to treat epilepsy and also bipolar disorder. It can disrupt metabolism.
* Benzodiazepines commonly cause constipation but also can cause vagueness and balance issues.
* People with intellectual disability being unsure of time frames is a common practical challenge that health professionals may face.

## Joe’s case highlights important clinical and practical considerations, and reasonable adjustments that can be made

**Clinical:**

* Constipation is really common – and commonly missed – in people with intellectual disability.
* Joe’s constipation could be a medication reaction:
* Benzodiazepines increase risk of constipation.
* Age-related changes in pharmacokinetics of sodium valproate.
* Joe’s fall could be from seizure activity.
* He is showing balance issues (grabbing counter).
* Age and frailty can change the way the body metabolises drugs, causing new side effects even when someone has been on a drug for some time.
* Early frailty is more common in people with intellectual disability - even as early as their 50’s
* Missed health conditions are also common in people with intellectual disability, further complicating the picture.
* The pharmacist should:
* encourage Joe to go back to his doctor – and communicate directly with the doctor and
* check Joe’s blood pressure.

**Practical:**

* It is common for people to not be able to recall all needed information.

It is hard to know if Joe has been taking the sodium valproate consistently. Even if he used to, a benzodiazepine might make him forget to. This could impact his epilepsy. Practical ways to help with this include:

* + Keep scripts on file; check dates of when filled
  + Touch base with the doctor
  + Suggest a Webster pack and a reminder app/device.
  + Joe is gripping the counter. Invite him to sit down.

**Reasonable adjustments:**

* Adjusting your communication
* Speak slowly, use plain language, ask one question at a time and give Joe thinking time.
* Write down steps for him.
* Say why you are asking personal questions (e.g. about poo).
* Visuals – Bristol Stool chart.
* Home-based medication reviews are possible for people with intellectual disability. GP referral is needed.
* Showcase the Therapeutic guidelines on psychotropic drugs and on Developmental disability.

# Pharmacist Case Study - Daryan



Daryan is a man in his mid-20’s who enjoys nature and shares a close bond with his mum. He has lived in supported accommodation since the age of 16 and currently receives 2:1 care in a unit on his own.

He is obese and has a family history of cardiovascular disease.

Daryan has intellectual disability, autism, bipolar disorder and “challenging behaviours”. These include noise and property destruction, inappropriate urination and smearing faeces, and spitting. He paces often and has a poor attention span.

However, he loves nature – his support workers report that Daryan is always calmer when they take him to a bushwalk or the beach – both of which are a 15-minute drive from his home.

Daryan sees a psychiatrist and also engages a psychologist and OT via the NDIS. He consulted a senior psychologist as part of a review of his Positive Behaviour Support plan. The psychologist requested the GP make a referral for a Home Medications Review.

Daryan is currently prescribed 11 medications (see chart).This includes 2 daily antipsychotics and a third on a PRN basis.

## Important things to know about Daryan’s case

* Daryan is based on a real case. However, it is an extreme example of polypharmacy and includes elements of chemical restraint. Share the fact that it’s real with the participants.
* Pause to allow people to react to the 11 medications sentence including 3 antipsychotics, before you move on to give instructions.

## Tips for using Daryan case study

* A different approach is used for this case study. Rather than listing all medications in the case study, they are included on a handout, with space for notes.
* The activity is to discuss in small groups and take notes about the most concerning issues in Daryan’s medications.
* Ask participants to pay attention to your instructions first, as they will be able to read the medications list together in their small groups.
* Direct participants to find the chart of Daryan’s medications in their handouts.
* Emphasise the point is not to discuss the detail of every medication (it would take too long) but to discuss the major alarm bells.
* Then, give them time to read through this together in their small groups.
* After about 10 minutes, ask groups to highlight any particular points they noted.
* As an optional post-workshop activity, participants can take more detailed notes and do necessary research to complete the medication review for Daryan.

Appendix H – Handouts to accompany the training

# Summary of handouts

Below is a summary of the handouts to send before and after the training course. The entire package of handouts is designed to be used for a standalone training session. There is scope to tailor the handouts according to the target audience of the session.

If you are using just a portion of the training materials for example, incorporated into training on another topic, we recommend not sending the pre-workshop materials. However, in such a circumstance it is still helpful to send the links to key resources along with the post-workshop reading, as is relevant for the audience. The post-workshop activity and reflection questions may also be tailored and used.

### Suggested handouts to send before the training course

1. Copy of all slides for the session – For the sake of accessibility, it is suggested you send these formatted as a ‘handout’ with 3 slides to a page and also as 1 slide to a page.

If preferred, these could also be sent at the very start of the workshop.

1. Pre-workshop activity and reflection. This could also include a pre-workshop survey for evaluation purposes. Tailor the activity as appropriate.
2. The case study descriptions – only those applicable to the specific workshop.
3. Links to resources, with those referenced in the workshop at the start.

### Suggested handouts/links to be sent after the training course

1. Post-workshop activity and reflection questions. Tailor the activity as appropriate.
2. Your evaluation survey link, unless distributed within a face-to-face workshop.

### Recommended dates for sending handouts:

* Pre-workshop handouts - 3 weeks before.
* Reminder - 1 week before.
* Second reminder - a day before.

However, this timeframe can be adjusted as needed.

We have included suggested emails to explain the handouts. You can tailor this as you wish or write your own.

### Suggested email to accompany pre-workshop materials

We look forward to meeting you at the [Title of your workshop] session on [DATE] at [TIME].

We have attached here a copy of the cases to be discussed in the workshop, along with key resources which will be highlighted during the session.

[Optional] - We have also included all **slides** to be used in the session.

Also attached is a **pre-workshop activity and reflection** which has been designed to:

* help you identify your own learning needs;
* prompt questions you may wish to bring along to the session; and
* allow you to more fully engage in the workshop activities.

If you plan to claim Continuing Professional Development Points, the time spent completing the pre-workshop activity can be counted.

Your reflection answers are for your own records only - so you can be as honest as you like. If time permits, please review your notes just before the session to refresh your memory.

Just a reminder of the session details:

**For face to face:**

The session will be held at [location]

[Insert transport and parking details]

**For a webinar:**

To access the session, click here: [LINK]

[Insert details of required software/access here:]

If you have any difficulty getting online, please contact [NAME] on [PHONE].

If you need any further information, or wish to talk to us about ensuring the workshop is accessible for you, please don’t hesitate to contact [NAME] on [PHONE] or [EMAIL].

Kind regards,

[EMAIL SIGNATURE]

## Pre-workshop activity

### Part A

Do you regularly provide services to people with ID in your work?

*Or*, do you regularly encounter people with intellectual disability in your work?

**If yes**, complete this page. **If no**, complete the next page.

Take a moment to reflect on a recent experience providing services to a person with ID and make some notes about that experience. You may want to consider these questions:

* At the time, did you feel confident that you were providing good care?
* What did you do well?
* What could have been improved upon?
* Were there any barriers to meeting their needs?
* Were there any factors that helped facilitate good care?

Type your answer here:

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**If no**, complete this page.

**Take a moment to reflect on the possible reasons you do not regularly see people with ID.**

* List 3 – 5 possible reasons.

Type your answer here:

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**What do you think are the key challenges to providing services for people with ID?**

Type your answer here:

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**Can you think of some ways to overcome such challenges?**

Type your answer here.

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## Part B – for health professionals working in practices where intake procedures apply

Gather together:

1. any paperwork a new patient must complete before they are offered an appointment at your practice; and
2. any paperwork a new patient is asked to complete at the time of their appointment.

**What sorts of supports does your practice offer someone who needs help to complete these forms?**

Type your answer here.

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# Case studies discussed in the workshop

Share only those case studies you will use for this workshop ahead of time. For most workshops, this will be two or three case studies.

You may also choose to share the slides ahead of the workshop if you wish.

For Kit, Amir and Amelia case studies, ensure you share the correct version for your target audience.

## GP Case study - Kit

Kit is a 51 year old man who enjoys gardening and Star Wars.

He lives with his mother Sherrie. His father David passed away last year. Kit also has a sister who lives interstate.

Kit’s father used to drive him to work where he restocked shelves at a small grocery store. Since his father’s passing, Kit left his job as it was too difficult to get there. His only NDIS supports cover his psychology services.

Kit has a history of anxiety, for which he takes an antidepressant (an SSRI). This was first prescribed by a psychiatrist over 10 years ago and the dose has remained stable for the past 8 years.

In the past year, Kit has become increasingly irritable, and on two occasions he has become aggressive towards Sherrie. Sherrie, who is 76 and has a history of osteoporosis, is concerned for her own safety, and for Kit’s wellbeing.

Kit has seen his psychologist 6 times so far this year to try to reduce his levels of agitation to discuss behaviour management. However, it is not working.

They have come to you for further assistance.

## GP Case Study - Amelia

Amelia is a woman in her early 20’s who loves cats and enjoys watching cooking shows on TV.

She has an intellectual disability and cerebral palsy.

She is able to vocalise and use some sign language. However, it is very difficult for people to understand her communication.

This is Amelia’s first visit with you. Her previous GP (whom she had seen since she was a child) recently retired. You see two other residents in Amelia’s group home.

Support staff inform you that Amelia has lived in their residential service for the past 3 years. She sees her Mum every weekend.

They tell you she has epilepsy for which she takes medication.

They also tell you that Amelia has a history of trauma – as a teenager she was sexually and physically abused by someone who was not a family member.

In recent years, she has had mental health problems, including a suspected suicide attempt. She has also exhibited behaviours of concern (including non-suicidal self-harm).

Support staff report that for the past month Amelia has exhibited 'sexualised' behaviours – this includes taking off her clothes, exposing her genitals to staff (male and female), and touching her genitals in public.

Staff report that these behaviours are becoming more frequent.

They report that there were no changes in Amelia’s group home or day program close to when these behaviours began, and no other signs of any mental health crises emerged around then.

## GP Case study – Amir

Amir is a 19 year old man who enjoys walks and spending time with his family. He moved to a group home 8 months ago. He visits his family’s farm one weekend a month.

He has an intellectual disability in the moderate range. He needs support in many areas, including for planning his activities, as well as some more complex self-care activities such as shaving. Amir has no speech - he communicates through basic sign language.

Amir attended a special education school where his parents report he received excellent support. The transition to post-school options was difficult and he often refused to go. This was a reason for his move into residential care 8 months ago. He still frequently refuses to attend the program and, on these days, he spends most of the day on his bed watching TV.

Most of Amir’s health care to date has been provided by a developmental paediatrician who has liaised with a paediatric neurologist and more recently, a child and adolescent psychiatrist. As a result, Amir has only seen you sporadically. He previously accessed some allied health services through the children’s hospital but now he has transitioned out of the children’s services. He still sees his psychiatrist 3 times a year and neurologist biannually. Amir’s medical history includes Epilepsy, which appears to be well controlled using Tegretol. His parents made the appointment and asked group home staff to bring him to see you, because he has been refusing to eat for 3 weeks.

Staff report that Amir has always been a picky eater while in their care but this has gradually become worse. A few months back, Amir’s psychiatrist prescribed risperidone for behaviours of concern, initially on a low dose but then increased to 3 mg per day. It was hoped this would help his eating, but staff report his eating seems to be even worse since the dose was increased. Amir stopped eating following a choking episode exactly 3 weeks ago – he appears ‘scared’ of food since this time. He refuses to go to the table for meals. He will eat small amounts of banana smoothie, only.

Amir appears very thin and underweight. By the time you see him, he has been in the waiting room for 40 minutes and he is agitated, though no one knows exactly why. He appears to be trying to communicate but the staff member who has come with Amir is not his key worker and does not know all of his signs.

## Allied health Case study - Kit

Kit is a 51 year old man who enjoys gardening and Star Wars.

He lives with his mother Sherrie. His father David passed away last year. Kit also has a sister who lives interstate.

Kit’s father used to drive him to work where he restocked shelves at a small grocery store. Since his father’s passing, Kit left his job as it was too difficult to get there. His only NDIS supports cover his psychology services.

Kit has a history of anxiety, for which he takes an antidepressant (an SSRI). This was first prescribed by a psychiatrist over 10 years ago and the dose has remained stable for the past 8 years.

In the past year, Kit has become increasingly irritable, and on two occasions he has become aggressive towards Sherrie. Sherrie, who is 76 and has a history of osteoporosis, is concerned for her own safety, and for Kit’s wellbeing.

Kit has seen his psychologist 6 times so far this year to try to reduce his levels of agitation to discuss behaviour management. However, it is not working.

They have come to you for further assistance.

## Allied health case Study - Amelia

Amelia is a woman in her early 20’s who loves cats and enjoys watching cooking shows on TV.

She has an intellectual disability and cerebral palsy. She is able to vocalise and use some sign language. However, it is very difficult for people to understand her communication.

This is Amelia’s first visit with you. Support staff inform you that Amelia has lived in their residential service for the past 3 years. She sees her Mum every weekend. They tell you she has epilepsy for which she takes medication.

They also tell you that Amelia has a history of trauma – as a teenager she was sexually and physically abused by someone who was not a family member.

In recent years, she has had mental health problems, including a suspected suicide attempt. She has also exhibited behaviours of concern (including non-suicidal self-harm).

Support staff report that for the past month Amelia has exhibited 'sexualised' behaviours – this includes taking off her clothes, exposing her genitals to staff (male and female), and touching her genitals in public. Staff report that these behaviours are becoming more frequent.

They report that there were no changes in Amelia’s group home or day program close to when these behaviours began, and also no other signs of any mental health crises emerged around then.

**Further information:**

A psychological interview reveals no other current concerns about Amelia’s mental health:

* During her prior mental health episodes, Amelia displayed signs of distress such as crying, withdrawing to her room, reduced signing or vocalisation and refusing to cooperate with any self-care. None of these things have occurred lately.
* Instead, when asked how she is, Amelia signs ‘good’ and ‘happy.’

Staff and her mother report that she continues to engage with her regular activities with her typical level of enthusiasm.

The group home manager investigates and confirms that no changes in staff or attendance occurred at either Amelia’s home or day program. Amelia’s mum confirms that during Amelia’s visits, no other visitors were present.

## Allied Health Case Study – Amir



Amir is a 19 year old man who enjoys walks and spending time with his family.

He has an intellectual disability in the moderate range. He needs support in many areas, including for planning his activities, as well as some more complex self-care activities such as shaving. Amir has no speech - he communicates through basic sign language.

He moved to a group home 8 months ago. He visits his family’s farm one weekend a month.

Amir attended a special education school where his parents report he received excellent support. The transition to post-school options was difficult and he often refused to go. This was a reason for him to move to into residential care. He still frequently refuses to attend the program and on these days he spends most of the day on his bed watching TV.

Amir’s parents made the appointment and asked group home staff to bring him to see you, because he has been refusing to eat for 3 weeks. Staff report Amir has always been a picky eater while in their care but this has gradually become worse. A few months back, Amir’s psychiatrist prescribed a medication for behaviours of concern (risperidone, usually prescribed for psychosis). Initially the dose was low, then it was raised. It was hoped this would help his eating, but it seems to be even worse since then, especially since the dose was increased.

Amir stopped eating following a choking episode exactly 3 weeks ago – he appears ‘scared’ of food since this time. He refuses to go to the table for meals and can become agitated if staff try to cajole him. He will eat small amounts of banana smoothie only.

Amir appears very thin and underweight. He appears to be trying to communicate but the staff member who has come with Amir is not his key worker and does not know all of his signs.

Dentist Case study – Stacey



Stacey is a young woman who lives with her family and has a companion dog. She works as a mail clerk and occasionally as an actor. She has an intellectual disability and needs support across several areas of life.

Stacey communicates using simple speech and can mostly be understood well. She is well supported by her mum, Anna, who attends all appointments with Stacey.

Stacey is a mouth breather and often gags. She also has bruxism, but cannot wear a splint due to gagging. She has a phobia of needles and so won’t tolerate regular muscle relaxant injections, they make her extremely anxious.

Recently, she had a vertical root fracture of an unrestored premolar tooth.

## Dentist Case Study – Leon



Leon is a man in his late 30’s who enjoys watching home videos. He has a severe intellectual disability and requires support for most activities. Leon relies on non-verbal forms of communication. He also has a physical disability and uses a wheelchair.

He lives in a group home but stays with his father every second weekend.

Leon’s medical history includes dysphagia and epilepsy which is not well controlled. He tolerates having someone brush his teeth. His tolerance for dental work is lower – in the past he’s been able to manage small sections of scaling with good suctioning. However, he opens his mouth very wide making it hard to access the buccal surfaces.

His last comprehensive dental evaluation was 6 years ago, under general anaesthetic.

His GP has referred him to you for an assessment and possible extractions prior to commencing bisphosphonates.

## Pharmacist case study – Joe

Joe is man in his late 50’s who lives alone in a public housing unit. He has a mild intellectual disability. He communicates through speech and can read some simple text. Joe has never mentioned having a family or supports. He has always attended the pharmacy alone.

Joe has epilepsy for which he takes 900 mg sodium valproate daily in 2 doses. The dose has remained the same for at least the past 10 years.

3 weeks ago, his GP prescribed 2 mg diazepam at night. Joe reports this was for an injury. There are 3 repeats on this script.

When questioned, Joe reports that the diazepam helps him sleep. His sleep was compromised recently due to shoulder pain which remained after a fall. It’s unclear from his report whether he fell or slipped. He can’t recall when the injury occurred. He does know that he tried a cream first but it did not help. He does not know what the cream was called. He already owned it before the injury, having used it for an injury some years ago. He reports the tube has now run out.

Today Joe is at his local pharmacy, asking for a repeat of the sodium valproate. The script is on file. He also asks if he can get another box of diazepam while he’s here, he is not sure how many pills are left. It’s not due to be refilled for another week.

Joe also asks if you can recommend a product to help with constipation. When asked, he says he has been feeling blocked up for a while but he is not sure how long.

You note that Joe is holding on to the counter and appears generally slower than typical for him.

When asked, Joe can’t remember the last time he went to the doctor. He thinks he has not been since the script for diazepam was issued (4 weeks ago).

## Pharmacist Case Study - Daryan



Daryan is a man in his mid-20’s who enjoys nature and shares a close bond with his mum. He has lived in supported accommodation since the age of 16 and currently receives 2:1 care in a unit on his own.

He is obese and has a family history of cardiovascular disease.

Daryan has intellectual disability, autism, bipolar disorder, and “challenging behaviours”. These include noise and property destruction, inappropriate urination and smearing faeces, spitting. He paces often and has a poor attention span.

However, he loves nature – his support workers report that Daryan is always calmer when they take him to a bushwalk or the beach – both of which are a 15 minute drive from his home.

Daryan sees a psychiatrist and also engages a psychologist and OT via the NDIS. He consulted a senior psychologist as part of a review of his Positive Behaviour Support plan. The psychologist requested the GP make a referral for a Home Medications Review.

Daryan is currently prescribed 11 medications (see chart). This includes 2 daily antipsychotics and a third on a PRN basis.

# Key resources referenced in the workshop

The specific resources shared can be tailored to the audience for dentists, pharmacists, and positive behaviour support therapists.

## Clinical resources and Guidelines

***HealthPathways*** is an online clinical and referral information portal for clinicians. Our local *HealthPathways* can be accessed here: ***[PHN co-facilitator to INSERT LINK TO LOG IN PAGE]***

The ***Therapeutic Guidelines*** is an online book providing clinicians with excellent guidance for management of a range of challenging issues. The chapter on Developmental Disability is comprehensive and has been written by, and for, Australian practitioners:

<https://tgldcdp.tg.org.au/guideLine?guidelinePage=Developmental+Disability&frompage=etgcomplete>

**What not to miss by Professor Nick Lennox**

This 1-page sheet highlights medical problems commonly missed or poorly managed in children, adolescents and adults with intellectual disability. It is available for download here:

[www.cid.org.au/health/resources-health-professionals-not-miss](http://www.cid.org.au/health/resources-health-professionals-not-miss) .

**The PCEP Suite of Resources for Health Professionals**

A suite of links to resources for health professionals was compiled as part of the Primary Care Enhancement Program. That document is available here:

[www.cid.org.au/health/resources-health-professionals](http://www.cid.org.au/health/resources-health-professionals)

It includes the following:

* Links to resources on **prescribing**
* A **Tips sheet** on achievable ways that you can ensure the best possible appointments with a person with intellectual disability through simple measures focused on communication, scheduling and safety.
* Links to helpful resources on the **NDIS**. The links include a guide for practitioners on writing for the NDIS, a glossary of terms, and an FAQ for health professionals.
* A list of **Medicare item numbers** which can be used in General Practice when coordinating the care of a person with intellectual disability.
* A **checklist of evaluations** and preventative medicine to consider scheduling opportunistically when a person is under sedation.
* Information on **supported decision-making** and the contact details of guardianship boards in each state.
* A tailorable easy-read appointment letter that includes pictures is available **here.**
* Information on how to support a person **transitioning** from child to adult services.

## Resources to share with people with intellectual disability and their supporters

**Council for Intellectual Disability** has a range of Easy read health fact sheets designed for people with intellectual disability, available from: <https://cid.org.au/resource-category/health/>

This includes:

* Your right to good health care - <https://cid.org.au/resource/your-right-to-good-health-care-fact-sheet/>
* Yearly Health Check - <https://cid.org.au/resource/yearly-health-check-fact-sheet/>
* Types of Health Checks - <https://cid.org.au/resource/types-of-health-checks-fact-sheet/>
* Chronic Health Plans - <https://cid.org.au/resource/chronic-health-plans-fact-sheet/>
* Health Services for adults - <https://cid.org.au/resource/health-services-fact-sheet/>
* Caring for your teeth - <https://cid.org.au/resource/caring-for-your-teeth-fact-sheet/>
* Mental health - <https://cid.org.au/resource/mental-health-guide/>

The **My Health Matters folder** is designed as a personal health record and contains visual cues to facilitate better communication between a person with intellectual disability and a health professional: <https://cid.org.au/resource/my-health-matters-folder/>

## Additional resources for specific groups

### Dentists

* An Australian Guide for Dental Practitioners is here: https://inclusionmelbourne.org.au/wp-content/uploads/2019/05/Oral-health-and-disability-web-spreads.pdf
* A US Guidance paper can be downloaded here:

<https://www.nidcr.nih.gov/sites/default/files/2017-09/practical-oral-care-intellectual-care.pdf>

* NICE guidelines for adults in residential care are here: <https://www.nice.org.uk/guidance/ng48>

### Positive Behaviour Support Practitioners and Pharmacists

Link resources from the Pharmacists Optimising Medication Prescribing for people with Intellectual Disability and Autism (POMPIDA): [www.cid.org.au/health/resources-health-professionals-prescribing](http://www.cid.org.au/health/resources-health-professionals-prescribing) .

## Suggested email to accompany post-workshop materials

We hope you enjoyed the [Title of your workshop] session on [DATE].

Attached is a **post-workshop activity and reflection** which has been designed to:

* help you reflect on your recent learning and
* identify how you can extend your learning.

If you plan to claim Continuing Professional Development Points, the time spent completing the reading and post-workshop activity can be counted.

Your certificate of attendance will follow shortly.

The Australian Government has committed funding to continue work to improve the health care of people with intellectual disability. Training courses like the one you attended will likely form a part of that program of improvements. We would therefore appreciate your honest **feedback** on the workshop, as it may help make training like this more effective in the future. You can send feedback anonymously via this link: [INSERT YOUR EVALUATION SURVEY LINK].

If you need any further information, please don’t hesitate to contact [NAME] on [PHONE] or [EMAIL].

Kind regards,

[EMAIL SIGNATURE]

## Post-workshop activity & reflection

PHN co-facilitator to tailor according to which cases were used and the audience – only one case is used.

Review the case example of [insert name of most relevant case] from the workshop:

[Case description goes here – copy from the slide notes or insert your own]

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Q1 a. (For GPs and practice nurses only)

Now look through the information on intellectual disability within *HealthPathways* for your area.

**Where will you refer [Case example’s name] and for which services?**

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Q1 b. (For any participant)

**What services can you offer to [Case example’s name]?**

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**Q2. What are the most important things you can do in the short term and in the longer term to provide good health care for [Case example’s name]?**

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**Q3. Review your answer above.**

* Circle things that reflect good practice for any patient.
* Underline things that are reasonable adjustments.

**Q4. Reflect on your capacity to provide services for [Case study name’s] health care needs.**

* How do you feel about your ability to provide services?
* How can you further improve your own capacity in this area?

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## Optional post workshop activity – Pharmacists



### Review the case of Daryan

Daryan is a man in his mid-20’s who enjoys nature shares a close bond with his mum. He has lived in supported accommodation since the age of 16, and currently receives 2:1 care in a unit on his own.

He is obese and has a family history of cardiovascular disease

Daryan has intellectual disability, autism, bipolar disorder and “challenging behaviours”. These include noise and property destruction, inappropriate urination and smearing faeces, spitting. He paces often and has a poor attention span.

However, he loves nature – his support workers report that Daryan is always calmer when they take him to a bushwalk or the beach – both of which are a 15-minute drive from his home.

Daryan sees a psychiatrist and also engages a psychologist and OT via the NDIS. He consulted a senior psychologist as part of a review of his Positive Behaviour Support plan. The psychologist requested the GP make a referral for a Home Medications Review.

Daryan is currently prescribed 11 medications (see chart); this includes 2 daily antipsychotics and a third on a PRN basis.

### Complete brief notes on Daryan’s medication review using the chart below

| **Medication and strength** | **Dose** | **Purpose** | **Your notes** |
| --- | --- | --- | --- |
| Sodium valproate 200mg/5mL (Epilim) | 25mL (1000mg) at 10 pm | Bipolar disorder |  |
| Benztropine 2 mg | 1 mane | Antipsychotic-induced extra pyramidal side effects |  |
| Amisulpride 100 mg/mL (Solian) | 4 ml (400mg) tds | ASD-related behaviour |  |
| Quetiapine 300 mg (Seroquel) | 2 (600mg) tds | ASD-related behaviour |  |
| Olanzapine 20 mg (Zyprexa) wafer | 1 tds prn | For aggression every 2 hours, up to 3 doses (60mg) daily. |  |
| Vitamin D 25 mg | 1 daily | Supplement |  |
| Paracetamol Elixir | 1000mg q4h | Pain/fever |  |
| Paracetamol/  codeine 500 mg/30 mg (Panadeine Forte) | 2 qid | Stronger pain |  |
| Ibuprofen 200 mg | 2 tds prn | Pain |  |
| Diazepam 5 mg | 4 prn (20 mg) 1 hour prior to medical or dental procedures | Anxiety |  |
| Movicol sachets | 1 tds prn | Constipation |  |

**What would be your overall recommendations regarding Daryan’s medications:**

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An example completed by a senior pharmacist can be found here: [www.cid.org.au/health/resources-health-professionals-prescribing](http://www.cid.org.au/health/resources-health-professionals-prescribing)

Appendix I – Tips for running any training

## Preparing for training

If you are prepared you will be able to deliver the content confidently and effectively communicate your message. This appendix focuses on practical and administrative considerations to ensure a successful training.

## General Considerations

These are considerations apply to both online and in-person training:

* The slides are designed to be edited with your co-facilitator (see how to use slides section). Make sure you’ve hidden or deleted the slides you won’t be using and have the right version somewhere easy to find. Consider using dates as a naming convention to keep track of multiple versions.
* Save slides locally (i.e. on your computer) instead of on a shared drive or cloud, so they are quick to access and run.
* Make sure to practice presenting with your co-facilitator. Discuss things like how you will hand off to each other, refer a question to someone else, ask for assistance etc.
* Close all programs and documents, other than what’s needed for training, before starting. This will minimise distractions and load on your computer.
* Open the session early and encourage people to arrive well before the start time. Set the expectation in the invite that the training will begin sharply on time and stick to it as consideration for those who arrive on time.
* Set the expectation early that things will need to be kept to time and ask people for their cooperation with this. Consider strategies like:
* Distinguishing between questions and anecdotes. Encourage people to be considerate of time and relevance for others when speaking.
* Create a space and time for questions and use the parking lot method for anything that arises outside of this. Set aside time after the training to have further discussions.
* Seek agreement from the room on the above, explaining the reasons, and ask if anyone objects. This way, people have had a chance to speak up and are participating in a structure they’ve agreed to.
* Have a few key phrases ready to gently interrupt long comments and keep things on track e.g. “Sorry to interrupt [name], I’m just mindful of time and am wondering if we could park this and come back to it?”

## Online presentation

Technical issues are the main consideration when preparing for online training. Some of these may be out of your control, for example an international outage of Microsoft but you can prepare contingency plans for many of them.

### Webinar Software

It is best practice for someone else to run the webinar while you present, as there can be a lot of things to juggle at once. If you need to do those and present, it may be clunky and eat up limited training time.

Practice running meetings in your chosen webinar software before you run the training. Each program has its own features and quirks which should be well known before running a live training. It’s a good idea to practice using the software with as many people as you can, as so to understand how you can interact with the audience and what they can see.

* Some software allows you to set the break out rooms ahead of time. Doing this will allow you to simply send people to their pre-assigned rooms, rather than spending time doing it as participants watch. See the breakout room guides for your chosen software for more information.
* Dial-in may or may not be needed, depending on your audience. Dial-in options are standard with Zoom but may not be included in other programs depending on your organisations subscription. See the dial-in guides for your chosen software or speak to your IT administrator for more information.

### Participant Technical Issues

Expect that some participants may look to your organisation to assist with technical problems when accessing the webinar. Consider having another person be the contact person for these problems so that you can present unimpeded.

Other options to manage participant technical issues are listed below.

* Inviting them to practice using the software ahead of time.
* Providing links to user guides in the invite, well ahead of time.
* Sharing webinar etiquette expectations ahead of time, covering things such as muting, raising hands, chat box etc.
* Having an extra person running the webinar can also be helpful for muting participants.
* Providing dial-in options in case of internet connectivity issues (note that not all software may have this option enabled. See webinar software for more information).
* Recording the session to send to anyone unable to attend (note that permission to record people is needed and that it may affect CPD points).

### Get ready to run a Webinar

Being as prepared as you can will help you feel calm and in control of the presentation.

Things to consider include:

* Have you practiced playing videos with sound shared in the webinar software? There can sometimes be extra steps to share sound, it’s best to know what those are ahead of time and be confident in using them.
* Presentation space, noise, and privacy. Whether you’re working from home or the office, do you have a quiet space to present from where you won’t be interrupted? Can you speak with those you share the space with to gain their cooperation for the length of the training? If not, it’s best to let participants know ahead of time you may be interrupted.
* Internet connectivity problems can occur at any time. Does your workplace have mobile internet dongles you could borrow? Can your phone act as a Wi-Fi hotspot? Investigate and test these options ahead of time.
* Does your cordless mouse or keyboard require batteries?

## In-person training

In-person training can present a different set of challenges to webinar training. While technical issues may still arise, they’re much easier to navigate when your audience is physically in the same space. The main considerations for in-person training are related to space.

If you are able to choose the venue for training, consider:

* Accessibility requirements. Not only physical accessibility (toilets, ramps etc.) but also sensory and emotional. Is there a quiet space your co-facilitator can go if they choose? Are there hearing loops for any Deaf or Hard of Hearing people? Consider all needs when choosing a venue.
* Is there enough space and equipment for participants to work together comfortably? The case studies require group work, which is best done in groups of 3-5 people. Can the desks be arranged for 3-5 people, with enough space for comfort?
* If someone uses a wheelchair, are there accessible desks for them?
* Noise and acoustics: are there external noises that may be disruptive e.g. close to a train line? Will everyone be able to hear each other in the room? The acoustics of a too-large room can be cacophonous and make it difficult to hear people.

When you’re getting ready to present, use the checklist below to make sure you have all the equipment and resources you need. Rushing around on the day of a training could make you stressed for your presentation, particularly if problems arise e.g. printer outage.

Other tips for getting ready include:

* Arrive at the venue early to set everything up and ensure its working, or enact any contingency plans if it’s not. Having extra time to prepare and address any issues will help you feel calm and confident when the participants arrive.
* Set up desks for group work ahead of time, so that time isn’t lost with people moving around the room. If you would like certain people to be grouped together (e.g. similar or different health professionals) then assign seating ahead of time, as people will likely sit with those they know.
* If there is insufficient space to set up desks for group work, an alternative is to have people work in pairs.
* Have back up plans for technical issues such as:
* Keep your laptop charged in case there is a power outage.
* Have everything on local drives (i.e. on your computer) in case there is an internet outage.
* Have everything backed up on an external drive in case you need to use another computer.
* Be prepared to present without the audience seeing the slides, in case a projector/TV failure occurs.

## In-Person Training Checklist

* **Room set up:**
* Accessibility of venue e.g. stairs, toilets, space, doorways etc.
* Seating for group work.
* Equipment for group work.
* Tables for presentation equipment e.g. laptop, projector (consider height).
* Internet connections.
* Location of power points.
* **Computer equipment:**
* Laptop.
* Projector.
* Power cords.
* Connecting cables including HDMI, Ethernet etc.
* Back-up of presentation on portable or cloud drive.
* Projection screen/TV.
* **Presentation notes:**
* Speaker notes and plan hard and soft copy.
* Audience materials/handouts.
* Registration form/sign-in sheet.
* Evaluation forms.
* Paper, markers and other equipment for group work.
* **Personnel:**
* Attendee list/ name tags.
* Special requirements – accessibility, dietary etc.
* Venue/organisation contact list in case of emergency.

Appendix J Webinar user guides

## Zoom

How to use Zoom:

<https://support.zoom.us/hc/en-us/articles/360034967471-Getting-started-guide-for-new-users>

* Breakout rooms for Zoom:

<https://support.zoom.us/hc/en-us/articles/206476093-Enabling-breakout-rooms>

* Dial in for Zoom:

<https://support.zoom.us/hc/en-us/articles/201362663-Joining-a-Zoom-meeting-by-phone>

## Teams

How to use Teams for meetings:

<https://docs.microsoft.com/en-us/microsoftteams/tutorial-meetings-in-teams>

* Breakout rooms for Teams:

<https://support.microsoft.com/en-us/office/use-breakout-rooms-in-teams-meetings-7de1f48a-da07-466c-a5ab-4ebace28e461>

* Dial in for Teams:

<https://support.microsoft.com/en-us/office/add-a-dial-in-number-for-a-meeting-in-teams-7c33e972-e5a2-4b32-aabd-09c0c5f18424>

## WebEx

WebEx User Guides:

<https://www.cisco.com/c/en/us/support/conferencing/webex-meeting-center/products-user-guide-list.html>

* Breakout rooms for WebEx <https://kb.wisc.edu/webex/page.php?id=105834#:~:text=Navigate%20to%20the%20Show%20Advanced,click%20the%20Preassign%20breakout%20sessions>
* Dial in for WebEx

<https://help.webex.com/en-US/article/gri717/Search-Global-Call-in-number-in-Webex-Meetings-and-Webex-Events>