



Australian Government

Department of Health, Disability and Ageing

Final Evaluation Report

Curriculum Development Project



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Executive Summary

Curriculum Development Project

The National Roadmap for Improving the Health of People with Intellectual Disability (the Roadmap) is a landmark document. The Roadmap puts people with intellectual disability at the centre of the reform process and sets out a comprehensive range of actions to improve their health outcomes.

The Curriculum Development Project (CDP) was a key project funded under the Roadmap. The Australian Government allocated \$4.7 million over 4 years (from 2021-22 to 2024-2025) to the CDP.

The CDP was established to design and develop intellectual disability health capabilities, tools and resources to improve pre-registration education for health professionals, improving their knowledge of intellectual disability health to instil positive, respectful attitudes towards people with intellectual disability.

The Department of Health, Disability and Ageing conducted the project in two phases:

- Phase 1 included development and promotion of the Intellectual Disability Health Capability Framework. Phase 1 commenced in March 2021, the completed Framework was published in April 2024, and promotional activity continued to June 2025.
- Phase 2 included development of education resources for use by health educators to support implementation of the Framework into pre-registration health education curricula. Supporting resources were developed through 2023, 2024 and 2025. Final education resources were published in June 2025.

Project evaluation

The mixed-methodology evaluation of CDP was focused on implementation and the short-term outcomes of the CDP. This Evaluation Report focuses on project outcomes in response to the three key evaluation questions:

- Has there been a quality, inclusive and collaborative co-design process in the development of the Intellectual Disability Health Capability Framework?
- Is the Intellectual Disability Health Capability Framework suitable for use by universities and accreditation authorities?
- What impact has the Intellectual Disability Health Capability Framework had on influencing consideration of the health needs of people with intellectual disability in university curricula and accreditation standards?

Both qualitative and quantitative data were collected from self-reported surveys and stakeholder groups to inform the evaluation.

Key evaluation findings

Key finding 1. Co-design process

The development of the Framework was guided by inclusive and collaborative processes. Broad and representative stakeholder consultation was conducted throughout the project, with co-design approaches employed in certain phases. These efforts also helped identify key opportunities for improvement.

- 1.1 People with intellectual disability were not core members of the Drafting Group. Instead, people with intellectual disability engaged with the Framework development through: Participation in the Intellectual Disability Focus Group consultation
 - Inclusion of a person with intellectual disability in a lived experience researcher role throughout parts of the Framework and associated resource development process.
- 1.2 Early in the project there was insufficient engagement with First Nations peoples and representatives. The Department acknowledged this as a major gap in the process and took action. Action taken included alternative consultation methods with stakeholders and renewed invitations to participate to the First Nations Disability Network.

Key finding 2. Suitability of the Framework

The Intellectual Disability Health Capability Framework was reported to be suitable for use by universities and accreditation authorities.

- 2.1. University stakeholders indicated they were willing to implement the Framework into curricula. It was important to recognise intellectual disability health in curricula and it is already included in curricula at some universities. The core capabilities within the Framework were considered relevant and there was some alignment and clarity on where the capabilities could be incorporated into curricula.
- 2.2. Accreditation authorities indicated they were willing to implement the Framework into accreditation standards. The Framework was considered relevant to their accreditation body, and it was important for the needs of people with intellectual disability to be recognised within accreditation standards and/or professional standards for health professionals.
- 2.3. The capacity assessment resources within the Framework were considered useful by university and accreditation sector stakeholders. An assessment of the suite of education resources was not within the scope of this evaluation as it was published in June 2025.
- 2.4. While stakeholders reported a willingness to implement the Framework, this did not translate to a corresponding level of action in implementation or preparing for implementation. The barriers to implementation are discussed in [Chapter 4](#).

Key finding 3. Impact and influence

At this early stage of implementation, the Framework has had minimal impact on influencing consideration of the health needs of people with intellectual disability in university curricula and accreditation standards. This level of impact was not surprising considering the barriers identified during the evaluation. Despite these barriers there were examples of Framework implementation.

- 3.1 There was awareness of the Framework among university and accreditation sector stakeholders. This may be because many stakeholders who participated in the evaluation were already engaged in the CDP and with the Framework development process.
- 3.2 Some universities had commenced implementation of the Framework, and planning for implementation increased over the 12 months after the Framework's release. Implementation was in the disciplines of dentistry and oral health therapy, occupational therapy, physiotherapy and psychology. Approaches to implementation included integration into both theoretical and practical teaching and learning.
- 3.3 Some accreditation authorities were planning to implement the Framework and 1 is not. Accreditation review cycles are 4-5 years in duration and the integration of the Framework into accreditation standards was considered to be a long-term endeavour.
- 3.4 There were barriers to implementation faced in both the education and accreditation sectors. The barriers included extended timeframes for curricula and accreditation reviews, crowded curricula, resourcing and workforce, and lack of understanding and support for the Framework. These barriers will require time, resources and targeted promotion of the Framework to be addressed. A key barrier for the accreditation sector was the incompatibility between the detailed capabilities in the Framework and the high-level attributes documented in accreditation standards. This indicates that the Framework cannot be implemented by the accreditation sector as the project intended, and further consideration about implementation will be required.
- 3.5 Based on the project timeline there were barriers to evaluating the impact and influence of the Framework. The publication of the Framework in April 2024 and the suite of education resources in June 2025 precluded meaningful evaluation of impact and influence. Additional evaluation to assess these domains over a longer time period will be required in the future.

Summary

In summary, the Framework was developed through inclusive, collaborative processes, including broad stakeholder consultation and co-design. University and accreditation stakeholders expressed willingness to integrate the Framework into curricula and standards, recognising its relevance and the importance of addressing intellectual disability health. While the Framework's capacity assessment resources were seen as useful, actual implementation efforts remained limited at this early stage. Despite minimal immediate impact, some examples of implementation were observed.

Introduction

The Australian Government Department of Health and Aged Care (the Department) commissioned the independent monitoring and evaluation of the Curriculum Development Project (CDP). The aim was to evaluate whether the CDP was appropriate and effective, and the evaluation period was between April 2022 and June 2025.

This Evaluation Report focuses on project outcomes in response to the three key evaluation questions. Further details on the evaluation questions and methods are provided in [Chapter 1](#).

Background and context

The National Roadmap for Improving the Health of People with Intellectual Disability (the Roadmap) is a landmark document. The Roadmap puts people with intellectual disability at the centre of the reform process and sets out a comprehensive range of actions to improve their health outcomes. It forms part of the Primary Health Care 10 Year Plan. The Roadmap also takes into account the health system issues that were identified in the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (The Royal Commission) and particularly the actions required to improve the health of people with intellectual disability. The Royal Commission identified that people with disability “face a range of barriers to accessing quality health care. These must be removed by building the capability of the health care workforce and identifying adaptations and supports required for a person-centred approach”.¹

Project overview

CDP was a key project funded under the Roadmap. The Australian Government allocated \$4.7 million over 4 years (from 2021-22 to 2024-2025) to the CDP. The CDP sits within element C of the Roadmap: Support for health care professionals to provide better care for people with intellectual disability.

The CDP was established to design and develop intellectual disability health capabilities, tools and resources to improve pre-registration education for health professionals, improving their knowledge of intellectual disability health to instil positive, respectful attitudes towards people with intellectual disability.

The goal of CDP was *‘To improve the health care of people with intellectual disability by improving the knowledge, communication, and attitudes of health care professionals in their pre-registration university education’*.

The objectives of CDP were:

- Develop an intellectual disability health capability framework by December 2022
- Develop supporting resources to align with the capability framework by June 2025
- Host resources online by June 2025
- Promote integration of intellectual disability health capabilities in health professional accreditation standards and university curricula

The Department conducted the project in two phases:

¹ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023) Final Report Executive Summary, Our vision for an inclusive Australia and Recommendations, p67. <https://disability.royalcommission.gov.au/system/files/2023-11/Final%20report%20-%20Executive%20Summary%2C%20Our%20vision%20for%20an%20inclusive%20Australia%20and%20Recommendations.pdf>

- Phase 1 included development and promotion of the Intellectual Disability Health Capability Framework. Phase 1 commenced in March 2021, the completed Framework was published in April 2024, and promotional activity continued to June 2025.
- Phase 2 included development of education resources for use by health educators to support implementation of the Framework into pre-registration health education curricula. Supporting resources were developed through 2023, 2024 and 2025. Final education resources were published in June 2025. The Framework was to be underpinned by an online resources hub with materials that can be adopted by education providers to assist with integrating intellectual disability health principles in their curricula. However, due to factors external to the CDP, establishment of the online resources hub is now being undertaken by the National Centre for Excellence in Intellectual Disability Health. The resources hub is no longer considered a deliverable under the CDP. The Framework and associated education resources will be transitioned to the online hub when it has been established by the National Centre for Excellence.

As part of the project governance processes the Department established an Intellectual Disability Education and Training Expert Advisory Group (ETEAG) to provide expert advice and guidance on the implementation of education and training actions under the Roadmap; this included the development and implementation of the Framework. The Department also established an Intellectual Disability Focus Group to ensure the voices of people with intellectual disability were included in the Framework.

The processes and stages within the project are outlined in Figure 1 below.



Figure 1. Project stages and timeframes for the Framework development

Project logic

The project had intended short-term, medium-term and long-term outcomes. These intended outcomes are summarised in the project logic in Figure 2 below.

Curriculum Development in Intellectual Disability Health - Project Logic

Goal: To improve the health care of people with intellectual disability by improving the knowledge, communication, and attitudes of health care professionals in their undergraduate training.

- Objectives:**
- 1) Develop an intellectual disability health capability framework by December 2022.
 - 2) Develop supporting resources to align with the capability framework by June 2025.
 - 3) Host resources online by June 2025.
 - 4) Promote integration of intellectual disability health capabilities in health professional accreditation standards and university curricula.

PARTICIPATION: *Who we need to reach?* Medical, nursing and midwifery, dental and allied health undergraduates, universities, health professional accreditation authorities, people with intellectual disability, families, carers and support workers

Assumptions: Accreditation authorities will be amenable to updating standards, universities will align with accreditation standards, a capability framework will be effectively integrated, the proposed Centre of Excellence in Intellectual Disability Health will be established and have the required expertise and infrastructure to host the framework and supporting materials.

External Factors: Policy change, accreditation review cycles, Disability Royal Commission

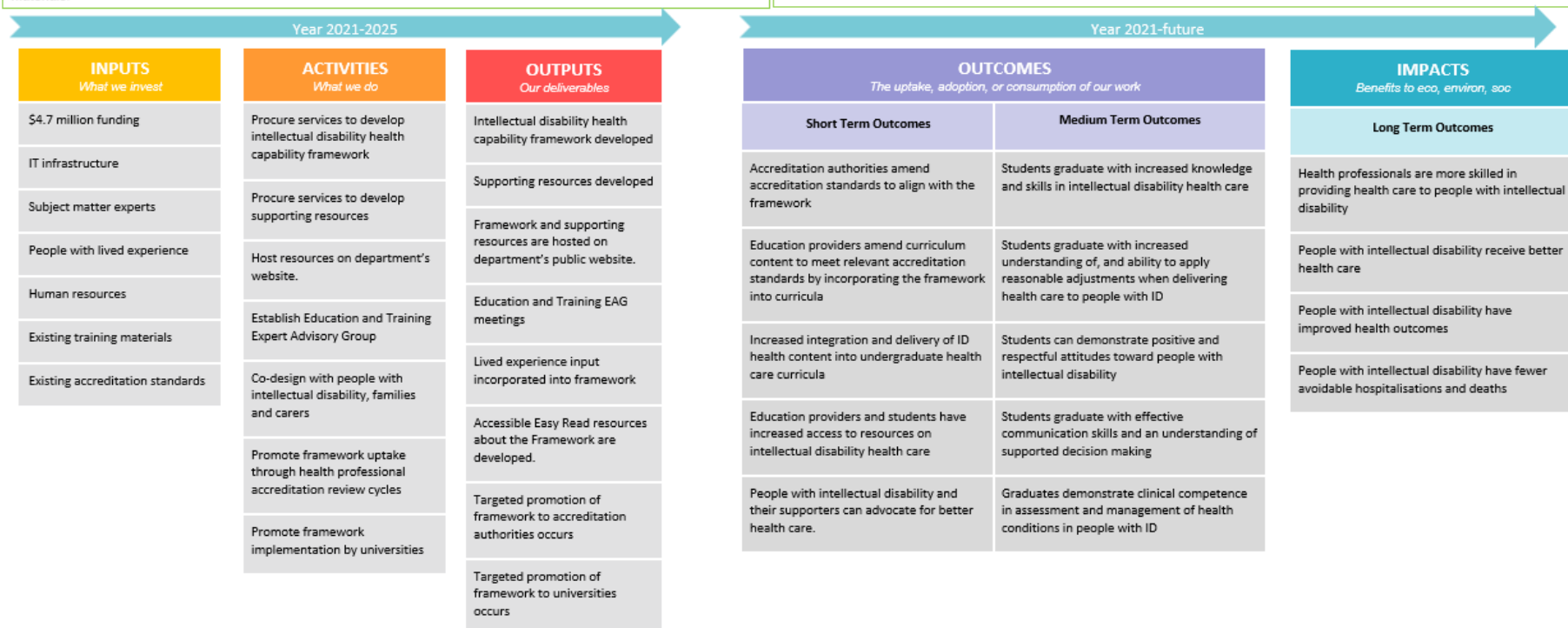


Figure 2. Project logic for the Curriculum Development Project

Chapter 1. Evaluation purpose and approach

This chapter outlines the purpose and scope of the evaluation, overall approach, key questions and the limitations associated with the evaluation.

Evaluation purpose and scope

The evaluation was focused on implementation and the short-term outcomes of the CDP. Monitoring and evaluation was undertaken over three years, commencing in April 2022 and delivering a final evaluation report for the CDP in June 2025. An interim evaluation report that focused on the process of drafting the Framework was delivered to the Department in June 2023.

The objectives of the CDP evaluation were to:

- assess the appropriateness and effectiveness of the development of the Intellectual Disability Health Capability Framework
- review implementation of the CDP, including promotion and uptake of the Framework, and
- explore the key lessons learned from the project to inform continued implementation of the Framework.

Evaluation methods

The evaluation used a mixed-methods approach and aimed to collect data from a range of stakeholder groups. Both qualitative and quantitative data were collected to inform the evaluation. A summary of the data collection methods and the relevant data collection tools informing this evaluation report is provided in Table 1, with a more detailed methodology available in the Supplementary File.

Table 1. Summary of data collection for monitoring and evaluation of CDP

Data collection method	Data source / participant	Key evaluation question	Frequency of data collection
Interviews	• Drafting Group members • ETEAG members • Intellectual Disability Focus Group members • Resource Development team	• KEQ 1-3	• Twice • Twice • Once • Once
Surveys	• Accreditation authorities • Universities	• KEQ 2-3	• Once • Twice
Observations	• Drafting Group meetings and consultation workshops	• KEQ 1	• Twice
Document reviews	• Project documents • Guidelines	• KEQ 1-3	• Quarterly from June 2022 to June 2025

Data collection method	Data source / participant	Key evaluation question	Frequency of data collection
	• Framework • Framework resources • Promotional material • Meeting minutes from Drafting Group, ETEAG, Resource Development team, Intellectual Disability Focus Group		

The results of the interviews, surveys, observations and document reviews were triangulated (cross-verified). This validated the overall evaluation findings to enrich, confirm, refute, or explain the outputs and outcomes observed. Triangulation tests the consistency of findings obtained through the different individual evaluation methods.

Ethics

The CDP evaluation did not collect information from people with an intellectual disability with respect to their personal health conditions. Rather, the evaluation team asked people with an intellectual disability about:

- how much they participated and contributed to the development of the Framework, and
- the quality of the products.

Therefore, a formal application to a Human Research Ethics Committee was not required. However, the evaluation consultants acted in accordance with section 4.5 (People with a cognitive impairment, or an intellectual disability, or a mental illness), of the National Statement on Ethical Conduct in Human Research.

Data management

The evaluation used a comprehensive approach to data governance and information management that guided appropriate data access, security, transfer, management, and storage, and complied with all relevant legislation. Further detail on the data management approach can be provided on request.

Constraints

The following constraints and limitations to the evaluation were identified.

Expectations for implementation of the Framework were ambitious, and some outcomes were unable to be realised within the evaluation period

- At the outset of the CDP, the assumption was that the Framework would be integrated into pre-registration curricula and accreditation standards during the project lifecycle. Early in the project, stakeholders advised that this expected timeframe was unrealistic and that the timeline for changing curricula and accreditation standards could not be completed according to the project implementation timeline.
- The change in the implementation plan impacted the evaluation timeframes and outcomes. There were some data collection activities that could not be conducted and there were some evaluation questions that cannot be answered. These are noted in [Chapter 4](#).

Engagement with First Nations representatives was limited

- There was limited engagement with First Nations representatives in the development of the Framework and in the evaluation. The lack of engagement was acknowledged by the Department and the Drafting Group.
- To increase the reach of engagement and to ensure consultation with First Nations representatives occurred, alternative mechanisms were applied. For example, one of the Drafting Group members arranged a focus group discussion with First Nations members in their organisation; and First Nations representation was facilitated through the First Peoples Disability Network.

The evaluation had a small dataset to draw on

- The small dataset for this evaluation was due to two main reasons. The first reason was that the project had a small stakeholder group to interview. The second reason was the limited responses to surveys. To increase the responses from the education sector the survey was distributed a second time.
- The implications of the small dataset are that evaluation data may be identifiable, and the data is unlikely to be representative. Qualitative data and case studies do not always need to be representative. However, the reach of the project and the extent of its impact can only be measured when a majority of stakeholders participate in evaluations.

Key evaluation questions

Three key evaluation questions guided the CDP evaluation. The questions were then distilled into three key themes that framed the data collection and analysis for the evaluation and provide the structure for this evaluation report (see Table 2 below).

Table 2. Key evaluation questions and themes

Key evaluation question		Key theme
1	Has there been a quality, inclusive and collaborative co-design process in the development of the Intellectual Disability Health Capability Framework?	Co-design process
2	Is the Intellectual Disability Health Capability Framework suitable for use by universities and accreditation authorities?	Suitability of the Framework
3	What impact has the Intellectual Disability Health Capability Framework had on influencing consideration of the health needs of people with intellectual disability in university curricula and accreditation standards?	Impact and influence

This Evaluation Report addresses the three key evaluation questions. An evaluation matrix (see Supplementary File) provides a summary of the range of indicators or evidence required, data collection methods and the timing of collection to conduct the evaluation and prepare this report.

Chapter 2. Co-design process

This chapter addresses the co-design process of CDP including the type and extent of stakeholders involved in the development of the Framework, and how the Framework captures the health needs of people with intellectual disability.

Co-design in health can be defined as “a process where people with professional and lived experience partner as equals to improve health services by listening, learning and making decisions together”.²

The key findings on the co-design process are presented, followed by the evidence that supports the findings.

Key findings on the co-design process

Key finding 1. Co-design process

The development of the Framework was guided by inclusive and collaborative processes. Broad and representative stakeholder consultation was conducted throughout the project, with co-design approaches employed in certain phases. These efforts also helped identify key opportunities for improvement.

- 1.1 People with intellectual disability were not core members of the Drafting Group. Instead, people with intellectual disability engaged with the Framework development through:
 - Participation in the Intellectual Disability Focus Group consultation
 - Inclusion of a person with intellectual disability in a lived experience researcher role throughout parts of the Framework and associated resource development process.
- 1.2 Early in the project there was insufficient engagement with First Nations peoples and representatives. The Department acknowledged this as a major gap in the process and acted to address this gap. Action taken included alternative consultation methods with stakeholders and renewed invitations to participate to the First Nations Disability Network.

Stakeholder involvement

A key activity for the delivery of a co-designed framework was the engagement of and consultation with stakeholders. In the CDP design, ‘relevant stakeholders’ were identified as people with lived experience, universities, intellectual disability health experts, and accreditation authorities. Stakeholders engaged in all stages of the CDP include:

- Engagement in Drafting Group
- Engagement in ETEAG
- Engagement in Resource Development Project

² <https://metronorth.health.qld.gov.au/get-involved/co-design/what-is-co-design> last accessed 21 May 2025

- Engagement in CDP monitoring and evaluation.

The Department acknowledged the importance of co-designing with people with intellectual disability, and people with lived experience were engaged in the project through the Drafting Group, the ETEAG, and the Resource Development Project.

The Drafting Group process commenced with consulting key stakeholders on draft capabilities to be included in the Framework; the Drafting Group then compiled and reviewed the main themes from the consultation prior to amending the draft documents. The feedback received from the stakeholder consultation process included potential modifications to capabilities, potential new capabilities, and suggested removal of capabilities.

The technical nature of the Drafting Group's function was considered to align with input from people with curriculum development and education capability experience. As such, it was decided that people with intellectual disability would not join the Drafting Group as members. Instead, people with intellectual disability engaged with the Drafting Group through stakeholder consultations and other stakeholder networks. The Department acknowledged that this was meaningful consultation rather than true co-design.

The Drafting Group's engagement with people with intellectual disability and other lived experience occurred throughout the development of the Framework. This included having a person with intellectual disability on the Drafting Group in a lived experience researcher role, and consultation with the Intellectual Disability Focus Group. In addition, the Drafting Group engaged families and support persons of people with intellectual disability, including via networks of the Drafting Group and ETEAG. Feedback from a person with intellectual disability from the Intellectual Disability Focus Group reflected they felt listened to, respected and valued during meetings.

Universities were engaged in all stages of CDP. Universities as a stakeholder group were well represented in the Drafting Group, with eight of the nine members affiliated with an Australian university. Four Drafting Group members identified that they had experience in curriculum development and auditing, and another member had experience in workforce and capacity development. Similarly, there was university representation in the Resource Development Project with the project team drawn from schools and centres across UNSW.

Intellectual disability health experts were represented in the Drafting Group and the Resource Development Project. All Drafting Group members were health practitioner with experience working with people with intellectual disability. Two members also had experience working in the mental health sector.

Accreditation authorities were represented in the Drafting Group, with one member representing the Australian Medical Council (AMC). At least one other Drafting Group member identified that they had experience in accreditation, however interviewees were unclear if other accreditation bodies were consulted.

Throughout the project other stakeholders were identified for enhanced and broader consultation and representation. These stakeholder groups were:

- non-medical accreditation bodies,
- Australian Health Practitioner Registration Authority (AHPRA), and
- Inclusion Australia (peak body for self-advocacy).

Early in the Framework development process stakeholders identified that there was insufficient engagement with First Nations peoples and representatives. The Department

acknowledged this as a major gap in the process and took action. Action taken included alternative consultation methods with stakeholders and renewed invitations to participate to the First Nations Disability Network.

Co-design

As stated above, there were no core members of the Drafting Group with intellectual disability. While this remains a concern for conducting a true co-design process, stakeholders identified consultation through other processes had been robust. Evaluation feedback from an Intellectual Disability Focus Group representative provided further perspectives on the importance of co-design with people with intellectual disability:

- having a Framework co-designed with people with intellectual disability was highly valued by people with intellectual disability, and
- the curriculum ultimately had to be owned by people with intellectual disability.

Capturing the health needs of people with intellectual disability

The Framework was developed in three stages and each stage was informed by evidence-based literature and practices to capture the health needs of people with intellectual disability:

- Stage 1 was a scoping review and gap analysis that identified existing curricula and resources and benchmark capabilities.
- Stage 2 was the development of the intellectual disability health core capabilities. These capabilities were developed and refined from Phase 1, using robust research methods.
- Stage 3 was the finalisation of the Framework. This phase included further consultation with people with intellectual disability, First Nations people, and the general public.

Stakeholder consultations identified that the health needs of people with intellectual disability were captured through the consultation and co-design processes. This included people with intellectual disability as well as people with lived experience, and other academic and health professional subject matter experts.

Enablers and barriers in the co-design process

Stakeholder consultations identified a range of enablers and barriers for the co-design and Framework drafting processes.

Enablers

The key enablers for both the Framework as a product and a process, as identified by stakeholders included:

Composition of Drafting Group

There was good composition and size with a shared vision and dedication, diversity of backgrounds and skills/expertise among members. This included subject matter expertise, a person with intellectual disability on the Drafting Group in a lived experience researcher role, and strong project management and critical writing skills. Drafting Group members reported that members worked well as a team with no conflicts. The 3DN team identified that their

critical writing skills and experience was a necessary skill and enabled the progression of the Framework, noting this was not necessarily a skillset of other members.

Extent of consultation

There was wide stakeholder consultation for the timeframe, and opportunities to contribute through multiple methods. Stakeholders highlighted that the dedication and shared vision of the stakeholders involved also enabled progression of the Framework. Consultation with a range of stakeholders using different mechanisms worked well. This applied to development of the Framework and the Learning Outcomes.

Supported to succeed

There was good collaboration with and support from the Department and from the project managers at UNSW. All Drafting Group members agreed on and appreciated the Department's responsiveness, support, and engagement throughout the Framework development process. One member suggested "it felt like it was a team", and it was the best experience they've had in working with Government.

Less time pressures in the later stages

Stakeholders identified that in the last 8-10 months of the Drafting Group work there was less time pressure compared to early on. This enhanced the capacity for the project management team to undertake their role in incorporating feedback from consultations.

Barriers

The project encountered several key barriers for both the Framework as a product and a process, as stated below:

Timeframe challenges in the early stages

Drafting Group members felt the pace of the project early on limited their capacity to undertake more in-depth co-design processes. The project management team identified that it felt they needed to "get up to speed" early in the process as some of the capabilities had already started forming. They were tasked with validating the capabilities in a compressed timeframe. Short timeframes put limits on the breadth of consultation and engagement. The available timeframes also meant the well-intentioned approach to taking people 'on the journey' for this complex project was not necessarily achievable and instead felt like it "turned into a sprint".

Project management role more intensive than anticipated

The stakeholder management element of the project management role was identified as being more significant than anticipated. The project management team highlighted the challenges in managing communication and competing priorities among the multi-organisational Drafting Group members. They also identified varying accountability among some Drafting Group members toward contributions to the drafting process. This led to project management team allocating some tasks and undertaking the majority of the work, even after previous group agreement on roles and responsibilities. Contracting of Drafting Group members to the Department made the task of leveraging roles and responsibilities more challenging. The identified limited expertise in the group in critical writing and editing lead to the project management team taking on this role in addition to other responsibilities.

Extent of consultation

Due to the extensive consultation conducted, there were several challenges, including:

- accommodating and including the range of opinions provided and
- balancing the inclusion of specific information in the Framework with the need for broad capabilities that are applicable to multiple disciplines.

Lessons learned

The following lessons learned were identified about the co-design process:

Meaningful engagement with people with lived experience was crucial

Members of the Drafting Group stated that inclusion of the Intellectual Disability Focus Group was a crucial part of the Framework development process. Respect for communication preferences was important when working with people with lived experience, in particular when seeking feedback on content of the Framework. There was positive feedback on the artworks by people with intellectual disability that were included in the Framework, as well as the process of engaging and funding artists.

Opportunities for meaningful engagement with First Nations stakeholders should be considered in the Stakeholder Engagement Plan

There was limited engagement with First Nations representatives in the development of the Framework and in the evaluation and stakeholders felt there was limited strategic vision for engaging First Nations peoples. Opportunities for enhanced engagement included:

- Early discussions and consultations, and development of the Stakeholder Engagement Plan need to include perspectives of First Nations stakeholders such as defined by the Australian Government's Aboriginal and Torres Strait Island Cultural Capability Framework (2015). This could include development of specific engagement approaches for First Nations stakeholders within a framework development project.
- It was identified that the Stakeholder Engagement Plan should include a focus on First Nations led engagement; and provide a culturally safe and supported environment and culturally safe processes / data collection tools for First Nations to engage meaningfully from the outset of a project. This may include a First Nations Liaison role on the project to build connections and trust, and supporting culturally safe engagement processes such as yarning circles.
- There must also be recognition that First Nations consumers and stakeholders may need time to build relationship and trust with Government and related working groups. Further, consider the broader context and timing of concurrent cultural and Reconciliation initiatives (e.g. NAIDOC week) to optimise engagement.

Of note, the UNSW team was recognised by stakeholders as a trusted team to drive the importance of cultural safety and First Nations engagement for the development of the Framework.

Opportunities for early and ongoing engagement with the accreditation and education sectors should be considered in the project planning stage

Early and ongoing engagement with the accreditation and education sectors, including regulated and non-regulated health disciplines, could have enhanced project planning and implementation. Examples of opportunities include:

- Early engagement would have identified anticipated timeframes for curricula and accreditation reviews and contributed to realistic project timeframes.
- Optimise learnings for implementation and resource development through early engagement with the accreditation sector.
- Encourage internal stakeholders, as appropriate, to share information / updates with their organisations to support broader buy-in, promotion, awareness and inputs.

Chapter 3. Suitability of the Framework

This chapter addresses the suitability of the Framework for use by universities and accreditation authorities. The suitability of the Framework is critical to its uptake and implementation by education and accreditation sectors, and its long-term impact. Suitability was assessed by reviewing the Framework's strengths and weaknesses, the usefulness of resources developed to support implementation of the Framework, and the willingness of universities and accreditation authorities to implement the Framework.

The data in this chapter is primarily drawn from interviews and surveys with education sector and accreditation agencies. The key findings on the suitability of the Framework are presented, followed by the evidence that supports the findings.

Key findings on the suitability of the Framework

Key finding 2. Suitability of the Framework

The Intellectual Disability Health Capability Framework was reported to be suitable for use by universities and accreditation authorities.

- 2.1 University stakeholders indicated they were willing to implement the Framework into curricula. It was important to recognise intellectual disability health in curricula and it is already included in curricula at some universities. The core capabilities within the Framework were considered relevant and there was some alignment and clarity on where the capabilities could be incorporated into curricula.
- 2.2 Accreditation authorities indicated they were willing to implement the Framework into accreditation standards. The Framework was considered relevant to their accreditation body, and it was important for the needs of people with intellectual disability to be recognised within accreditation standards and/or professional standards for health professionals.
- 2.3 The capacity assessment resources within the Framework were considered useful by university and accreditation sector stakeholders. An assessment of the suite of

education resources was not within the scope of this evaluation as it was published in June 2025.

- 2.4 While stakeholders reported a willingness to implement the Framework, this did not translate to a corresponding level of action in implementation or preparing for implementation. The barriers to implementation are discussed in [Chapter 4](#).

Strengths of the Framework and other considerations

A key strength of the Framework was the evidence-based approach to its development and that of the supporting resources. The robustness of the development process ensured that the content of all materials was comprehensive and reflects current practice.

A range of evidence-based methodologies were used to develop the Framework. Methodologies included consultation with highly experienced experts across a range of fields and backgrounds, Delphi method for consensus on the capabilities, robust qualitative analysis of consultation findings, testing and validation of findings by range of stakeholders. In addition, the Framework development process was preceded by a comprehensive scoping review of the literature, existing Frameworks and education initiatives for intellectual disability health, and opportunities for the future. Stakeholders agreed that including diverse views has made the Framework a better product. Stakeholders also identified that the multi-faceted and robust process has supported the delivery of a comprehensive yet concise Framework.

Throughout the monitoring and evaluation of CDP, stakeholders identified areas for consideration, that have been captured and summarised in the following themes. It should be noted that many of the considerations were addressed and implemented as part of the Resource Development Project and promotion processes by the Department.

- **Accreditation support is critical:** If accreditation bodies do not see the importance of the Framework, then it will not be included in university curricula. As noted by stakeholders, one way to ensure its importance is to mandate the capabilities and the Framework.
- **Other ways to improve skills of health practitioners are still required to achieve change:** A further consideration identified was the need to continue to acknowledge that a capability framework is not the only way to improve skills of health practitioners. Other avenues included continuing to advocate for increased opportunities for practical and hands-on experience during training and involving people with disability in teaching and supporting them to do so. This was reinforced by the input from the Intellectual Disability Focus Group participant.
- **Tools and resources are needed to support Framework application:** Practical considerations identified for applying the Framework focused on ensuring the development of tools and resources to make it easy and practical for universities to integrate and apply. Examples included guides to show how the Framework augments existing curricula, online resources, a communication campaign to promote the Framework, map resources and the Framework, cross-reference the Framework with existing accreditation standards, and supporting academic staff to feel confident in teaching the curriculum. Stakeholders acknowledged that the Department had been proactive by incorporating the practical application of the Framework and the development of resources within the overall CDP.

Usefulness of supporting resources

The Framework was complemented by 2 sets of supporting resources. The first set of resources was the capacity assessment tools that formed Appendix 2 of the Framework. The second set of resources was the suite of education resources developed by the Resource Development Project and published in June 2025. This evaluation incorporated the capacity assessment tools, however due to the timing of the evaluation it was not possible to evaluate the suite of education resources.

Capacity Assessment Tools

The Framework included capacity assessment tools in Appendix 2. These tools, or supporting resources, were developed to help organisations assess their capacity to implement the Framework and identify opportunities for further activity. Different tools were developed for different audiences:

- Program content mapping tool for educators
- Accreditation standards development tool
- Inclusion of people with lived experience tool
- Education team intellectual disability capacity tool
- Knowledge/skills self-assessment tool for educators

To assess the usefulness of the resources, both the education and accreditation sectors were surveyed. Overall, the resources were considered useful.

In the education sector, the initial responses were that most survey respondents had reviewed the resources, and all considered the resources *will be* useful (n=8, 100%). In the subsequent survey 11 months following the publication of the Framework and the resources, 33% of respondents had not looked at the resources. Of the 18 respondents who had looked at the resources, 90% considered the resources *are* useful while 20% stated the resources are not useful. No further information is available on why the resources were considered not useful. Similar results were seen in the accreditation sector survey, with 100% of respondents (n=8) stating that the resources *will be* useful.

All survey respondents were asked if they were interested in hearing about additional education and teaching resources to support implementation of the Framework. In total 35 respondents provided contact details and consented to these details being shared with the Resource Development Project team via the Department.

Resource development project

Phase 2 of the CDP included development of education resources for use by health educators to support implementation of the Framework. This was undertaken as the Resource Development Project, which was part of the CDP. The purpose of this phase of CDP was to design, oversee and manage the development and promotion of education resources. The resources are to support uptake and implementation of the Framework through practical tools and resources that enable the translation of capabilities into health care practices. The Resource Development Project was conducted separately to development of the Framework and was undertaken by UNSW. The project included a literature review for each health discipline that focused on how the Framework is relevant to the work of accreditation bodies and their relevant accreditation standards. This helped build

the foundations for resource development and helped to inform strategies to increase awareness and buy-in for the future steps of implementing the Framework.

The suite of education resources produced under the Resource Development Project were co-designed with people with intellectual disability. The following resources were developed:

- 6 written case studies and discussion questions that highlight important issues from each of the 6 Framework Capability areas (see Box 1). These are accompanied by guidance on how to develop further resources.
- 2 case study films that aim to educate students on communication, and decision making and consent when working with people with intellectual disability. The films feature actors with intellectual disability.
- A simulation scenario focussing on effective communication, with a guide for facilitators.
- Lecture plans and tutorial activities, including a lecture reference book.
- Example assessment questions that cover the key capabilities and learning outcomes for each Framework capabilities area.
- A co-education toolkit to support educators work with Lived Experience Educators in a co-teaching arrangement to develop and deliver education to health students. This also includes an Easy Read information sheet on the toolkit.
- Information to support universities work with disability organisations to create student placement opportunities.

The resources were published in June 2025. As this evaluation concluded in June 2025 there was no opportunity to evaluate the usefulness of the suite of education resources. An evaluation of the uptake and usefulness of the education resources should be conducted to determine if the resources were suitable and supported implementation of the Framework.

Resources in action: Case study

One of the Framework case studies was used in a combined lecture and tutorial seminar held with postgraduate students in May 2025. This was prior to the official launch of the resources but was an opportunity to test responses to the resources.

The lecturer used the 'Arthur' case study that focusses on coordination and collaboration. The lecturer chose this case study because it was applicable to the health discipline. The lecturer thought that some of the other case studies could also be used for that specific health discipline, with minor adaptations to make them more applicable.

The lecturer's feedback was that the case study worked well to explore coordination and collaboration, and the questions provided with the case study facilitated good discussion.

Box 1. Feedback on the use of a Resource Development Project case study

Willingness to implement the Framework

The willingness of universities and accreditation authorities to implement the Framework was of interest to determine the suitability of the Framework and as a precursor to action or

implementation. Willingness was assessed in the evaluation surveys conducted in October 2024 and March 2025. Further survey responses on the commencement of implementation are addressed in [Chapter 4](#).

Education sector

The willingness of university stakeholders to implement the Framework was assessed by asking stakeholders how much they agreed with a number of statements. Overall there was strong alignment with the statements, indicating a willingness to implement the Framework. There was a small decline in the agreement with all statements between the two timepoints and a small number of responses that indicated disagreement (Figure 3, Figure 4).

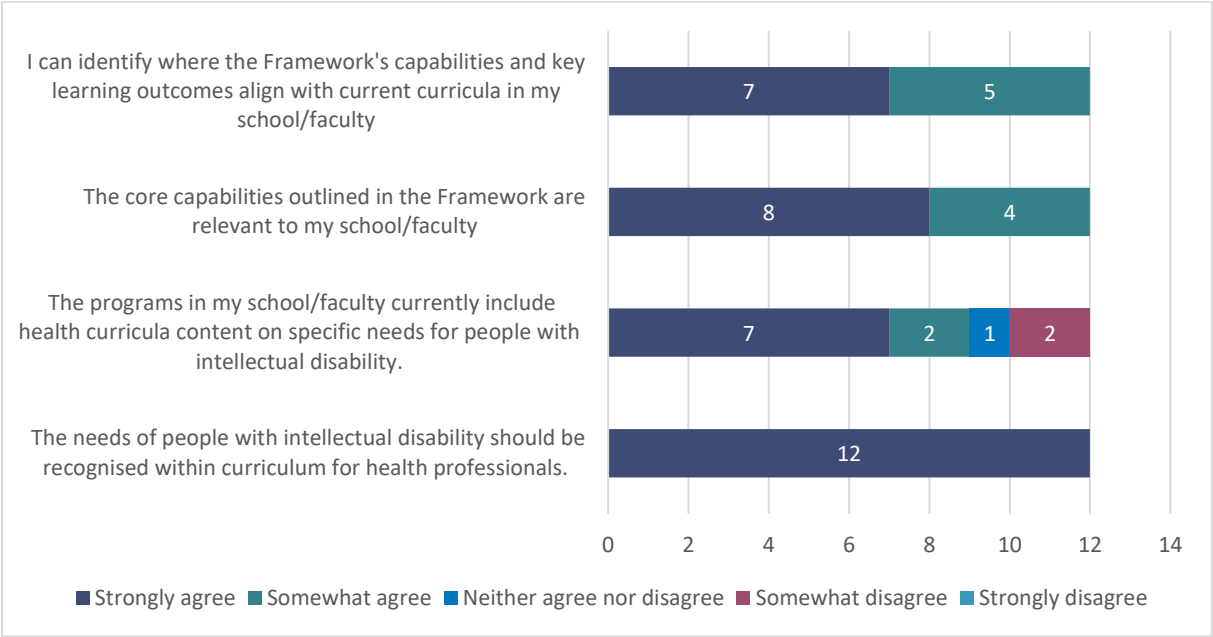


Figure 3. Agreement with key statements relating to integration of the Framework – education sector, October 2024

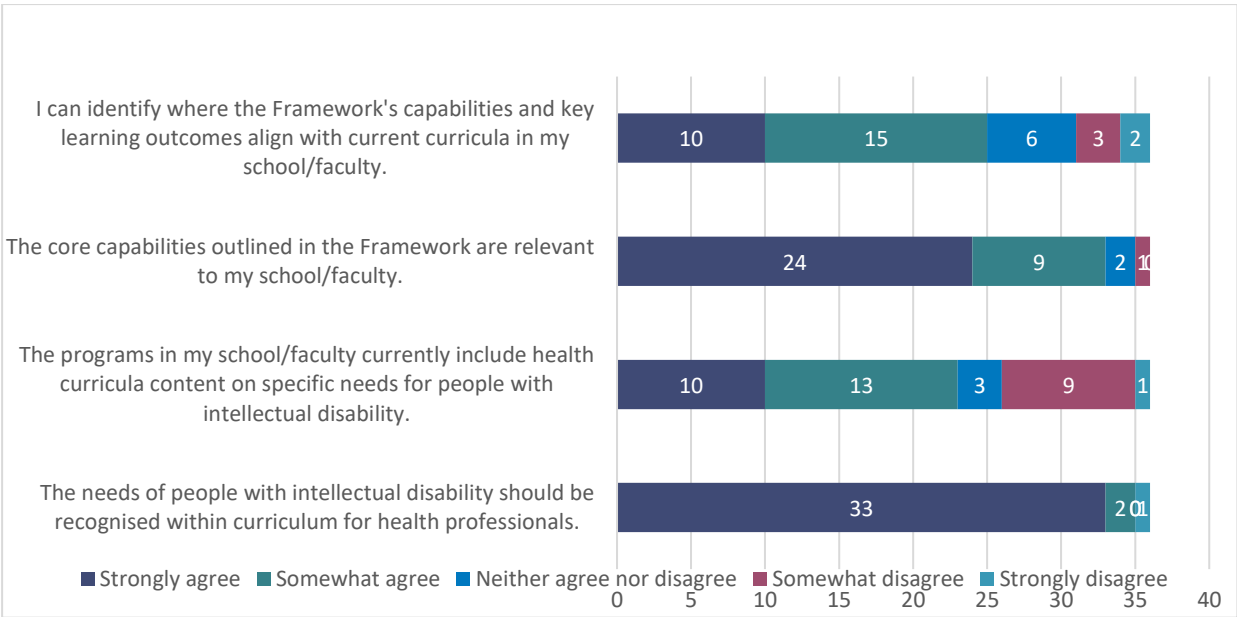


Figure 4. Agreement with key statements relating to integration of the Framework – education sector, March 2025

Accreditation sector

The willingness of accreditation authorities to implement the Framework was assessed once, at 6 months after the Framework's publication. Similar to the education sector surveys, stakeholders were asked how much they agreed with a number of statements. Overall there was strong alignment with the statements (Figure 5), indicating a willingness to incorporate the Framework within accreditation or professional standards for health professionals.

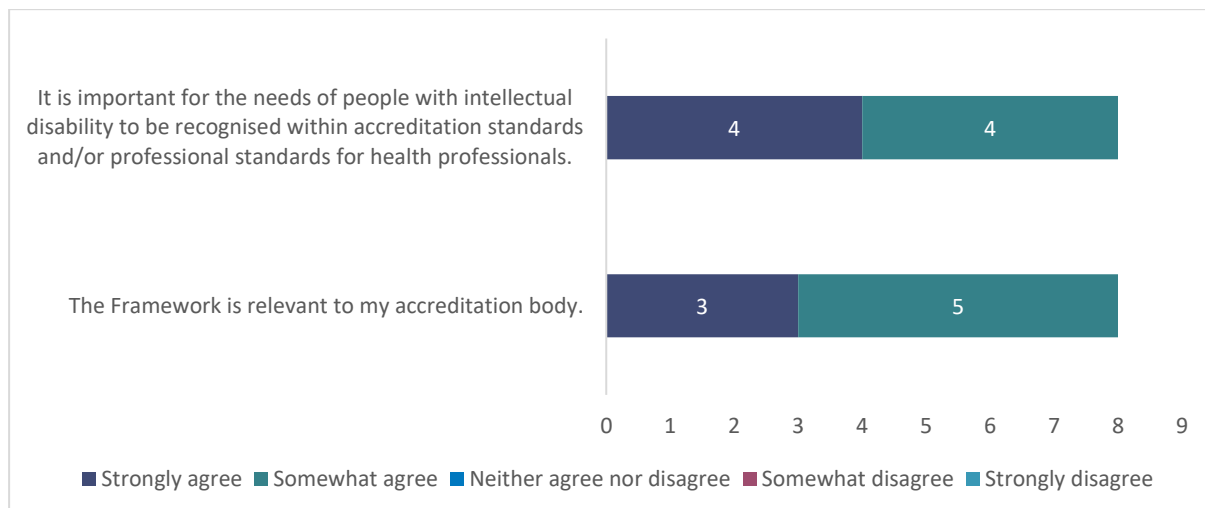


Figure 5. Agreement with key statements relating to integration of the Framework – accreditation sector, Oct 2024

Chapter 4. Impact and influence

This chapter addresses the impact and influence of the Framework, including the overall awareness of the Framework, the nature and extent of implementation, and lessons learned for implementation.

The data in this chapter is primarily drawn from interviews and surveys with education sector and accreditation agencies. The key findings on the impact and influence of the Framework are presented, followed by the evidence that supports the findings.

Key findings on the impact and influence of the Framework

Key finding 3. Impact and influence

At this early stage of implementation, the Framework has had minimal impact on influencing consideration of the health needs of people with intellectual disability in university curricula and accreditation standards. This level of impact was not surprising considering the barriers identified during the evaluation. Despite these barriers there were examples of Framework implementation.

- 3.1 There was awareness of the Framework among university and accreditation sector stakeholders. This may be because many stakeholders who participated in the evaluation were already engaged in the CDP and with the Framework development process.
- 3.2 Some universities had commenced implementation of the Framework, and planning for implementation increased over the 12 months after the Framework's release. Implementation was in the disciplines of dentistry and oral health therapy, occupational therapy, physiotherapy and psychology. Approaches to implementation included integration into both theoretical and practical teaching and learning.
- 3.3 Some accreditation authorities were planning to implement the Framework and 1 is not. Accreditation review cycles are 4-5 years in duration and the integration of the Framework into accreditation standards was considered to be a long-term endeavour.
- 3.4 There were barriers to implementation faced in both the education and accreditation sectors. The barriers included extended timeframes for curricula and accreditation reviews, crowded curricula, resourcing and workforce, and lack of understanding and support for the Framework. These barriers will require time, resources and targeted promotion of the Framework to be addressed. A key barrier for the accreditation sector was the incompatibility between the detailed capabilities in the Framework and the high-level attributes documented in accreditation standards. This indicates that the Framework cannot be implemented by the accreditation sector as the project intended, and further consideration about implementation will be required.
- 3.5 Based on the project timeline there were barriers to evaluating the impact and influence of the Framework. The publication of the Framework in April 2024 and the suite of education resources in June 2025 precluded meaningful evaluation of impact and

influence. Additional evaluation to assess these domains over a longer time period will be required in the future.

Awareness of the Framework

As noted in Chapter 2, stakeholder engagement for promotion of the Framework was driven by communication with an existing list of stakeholders. Most of those stakeholders had already been involved in the project in some way. The Department acknowledged that this list was not complete and that communications about the Framework likely did not reach all relevant stakeholders.

Awareness of the Framework in the education and accreditation sectors was measured through a survey 6 months after the publication of the Framework (April 2024). Stakeholders in both sectors reported being aware of the Framework prior to the survey, noting there was a small number of survey responses. Education sector stakeholders reported lower awareness of the Framework (75%) than accreditation sector (100%) stakeholders. The level of awareness aligns with the survey distribution to stakeholders who were already engaged in the CDP.

Implementation of the Framework by universities

Education sector

After the Framework was published, its uptake by universities was assessed twice. At 6 months after publication 42% of university stakeholders reported that their school/faculty had considered how to integrate the Framework into current curricula, and 82% reported that their school/faculty was well-placed to integrate the Framework within the next 1-2 years. At the second survey, nearly 12 months after publication, there had been some progress with implementation:

- 5 universities reported they had commenced integration of the Framework
- at least a further 2 universities had started to plan how to integrate the Framework.

The disciplines that reported that planning or integration had commenced were dentistry, occupational therapy, physiotherapy and psychology.

“Looks great - very detailed”

“Thank you, we are looking forward to having this framework to guide our actions”

“Well done to all involved. Such important work”

Approaches to implementation

Evidence of planning and progressing integration of the Framework across universities was sourced from the self-reported education sector surveys. Four approaches to integration of the Framework, both implemented and possible or planned, were provided by survey respondents. In addition to the surveys, a university stakeholder provided details of their university’s approach to implementation. This has been written up as a case study (Box 2).

The first approach to integration was to map the Framework's capabilities against existing curriculum, and to review and update current curricula to align with the Framework. One respondent identified that their university has established a working group on diversity and inclusion which has a mandate to enhance current curriculum and identify opportunities for inclusive teaching practiced.

“We plan to embed relevant content across both theoretical and clinical units (if feasible), ensuring a consistent and comprehensive approach”

“The framework could be used to support a more person-centred understanding of intellectual disability for medical students”

“The framework could assist with furthering education around the specific support needs of people with intellectual disability for occupational therapy students”

“I am able to integrate the framework into my teaching of social work practice in disability sector”

Approaches were also identified to incorporate the Framework in both theory and practice. Examples of approaches that have been implemented in theoretical teaching and learning and using the biopsychosocial model of teaching. Examples of planned implementation were a core lecture series on patient with disabilities, and the use of case studies in problem-based learning approaches, which were noted as a common mechanism used in pre-registration education for health professionals. Respondents noted that the use of case studies “humanises the content” and deepens student engagement”.

Integration of the Framework into practical teaching and learning was reported to have occurred through “intellectual disability clinical placements” and “community outreach placements that have provided valuable direct contact with people with intellectual disability”. Similarly for the planned approaches, other respondents identified ensuring that clinical rotations include working with people with intellectual disability.

“[The Framework will] serve as a trigger for incorporating the capabilities in areas such as clinical and communication skills, professional development and population health”

“More specific teaching in social determinants of health, specifically case studies in communication skills lectures and tutorials, integrated in problem-based learning cases”

The final approach was to increase consumer involvement in pre-registration learning. Identified ways of achieving this were to involve people with intellectual disability as lived experience guest speakers/clients. “Increase the consumer voice in research and use this Framework to elevate the profile of people with intellectual disabilities within the curriculum”

Further evaluation with universities once more have commenced implementation and have had sufficient time for implementation will be important to determine what approaches are used and their effectiveness.

Example of Framework implementation in the university sector

As noted in the Key Findings of Chapter 4, there were 5 universities in Australia that reported they had commenced implementation of the Framework. For this evaluation we spoke with an academic staff member in 1 university to hear about their experience of implementation.

How it started

The university commenced implementation within one year of the Framework being released. It was implemented in a faculty that already offered programs in the disability field more broadly, but not necessarily intellectually disability.

The approach to implementation started as opportunistic. There was some awareness of the Framework in the faculty prior to academic staff members talking about the Framework in the Faculty. Academic staff members decided to include the content in their own teaching.

Implementation activities

The following activities are examples of how the Framework was implemented.

Opportunistic examples

Academic staff members used examples that related to a person with intellectual disability as often as possible.

Co-teaching

The faculty engaged people with lived experience in intellectual disability to teach alongside the academic staff members.

Simulation exercise

The faculty arranged a simulation exercise where students could practise their communication skills. Students worked with an actor with intellectual disability and were mentored by a person with expertise in intellectual disability health. The actor was paid by the faculty.

Case study

Academic staff members used a case study from the Framework resources toolkit in a lecture. The students responded well to the case study.

Advocacy

Academic staff members talked about the Framework in the faculty and provided links to resources to other staff members who wanted to incorporate intellectual disability in their teaching.

Conference presentation

Academic staff members presented on their experiences of the Framework at a national conference for health professionals.

Lessons learned

Based on the 6 months of experience in implementing the Framework, there were 2 key lessons learned.

There needs to be a champion to drive implementation

The champion should have knowledge and expertise in intellectual disability health, be willing and comfortable to talk about intellectual disability health, and have the ability to connect people to places and content.

Health disciplines that already offer disability-focused content are primed for incorporating the Framework

Some health disciplines already offer disability content and programs of study in disability. This means that there is an existing place in the curriculum to incorporate the Framework and it is clearer to identify where those places are.

Areas for further action

Based on the 6 months of experience in implementing the Framework, academic staff members identified 4 areas that need ongoing action.

Capturing implementation

Capture examples of Framework implementation and lessons learned. This will help to maintain visibility of the Framework and the importance of its implementation.

Advocacy

Continue to look for opportunistic and creative ways to incorporate the Framework into teaching.

Build an evidence base that demonstrates the impact of including people with lived experience of intellectual disability in co-education.

Continue to advocate within faculty hierarchies for the incorporation of the Framework and opportunities for co-education.

Additional funding

More funding is needed in universities to enable people with lived experience to be engaged in paid co-teaching.

Promote the Framework resources toolkit

Using the recently published Framework education resources, academic staff will be able to promote and link people with the Framework resources.

Box 2. Example of Framework implementation in the university sector

Accreditation sector

On commencement of the project accreditation sector stakeholders advised that accreditation review cycles are 4-5 years in duration and therefore the integration of the Framework into accreditation standards would be a long-term endeavour. Stakeholders also noted that the timing of review cycles is dependent on the accreditation authority and thus integration by the various authorities will be staggered by nature and not occur at one point in time.

This feedback was consistent with the results of the accreditation sector survey conducted for the evaluation. The uptake of the Framework and the related resources by accreditation authorities was assessed once after the publication of the Framework: at 6 months in October 2024. Noting the small dataset, in the survey 88% (7 of 8 respondents) across the accreditation sector reported they were either discussing or planning to integrate the Framework. Due to the timing of the survey – 6 months after the Framework was published – it was not anticipated that accreditation authorities would have commenced integration.

Of note, 1 survey respondent stated that their accreditation authority was not planning to integrate the Framework (Box 3).

“The standards are not a vessel to be filled with required content. There are too many equally important areas to single out one. There are however synergies across multiple areas where the foundations of the framework could be represented e.g. capabilities that relate equally in palliative care, child and family health, primary health care, corrections health, (many more)”.

Box 3. Explanation from accreditation authority not planning to integrate the Framework

Approaches to implementation

Evidence of planning for integration of the Framework across accreditation authorities was sourced from the accreditation sector surveys. Seven approaches to integration of the Framework were reported as possible or planned. These were:

- Referenced in accreditation standards and explanatory / evidence guidance
- Integrated into special populations standards
- Integrate capabilities across range of contexts
- Grouping with other evidence-based contemporary frameworks
- Reference in consultation papers
- Identified in groups / populations at increased health risk / with barriers to access / have a support person
- Mapping of Framework’s capabilities against existing competencies and integration of additional capabilities as needed at next revision of standards.

Barriers to implementation

Education sector

Education survey respondents were asked about existing barriers to integration of the Framework, over the next 1-2 years, into their respective curricula. The barriers identified by respondents in both surveys were similar. Key barriers identified included:

- Crowded curriculum
- Time needed to review / update
- Competing issues / priorities
- Limited staff and funding
- Limited qualified teaching staff with sufficient experience working in disability
- Resources (time and funding) to ensure curricula are co-designed by a person with intellectual disability / Resourcing planning and integration including workforce capacity
- Ensuring teachers are universally adopting/following the model
- Ongoing support requirements including from the university at a higher level, and staff to review curricula and from the accreditation sector
- Lack of interest from school/faculty
- Lack of understanding and familiarity with the Framework, including the gaps and where changes can be made
- High volume of learning outcomes is challenging
- Difficulty in measuring the outcomes and effectiveness of the framework's implementation can hinder ongoing support and resource allocation.

Other stakeholder feedback received identified that whilst the universities are interested in the Framework, there is uncertainty and perceived challenges around implementation. This led to the overall suggestion that implementation will be a slow process.

In the March 2025 survey, stakeholders were invited to identify other supports that would help their organisation to integrate the Framework into curricula. The feedback provided included:

- Training and additional education resources, including workshops and communities of practice.
- Examples of experiences in implementing the Framework shared by other organisations
- Lobbying and awareness-raising, and recognition in health practitioner competencies
- Funding and resourcing, including scholarships and/or research grants, and additional staff to assist with integration

“To support integration of the Framework, we would benefit from staff training to build confidence in teaching about intellectual disability, and funding to develop resources and involve people with lived experience. Partnerships with disability organisations would help create more placement opportunities. It would also be valuable to connect with advocacy and consumer groups to involve people with intellectual disability in the curriculum”

“It would be beneficial to have a national-level, standardised resource developed and made mandatory for inclusion in all health-related courses. This would ensure consistency and ensure that all healthcare students, regardless of their program or institution, receive the same foundational knowledge and understanding of intellectual disability care”

“I am frustrated that this framework does not appear to have received much interest at [university]”

“We can use our university quality improvement cycles to embed the framework principles”

Other feedback received during stakeholder engagement was focused on the content, and could be considered in future revisions of the Framework:

“Consider reframing the descriptions as learning outcomes and the current learning outcomes as topics to support full implementation of the framework”

“If there are specific modules or teaching activities that can be adapted this will be easier”

Accreditation sector

Accreditation survey respondents highlighted barriers that were similar to those in the education sector. The barriers related to crowded education curricula, and existing curricula that already supports a culturally responsive approach. In addition, stakeholders identified that the Framework does not need to be implemented by them. This is because accreditation standards outline the knowledge, skills and professional attributes required for a profession but do not provide prescriptive detail about capabilities. Accreditation sector stakeholders considered the Framework to be useful, and highlighted opportunities for referencing the Framework for priority populations.

Another barrier to implementation identified was the timeframes and cycles of accreditation standard reviews. This was considered a key barrier because each accreditation authority has its own review cycle; some cycles take 4-5 years and therefore there would not be opportunities to consider revisions until the next review cycle.

“Our Standards already prescribe expectations for curricula around cultural responsiveness, the application of interprofessional learning and practice principles, and the achievement of the National Board's graduate competencies. Internal and external stakeholders are reluctant to have even more curriculum mandated.”

Box 4. Feedback on barriers to integrating the Framework for accreditation bodies

Considerations for future implementation

Despite the barriers identified, there has been some progress towards implementation. In part this has been due to work that has already been undertaken to overcome

implementation barriers. Further work will be needed to support the education and accreditation sectors to overcome implementation barriers in order to fully implement the Framework. This section reports on factors that stakeholders considered would promote successful implementation of the Framework. These success factors could be considered lessons learned about the Framework implementation.

Success factors for universities to implement the Framework

A champion to lead promotion of the Framework and advocate for its inclusion

Due to the challenges faced by universities on the demands of including new components, a champion within a school/faculty helps to advocate for the Framework and its content.

Practical solutions to address busy / overcrowded curricula

Feedback throughout the project identified the challenges faced by universities on the demands of including new components into already busy curricula. In particular, the very specific capabilities of the Framework may be challenging to incorporate. The Drafting Group incorporated practical tips on integration to accompany the Framework, and the Resource Development project was established to address this challenge.

Strong promotion and buy-in

Feedback on barriers to the integration of the Framework included limited funding and overarching “financial hardship” of the university sector as a whole. Stakeholders identified that introduction of new curricula and attracting new staff is a challenge for universities based on the available funding.

Strong in-house cooperation and coordination

Stakeholders identified that there are limited specialists to deliver the intellectual disability health content. Therefore, there is a need for strong cooperation and coordination across teaching specialties and to assist the integration of the Framework into existing curricula.

Development of in-house expertise

Stakeholders identified that education providers should be resourced and supported to teach the new content, noting it was unlikely to be an area of current knowledge or expertise.

Ongoing support for implementation

Stakeholders highlighted the benefits of ongoing support from the Department for implementation, including funding for universities to implement the Framework. Stakeholders suggested that ongoing support should be planned and considered, acknowledging that implementation will take time and occur in stages rather than all at once.

Success factors for accreditation authorities to implement the Framework

Support for understanding the implications of the Framework

Stakeholders identified that accreditation bodies often perceive the Framework as not applicable to their profession or standards, and are likely to push back if changes appear significantly detailed. This led to, as part of the Resource Development project, development

and sharing of a literature review / mapping report for each discipline. This aimed to increase awareness and dispel concerns among accreditation bodies.

Clear messaging of implementation expectations

During the project stakeholders identified that there was some “disconnect with language” regarding the promotion of the Framework to accreditation bodies. There was a perceived fear from accreditation bodies that the Framework will be mandatory. Stakeholders highlighted that promotion, communication and support for consideration of the Framework will require clear messaging for expectations of implementation, including clear processes and access to support.

Support for integrating a prescriptive Framework into broad accreditation standards

Stakeholders identified concerns of the accreditation bodies regarding integrating prescriptive information from the Framework into broader accreditation standards. The Resource Development project addressed this to some extent, including consulting with accreditation bodies to identify the key opportunities and solutions.

Additional considerations

Role of ETEAG in advocacy/lobbying and follow up

Membership of the ETEAG will conclude with the end of CDP in June 2025. However, there may be a role for individual members to continue to lobby for and promote the Framework and related resources, as well as championing the importance of continued action to ensure the Framework is integrated into accreditation standards and pre-registration curricula.

Determine the extent of implementation

This evaluation was conducted a little over one year after publication of the Framework; there is still time and opportunity for further implementation. Future engagement with universities and accreditation authorities will be important to assess the impact and influence of the Framework over time.

“Framework is great - would be nice to follow-up which schools have implemented the recommendations, and the processes/outcomes shared”

Consider suitability for other education levels

The Framework was developed for pre-registration health professionals. While the Framework is not intended for broader application, there could be consideration of the suitability of the capabilities for use across other education levels.

Chapter 5. Conclusion

The CDP was designed as an ambitious project with the goal to improve the health care of people with intellectual disability by improving the knowledge, communication, and attitudes of health care professionals in their pre-registration university education. The project has delivered a comprehensive Framework that sets out intellectual disability health core

capabilities, learning outcomes and guides that can be integrated into existing education curricula and accreditation standards.

The Framework was developed using robust and inclusive approaches to stakeholder engagement and co-design processes. The development of the Framework and the supporting resources and other planned project outputs were achieved, however the project has not yet been able to realise the expected short-term outcomes.

The processes of reviewing and amending curricula and accreditation standards are a long-term endeavour, and it is acknowledged that there will be ongoing progress towards these outcomes beyond this evaluation. Over time, it is expected that the Framework will improve the knowledge, attitudes and practice of pre-registration health professionals. However, further evaluation or analysis will be needed to demonstrate impact and implementation of the Framework into the future.

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All information in this publication is correct as at June 2025

