Intellectual Disability
Mental Health Connect

Development of localised intellectual disability mental health care pathways

A planning tool

AUTHORS

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Description of resource

This tool aims to assist mental health services in the planning of a localised intellectual disability mental health care pathway within their service or hospital.

See the Developing care pathways for people with intellectual disability section on the Intellectual Disability Mental Health Connect website for more details.

This is a PDF Form. Fill it out using Acrobat Reader (version 8 or later) or Adobe Acrobat Pro DC.

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You can navigate through this form using the tab button on your keyboard

Guidance

The tool is for use in conjunction with the Intellectual Disability Mental Health Connect webtool sections: Developing care pathways for people with intellectual disability and Care pathways for people with intellectual disability. The planning process and content of an intellectual disability mental health care pathway will vary widely depending on the nature, size, and context of a service within the mental health system. This planning tool includes broad actions and considerations and is meant as a first step in the planning process to assist mental health managers and clinicians to consider the required steps to develop such a care pathway for their specific service or district.

Service:	
Planning lead and role:	
Planning team and roles:	

Planning a care pathway

Considerations and actions	Planning notes	Initial actions	Considered
Determine key stakeholders to consult with during the planning stage including people with intellectual disability and their support networks (carers, family, paid and unpaid support workers); clinicians; managers; and government and non-government health, disability, and social services in the local district.			☐
Consider the formation of a working group with representatives from all key stakeholder groups. Planning days or workshops can be effective at key stages of development.			☐

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Planning a care pathway (CONTINUED)

Considerations and actions	Planning notes	Initial actions	Considered
Gather information to understand the clinical needs of people with intellectual disability in your district (e.g. using 3DN's Intellectual Disability Health Data Portal).			☐
Gather information about services with expertise in intellectual disability (or that have the potential to work with people with intellectual disability) within and outside of your service.			☐
Create a directory/map of these services within and outside of your organisation. Include their: • services offered • delivery methods • intake criteria • referral procedures • location • availability and waiting times • key contacts.			☐
Identify whether existing inter-agency protocols or agreements exist to facilitate co-operative working practices and referrals.			☐
Review evidence-based guidelines where available.			☐

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Care pathway content

Considerations and actions	Planning notes	Initial actions	Considered
Mental health promotion			
Include and encourage the routine use of mental health promotion activities for people with intellectual disability specific to your service.			☐
Referral and intake			
Develop and make readily available accessible information about accessing your service and available treatments for people with intellectual disability and their networks.			☐
Consider whether referral criteria can be modified or tailored for people with intellectual disability accessing your service.			☐
Develop the capacity for the referral of priority cases from other services and create guidelines around this for clinicians.			☐
Where applicable, nominate an intellectual disability care co-ordinator who can co-ordinate access, referral, and intake.			☐

Care pathway content (CONTINUED)

Considerations and actions	Planning notes	Initial actions	Considered
Referral and intake (CONTINUED)			
Assess whether the timeframe for intake will meet the needs of a person with intellectual disability.			☐
Create intake forms that include additional information to document for people with intellectual disability.			☐
Develop a set of steps for clinicians to take if a person with intellectual disability is not suitable for your service.			☐
Compile information on referral processes to disability and other health services in your area to include in the pathway.			☐
Develop resources for clinicians with details of individuals, teams or services that can offer specialist intellectual disability mental health advice within and outside of the service; include their role, responsibilities, and advice they can offer. See more information on specialist intellectual disability services.			☐

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Care pathway content (CONTINUED)

Considerations and actions	Planning notes	Initial actions	Considered
Assessment and diagnosis			
Review whether your service's standard mental health assessment and outcome measures are suitable for people with intellectual disability.			☐
Develop and disseminate a list of any screening, assessment, and outcome tools to consider/ be completed with people with intellectual disability.			☐
Specify any information specific to your service that clinicians need to document during the assessment stage and create checklists/forms.			☐
Where relevant include opportunities for multi-service assessments, including the criteria and process.			☐
Develop guidance around the environment and procedures for assessments for people with intellectual disability to meet accessibility and sensory needs.			☐

Care pathway content (CONTINUED)

Considerations and actions	Planning notes	Initial actions	Considered
Assessment and diagnosis (CONTINUED)			
List details of local services with expertise in intellectual disability that clinicians may require for referral during the assessment stage For example: • specialist intellectual disability mental health service • specialist intellectual disability health service • neuropsychologist or psychologist • behaviour support specialist • dietician • exercise physiologist • speech pathologist • occupational therapist • special care dentistry service • social worker.			☐
Detail procedures if the service is deemed not suitable for a person with intellectual disability during the assessment stage.			☐
Outline steps to take if there is diagnostic ambiguity or disagreement.			☐

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Care pathway content (CONTINUED)

Considerations and actions	Planning notes	Initial actions	Considered
Care planning and treatment			
Discuss and clearly list the roles and responsibilities of a multidisciplinary team and who is responsible for care co-ordination if applicable.			☐
When developing a care pathway for emergency departments, include guidance around admission decisions for a person with intellectual disability including alternative treatment pathways to inpatient admission.			☐
Include links to resources available on your intranet/ shared drive or online that clinicians can utilise during the treatment stage (e.g. prescribing guidelines, modifying CBT techniques). See the Treatment section of the Care pathways for people with intellectual disability section for more information.			☐
Consult widely around how people's support networks can be involved in the treatment and monitoring process and develop guidance.			☐
Provide links to service directories/maps clinicians can consult when they need to refer to a different tier of care within their service, or external service in the local area.			☐
Develop a list of contacts clinicians can consult when they require specialist advice during the treatment stage.			☐
Develop protocols for measuring treatment outcomes.			☐

Care pathway content (CONTINUED)

Considerations and actions	Planning notes	Initial actions	Considered
Transfers of care			
Develop protocols specific to your service that detail steps for discharge planning, including information to be included in transfer of care plans for people with intellectual disability. Include a link : Planning for the discharge of a person with intellectual disability after a mental health admission – A planning tool			☐
Consult widely around pathways to appropriate services for people with intellectual disability on discharge from acute care and inpatient services, and provide guidance for clinicians.			☐
Create a checklist of actions specific to your service for clinicians to refer to when following up with people with intellectual disability post-discharge and establish procedures to monitor this.			☐
Develop procedures for co-ordinating effective transfers of care between your service and others at key transition stages (e.g. for adolescents transferring to an adult service).			☐

Implementation

Considerations and actions	Planning notes	Initial actions	Considered
Consider plans to pilot, evaluate, and review the pathway. Evaluations include consultations with all key stakeholders including people with intellectual disability, their support networks, clinicians, and managers.			☐
Record pathway variances to help inform the development of future versions of the pathway. Develop ongoing monitoring processes relevant to your service.			☐
Develop training and education for clinicians in the use of the care pathway. Reflect on ways to increase awareness of the new pathway.			☐
Develop strategic co-operative information sharing and communication practices between services included in the care pathway. See the Working with people with intellectual disability and their team for more details.			☐