CHSD

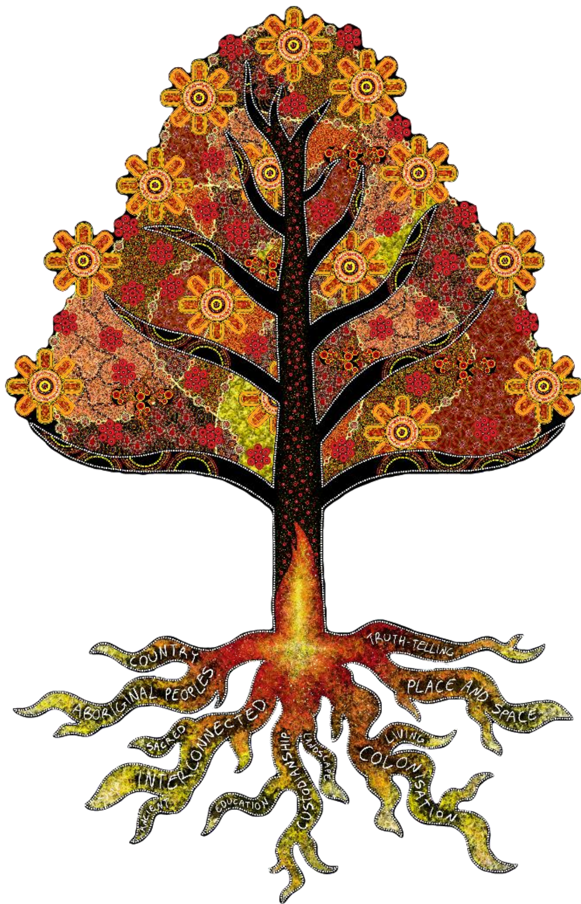
centre for health service development

Evaluation of the Capacity Building in Disability for Dietitians education program

Report on interview findings

September 2023

UNIVERSITY OF WOLLONGONG AUSTRALIA



Acknowledgement of Country

We acknowledge that Country for Aboriginal peoples is an interconnected set of ancient and sophisticated relationships.

The University of Wollongong spreads across many interrelated Aboriginal Countries that are bound by this sacred landscape, and intimate relationship with that landscape since creation.

From Sydney to the Southern Highlands, to the South Coast.

From fresh water to bitter water to salt. From City to Urban to Rural.

The University of Wollongong acknowledges the custodianship of the Aboriginal peoples of this place and space that has kept alive the relationships between all living things.

The University acknowledges the devastating impact of colonisation on our campuses' footprint and commit ourselves to truth-telling, healing and education.

Artwork by Samantha Hill, Dharawal / Wandandian woman

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Suggested citation:

Thompson C and Morris D (2023) Evaluation of the Capacity Building in Disability for Dietitians education program: Report on interview findings. Centre for Health Service Development, University of Wollongong.

Acknowledgements:

Our thanks to Dietitians Australia's Dr Sayne Dalton, Senior Policy Officer, for her leadership of the project and ongoing support, and Ms Maddison Balthazaar, Policy & Advocacy Support Officer, for her assistance in coordinating interviews. We also appreciate the contribution of all program participants who volunteered to participate in interviews.

We recognise that many have collaborated on the Capacity Building in Disability for Dietitians project. We wish to acknowledge the team at Dietitians Australia including the Centre for Advanced Learning, and the program partner, the Australian Federation of Disability Organisations.

We also wish to acknowledge people with disability, and their families, carers and advocates, for their meaningful contributions to this project and the greater community.

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Executive summary

Aim

- Dietitians Australia in partnership with the Australian Federation of Disability Organisations, developed the client-informed Capacity Building in Disability for Dietitians (CBDD) educational program (consisting of an online course, In Practice sessions and supervision) and complementary resources to increase dietitians' knowledge, attitude, skills and confidence in working with people with disability.
- The overall aim of the program was to enhance the capacity of dietitians who work in mainstream dietetic practice settings to respond to the needs of people with disability, and to improve access to timely, inclusive, relevant and high-quality dietitian services for people with disability.
- Researchers from the Centre for Health Service Development (CHSD) were engaged to interview dietitians who had completed the program to explore their experience of the program and its impact on practice. This qualitative study aimed to complement the evaluation conducted by Dietitians Australia.

Methods

- Semi-structured online interviews were conducted with 15 dietitians in May and June 2023. The sample was purposively selected with a focus on early career dietitians working in mainstream roles. The average duration of interviews was 31 minutes.
- All interviews were audio-recorded and transcribed, with NVivo used to facilitate analysis.
- A deductive approach to thematic analysis was used, underpinned by a coding framework and the Kirkpatrick model of training evaluation.

Findings

- Of the 15 participants interviewed, 60% were early career dietitians and 73% worked in a mainstream role. Around two-thirds of participants worked in metropolitan settings and the primary area of practice for most was either private practice or community nutrition. Only two participants had completed all program components (online course, In Practice sessions and supervision); around two-thirds had completed only the online course (all modules).
- Overall, participants were positive about their experience with the program (relating to Level 1 of the Kirkpatrick model). Most identified the online course as the most useful program component, although those that had also completed In Practice sessions and supervision found these components to be valuable. Content was relevant and helpful, with information on specific topics identified as particularly useful, including the International Classification of Functioning, Disability and Health (ICF), the National Disability Insurance Scheme (NDIS) (particularly writing NDIS reports to obtain appropriate funding to best support clients with a disability) and the biopsychosocial model of disability.
- Positive user interactions with the program were also reported, with online delivery providing a flexible and accessible format. The main motivations for enrolling in the program related to participants' professional interest, a perceived need for greater education about disability, and affordability (online modules were fee-free, and the cost of In Practice sessions and supervision were significantly reduced).
- While few participants reported any negative experiences associated with completing the program, potential program improvements were suggested, mainly concerning enhancements to program content and design for example, greater focus on clinical safety and further integration of client perspectives into modules. Future developments, such as development of additional modules and provision of refresher workshops were suggested.

- All participants reported positive short-term impacts associated with completing the program (relating to Level 2 of the Kirkpatrick model). Benefits for participants themselves, and their organisations, related to changed attitudes and beliefs among many participants about supporting people with disability. For example, including a shift toward a more holistic, empowering and inclusive client-centred, strengths-based approach. Most felt they had acquired new knowledge (particularly relating to the ICF, the NDIS and the biopsychosocial model), built confidence (in working directly with people with disability, as well as with broader multidisciplinary teams involved in providing care to this client group) and developed practical skills (for instance, assessment skills and NDIS report writing).
- Almost all participants had applied learnings from the program and adapted their dietetic practice accordingly (relating to Level 3 of the Kirkpatrick model), for example modifying approaches to communication, consultation, assessment and goal setting. A small number of participants with more extensive experience working with people with disability did not change their outlook, capability or practice, however, the program supported and affirmed their attitude and aptitude regarding working with people with disability.
- Participants also identified benefits for their workplace or organisation presented by the program (relating to Level 4 of the Kirkpatrick model), including access to high-quality resources developed by the program, as well as the professional development opportunity itself. Others reported an enhanced capacity to contribute to development or revision of organisational policies, procedures and guidelines, and most participants spoke of their enhanced capacity to write NDIS reports advocating for dietetic services on behalf of their organisation.
- Completion of the program was perceived by all participants to also have benefits for people with disability, primarily through improved access to dietetic services (as a result of more dietitians being confident to work in the disability area and advocate more effectively for services) and the provision of higher quality care that meets clients' needs.
- Most participants identified positive impacts related to the program for the broader dietetic profession, with many referring to the program's potential to positively influence the perception of the profession, with the public generally, and the National Disability Insurance Agency (NDIA) more specifically. This was seen as achievable through an increased understanding of how dietitians can contribute to improved health and wellbeing broadly, as well as of the specific supports a dietitian can offer people with disability.
- A range of factors that influence dietitians' ability to work with people with disability were identified by participants. Limitations of undergraduate training, the complexity of navigating the health and disability systems (including challenges working with the NDIA), and features of mainstream service delivery settings were perceived as major barriers to the provision of dietetic support to people with disability. Conversely, professional confidence, accessible training, and professional advocacy by Dietitians Australia were identified as important in supporting mainstream dietitians to work with people with disability.

Conclusion

- The findings of this qualitative study demonstrate that the CBDD program has contributed to the capacity of the interviewed dietitians who work in mainstream and non-mainstream dietetic practice settings to respond to the needs of people with disability.
- Participants reported positive experiences about completing the program. Most felt the completion of program improved their knowledge, attitudes, skills and confidence in working with people with disability. Encouragingly, many of the examples of skill development and knowledge acquisition identified by participants align with those outlined in Dietitians Australia's disability role statement (Dietitians Australia, 2021).
- Dietitians Australia should continue to offer the online course to dietitians, with consideration of the suggested improvements. As information relating to In Practice sessions and supervision was available from fewer participants, findings about these program components are less conclusive.

Section 1 Introduction

This is a report based upon interviews conducted by a research team of the Centre for Health Service Development (CHSD) at the University of Wollongong, as part of Dietitians Australia's evaluation of the Capacity Building in Disability for Dietitians (CBDD) education program.

1.1 Overview of the CBDD project

The CBDD project was a four-year project (2020–2024), funded by the National Disability Insurance Agency (NDIA) through a Mainstream Capacity Building grant, delivered through the National Disability Insurance Scheme (NDIS) Information, Linkages and Capacity Building program. The grant program is now managed by the Department of Social Services.

The CBDD project aims were to:

- Enhance the capacity of dietitians who work in mainstream dietetic practice settings to respond to the needs of people with disability.
- Improve access to timely, inclusive, relevant and high-quality dietitian services for people with disability.

The CBDD project objectives were to:

1. Conduct a needs assessment to inform the development of an educational program (the program) and resources.
2. Develop a client-informed program (consisting of an online course, In Practice sessions and supervision), to enhance dietitians' knowledge, attitude, skills and confidence in working with people with disability.
3. Develop a suite of resources complementary to the program to support dietitians and their clients with disability.

The online course was offered as a pilot to members of Dietitians Australia at no cost. Implementation occurred through the Centre for Advanced Learning (CAL) in 2022/2023.

1.2 Role of CHSD

The CHSD team was engaged to conduct approximately 15 targeted interviews with participants during the final stages of the project. This qualitative study aimed to provide an independent analysis of participant experience to complement the evaluation conducted by Dietitians Australia throughout project implementation. This report has been produced for the CBDD project team and outlines the key findings. It has been developed to be used in conjunction with other evaluation outputs.

Section 2 Methods

2.1 Study design

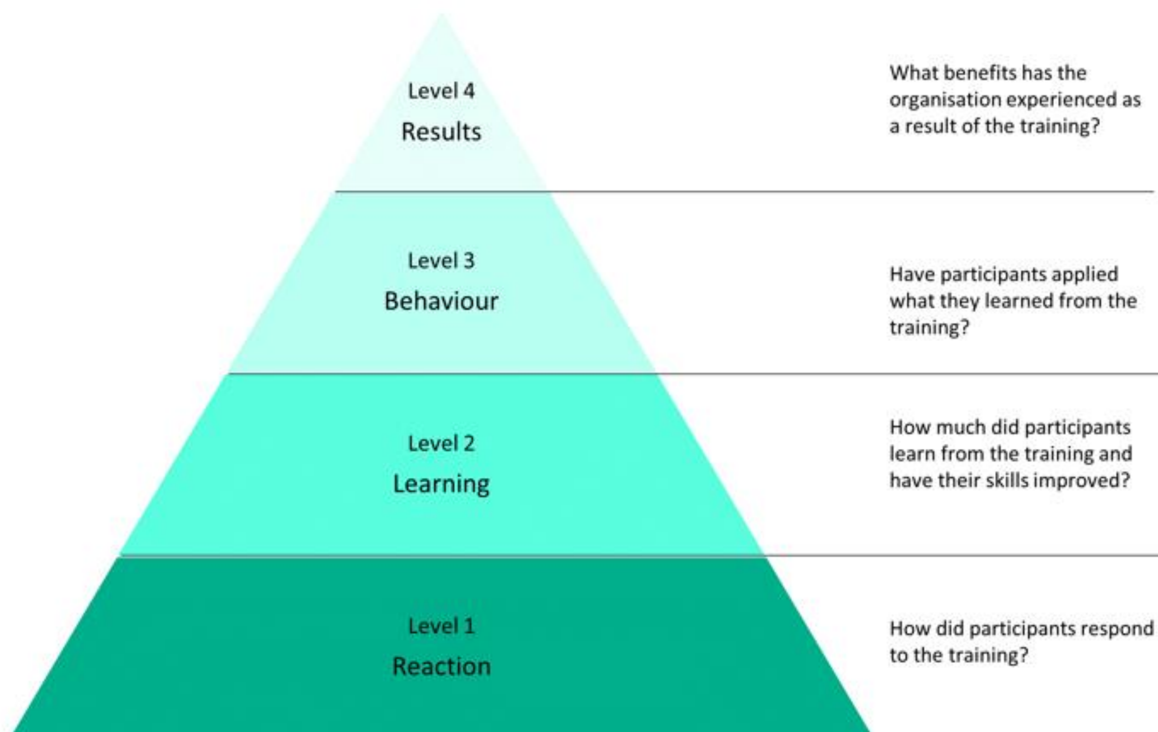
A qualitative descriptive approach informed data collection and analysis. This study design is often used in health care research because of its wide-ranging applicability to different healthcare settings and contexts (Kim et al., 2017; Polit & Beck, 2020). It produces rich data and is useful in refining interventions (Kim et al., 2017).

2.2 Theoretical model

2.2.1 Kirkpatrick evaluation model

The Kirkpatrick training evaluation model provided the theoretical underpinning for the broader CBDD evaluation. The model comprises four criteria or levels of evaluation: reaction, learning, behaviour, and results (refer to Figure 1). It facilitates the examination of results and impact from both individual and organisational performance perspectives (Reio Jr et al., 2017). One criticism of this model is that it can be difficult to address all four levels within the timeframe of an evaluation (Reio Jr et al., 2017). Given the time available for implementation of the CBDD program, assessment at the level of behaviour is likely to be limited and assessment at the level of results not possible. However, Kirkpatrick's model provides a suitable theoretical basis for the evaluation and informed the synthesis and discussion of these qualitative findings.

Figure 1 Kirkpatrick evaluation model



2.2.2 Program logic and theory of change

The intended outputs and outcomes of the CBDD program were summarised in a program logic model, which visually depicts what the program will do and how it will do it, outlining how the program is intended to work and underpinned by the program's theory of change. A more detailed depiction of the theory of change and the planned learning journey was also developed. The theory of change informed the evaluation questions

and all phases of data collection including interviews with program participants. Alignment of the key evaluation questions with the logic model and Kirkpatrick model is displayed in Table 1.

Table 1 Alignment of evaluation priorities

<table>
<tr><th>Kirkpatrick model</th><th>Logic model – short-term impacts</th><th>Key evaluation questions</th></tr>
<tr><td>Level 1 – Reaction</td><td></td><td>▪ What did participants think about it?
▪ Can the program be improved?</td></tr>
<tr><td>Level 2 – Learning</td><td>▪ Increase knowledge about disability and inclusion
▪ Improve attitudes towards people with disability
▪ Improve skills in working with people with disability
▪ Increase confidence to respond to the needs of people with disability</td><td rowspan="2">▪ Did the program have an impact?
▪ Can participants demonstrate acquisition of desired learning outcomes?</td></tr>
<tr><td>Level 3 – Behaviour</td><td>▪ Apply skills and knowledge when working with people with disability</td></tr>
<tr><td>Level 4 – Results</td><td></td><td></td></tr>
</table>

2.3 Sample

This report contains findings from interviews with 15 program participants. These semi-structured interviews collected qualitative data to explore participants' experience of the program and its short term impact. The program was implemented from October 2022 to March 2023 as a pilot, and open to all members of Dietitians Australia at little to no cost. Program participants required English-language skills to participate, therefore, it was assumed all would be able to take part in an interview in English.

A convenience sample was purposively selected after a detailed analysis of the demographic profile of all program participants who had consented during implementation for follow-up contact about their experience of the program. In conjunction with the CBDD project team, a decision was made to focus on early career dietitians working in a mainstream role, as a sample of 'typical cases', as it was anticipated that the program would be of most relevance to dietitians at this career stage (Patton, 2014). Early career was defined as within one to five years of becoming an Accredited Practising Dietitian. All early career dietitians were then categorised in a matrix according to their location of work, metropolitan, rural or remote, and their primary area of practice: clinical dietetics, community nutrition, private practice, public health or research. Additionally, program participants were grouped based on the program components they had completed: course only, including the number of online modules; In Practice sessions; and supervision sessions. Priority was given to participants who had participated in most course components. Thirty-three participants met these selection criteria (Table 2).

Participants were progressively sent an email invitation by the Dietitians Australia Education Centre Course Coordinator to participate in an interview (presented in Appendix 1). A participant information sheet was included. The participant was asked to email the CHSD research team, with the email address provided, if they wished to participate. A digital gift certificate to the value of $100 was provided to participants who completed an interview in appreciation of their time.

If declines were received, or replies not received after the initial contact and two follow-up calls, additional participants that met the selection criteria were progressively invited until all 33 early career dietitians had been approached. It proved more challenging than anticipated to secure volunteer participants so invitations were subsequently offered to mid-career dietitians (6-15 years post-registration) who worked predominantly in mainstream roles (n=16). Recruitment continued until the participation of 15 individuals was secured.

Table 2 Interview sample

Program component	Career stage		Location of work [a]		
	Early	Mid	Metropolitan	Rural	Remote
All components	4	0	3 (0)	1 (0)	0 (0)
Course and In Practice session	1	1	1 (1)	0 (0)	0 (0)
Course only	28	15	21 (13)	3 (1)	4 (1)
Sub-total	**33**	**16**	**25 (14)**	**4 (1)**	**4 (1)**

[a] Brackets depict numbers of mid-career dietitians in each category.

2.4 Data collection

The CHSD team arranged an online interview using the Zoom platform. Consent was obtained prior to the interview's commencement. The interview schedule (provided in Appendix 2) was developed collaboratively with input from the Dietitians Australia program manager who had direct experience of the program. The researchers conducting the interviews had no prior experience with the program, other than the support provided to Dietitians Australia in the development and implementation of a program monitoring and evaluation framework.

Two researchers attended each interview and all interviews were recorded. The interviews were semi-structured with a conversational approach and conducted between 19 May and 28 June 2023. One researcher asked the interview questions and the second recorded notes and observations. The duration of interviews ranged from 19 – 51 minutes (mean 31 minutes) with total interview time 472 minutes. Participants were asked open-ended questions covering a range of topics including:

- Experience of and attitudes toward working with clients with disability prior to undertaking the program (including challenges in providing services to clients with disability);
- Experience of undertaking the program;
- Perceived impact of the program on knowledge, attitude, skills and confidence in working with people with disability (including application of learning to practice); and
- Perceived benefits of the program (including for clients with disability, dietitians providing services to clients with disability, dietitians' workplaces, and the broader profession).

Participants were given an opportunity to provide other relevant information and ask questions before the interview ended. At the conclusion of all interviews the research team recorded their reflections. All interviews were audio-recorded (with the participant's permission) and transcribed by a professional transcription service. Transcripts were imported into NVivo (Version 12) (QSR International Pty Ltd., 2020).

2.5 Data analysis

A coding framework was developed based on the evaluation aims and the interview questions. A deductive approach to thematic analysis was used, underpinned by the evaluation theory previously described (Section 2.2). Following familiarisation with the data, two researchers (DM & CT) each coded three interview transcripts using the framework. A comparison of coding outcomes was conducted with attention to any differences in interpretation and to ensure that the coding captured the data meaningfully. This led to refinements with several initial codes deleted and others combined as they addressed different aspects of the same issue. All transcripts were then coded using this revised framework. The data from codes was charted and organised into preliminary themes in relation to the primary domains of inquiry and these were reviewed and revised by the research team. Further comparison of coded transcripts occurred in the context of the

entire dataset and through an iterative process key themes were identified. All members of the research team agreed on the naming of themes and underlying narrative with a consensus approach taken to resolve any differences in interpretation.

2.6 Ethical approval

Ethical approval for this study was provided by the University of Wollongong Health and Medical Human Research Ethics Committee (Approval Number 2020/435).

Section 3 Findings

3.1 Presentation of findings

Thematic analysis provides a means to analyse qualitative data and assists in making sense of what may initially be seen to be disparate information (Boyatzis, 1998). Reporting of results was guided by the evaluation questions and theoretical model underpinning the evaluation. Quotations are presented in *blue italicised text,* a code denotes whether the participant was in a mainstream (M) or non-mainstream (NM) role, this classification was determined by each participant. Participants were randomly allocated a number from 1 – 15 to preserve anonymity. Quotations are included that best illustrate the themes identified through analysis. A deliberate decision was made to include a substantial number of quotations, in some instances to provide context and in others to illustrate thematic nuances. A summary of themes is included in Appendix 3.

3.2 Demographic characteristics

This section presents the demographic characteristics of the 15 interview participants. The majority of participants (60%, n=9) were early career dietitians and the remainder mid- or late-career. Approximately two-thirds of participants (67%, n=10) worked in metropolitan settings with three participants from regional areas and two based in rural locations. The primary areas of practice were private practice (47%, n=7) and community nutrition (40%, n=6) with two participants working in clinical dietetics. Most participants (73%, n=11) were in a mainstream role. Only two participants had completed all program components, with the majority (67%, n=10) only completing the online course (all modules).

Table 3 Demographic characteristics

Characteristic	N = 15 (%)
Stage of career	
Early (1-5 years)	9 (60)
Mid (6-15 years)	5 (33)
Late (16+ years)	1 (7)
Location of work	
Metropolitan	10 (67)
Regional	3 (20)
Rural	2 (13)
Primary area of practice	
Clinical dietetics	2 (13)
Community nutrition	6 (40)
Private practice	7 (47)
Public health	0 (0)
Mainstream	
Yes	11 (73)
No	4 (27)
Engagement with program	
Course only (all modules)	10 (67)
Course (all modules) + one or more In Practice sessions only	3 (20)
Course (all modules) + one or more In Practice + supervision	2 (13)

3.3 Participant experience

Overall, participants were positive about their experience with the program. As most had only completed the online course, unsurprisingly they identified this as the most useful program component. Several themes emerged relating to participant experience including user interaction with the program, motivation for enrolling, positive experiences, negative experiences, and potential program improvements.

3.3.1 User interaction with the program

Participants valued the online delivery of the program as this was seen as an accessible and flexible format. For example, participants appreciated avoiding the time and costs associated with in-person attendance. Participants liked the flexibility of the program in that they could access the program in between client appointments and from home.

> *It was great for me; I don't know about other people but I started undertaking it as soon as I took on the position where I am here, and I was able to do it around my clients. So, if I had a gap, I did a module or two (NM8).*

Particular mention was also made of how the modules built upon each other and followed a logical sequence. One participant commented about how the modules linked effectively to the In Practice case studies as they took the learner from the general to the specific.

> *I just really liked the way it was set out, how it had questions and then the videos and the reading material. It was really easy to go through…no technical issues (M10).*

> *I really liked it. I thought it was innovative, and I thought that building on each one was really, really helpful. So I guess the supervision helps us to reflect on whatever we've implemented in our practice. And yeah, that's been incredibly useful (M7).*

Moodle was an acceptable learning platform and did not present any issues for participants.

> *I'd never used it [Moodle] before, but it was fairly user-friendly (NM8).*

The only technical issue recurrently reported related to difficulties initially logging in through the Dietitians Australia Centre for Advanced Learning (CAL).

> *It was quite difficult logging in. I had to actually ask one of my colleagues because I think it was a whole separate website or different to the normal website (M1).*

Several participants only did the online modules as they were unaware that the In Practice and supervision sessions were available, which appeared to be related to the timing of their enrolment in the online modules. Reasons for not participating in the In Practice and supervision sessions included participants already having access to supervision in their workplace, the timing not working, and for one participant as they were not currently practicing they did not feel these sessions were relevant.

3.3.2 Motivation for enrolling

Participants identified three key reasons for enrolling in the program: professional interest, a need for greater education about disability, and the low cost of the program.

Participants spoke of their professional interest in working with people with disability and anticipated that the program would improve future employment prospects and, for those working in private practice, provide access to a wider range of clients. Some participants felt the program was particularly relevant to their

professional practice and others felt it would help them to benchmark their current level of knowledge about supporting people with disability.

> *It was a way of benchmarking myself to make sure that I was up to date with everything else going on within the sector, and making sure my staff were as well, and just finding ways that we could do it better (NM6).*

The most consistently reported issue driving this professional interest in the program was a need for more education about supporting people with disability. Almost all participants described the inadequacy of the training they had received during their undergraduate degree in relation to disability.

> *That is super relevant to what I am doing every day in my daily practice, and it's filling the learning gap. Because before this training came on board, my university training is mainly for quite a clinical focus, like treating health conditions, how nutrition can treat and/or prevent lifestyle conditions down the track. But with the NDIS funding stream, because it's an insurance scheme, so their requirement, the wording, how it works, is totally different. So it's a completely different mindset. So this training has filled my learning gap (M3).*

The advent of the NDIS had increased awareness about the needs of people with disability and participants expressed a desire for greater education about disability. For some this was because they wanted a better understanding of the NDIS.

> *I think I always look to do professional development that's relevant to my role, for when I started working with specific clients. In my community role, I did that initial introduction on the NDIS website. This time it [the program] was much more dietetic, so I'm, "Let's do this" (M13).*

Other participants spoke of being part of a multidisciplinary team or working with health professionals who referred to the International Classification of Functioning, Disability and Health (ICF). Other disciplines demonstrated the application of the ICF in the care of people with disability. Several participants also spoke of their longstanding interest in disability and in some cases this was because they had direct personal experience of people with disability in their families.

> *I actually work also in a multidisciplinary team. I believe I have a better understanding of function the most, but still doing the course, I always kind of still come away going, "All right, still know how to write a really good NDIS report" (NM6).*

> *The fact that I'd had no education on disability, and I was like, "You know what? Some formalised education would be just nice, at least on my CV if I know everything." But more so for the fact that I work in a clinic where I'm the only dietitian and everyone else is speechies and OTs and physios. And they all knew what this ICF was and I was like, "What is this?" (NM8).*

The most frequently mentioned motivator for enrolling in the program was undoubtedly the low cost (free for the online modules and significantly reduced costs for the In Practice and supervision sessions). This was particularly important for early career dietitians who found the costs of professional development expensive and at times prohibitive. Participants confirmed that they would have been less likely to enrol in the program if the usual Dietitians Australia charges for online education had applied.

> *I can't remember if it was free or low cost to enrol, but it was accessible which I appreciated… After I finished, or when I was almost finished the modules, that is when I saw the supervision advertised, and again it was low cost, and I thought that's fantastic (M2).*

…it was cheap. That definitely helped because as a fairly new graduate, especially the first 12 months, I think we're underprepared for the amount of money that it costs us to upskill in whatever areas we want to specialise in. So yeah, definitely a factor (M7).

For providers, the education and resources are invaluable. And then the supervision, I think, is something that dietitians haven't typically done. But it should be an area where we're moving into, and it needs to be accessible, because otherwise, you know, private supervision is $150 - $200 an hour, this being $45, that just was so, so much more accessible. So from that kind of private provider perspective, having a safe space to, you know talk about it, and it just prevents burn out (M2).

3.3.3 Positive experiences

Overall participants were positive about the program with positive feedback significantly outweighing negative feedback.

I believe it gave a really good outline of how we can support clients and being inclusive to everybody, and really looking at those barriers and facilitators I think it did a good job of how we can be looking for those things instead of a clinical answer to actually look at that answer of, "Let's stop trying to cure something and what can we actually do to facilitate a better life" (NM6).

Several participants said they would recommend the program to others.

I couldn't recommend it enough, I told my girlfriend who unfortunately was unable to obtain a job in the field that she needed to do it, and then go and apply for other roles. Because I just said to her, I was like, "It just explained everything" (NM8).

I definitely think if they [dietitians] hadn't been working in the disabilities space long or if they just wanted even a refresher or anything like that, I think I would definitely recommend that they explore it and give it a go (NM4).

The positive experiences reported addressed the three key program components: online modules, In Practice sessions and supervision. Participants mostly provided feedback about specific aspects of module content, for example, the modules provided a good understanding of the NDIS. The modules or content perceived by participants to be of high value included the information about the ICF and its practical application. Some participants felt that the ICF was the anchor of the program and needed to be completed first to allow full engagement with subsequent content.

The ICF document and the really just minute descriptors of everything that could possibly be considered under a disability has helped me so much in being able to really unpack what's going on for a person, and to have the words, and I guess, like kind of, like the coding, the framework. To be able to advocate from that perspective as well, and to be able to refer to a document and be like this, you know, this is defined as something that is disabling, and so we've got to be taking it seriously (M2).

It was good to get introduced to the ICF, because that's where it looks like dietetics is going in regard to just writing reports and getting that funding from the NDIS for dietetics (M13).

Participants found the information provided about the NDIS, particularly report writing for the NDIS, very valuable. The third most frequently mentioned content area was the information about communication with people with disability, which was also perceived to be highly useful. Other areas that were received positively included any session that included lived experience speakers and / or real-life case scenarios / videos.

The useful things I thought were the stuff on funding streams in NDIS and NDIS report writing. I think that's very practical and I will certainly be reviewing that. And these ideas about low-tech and high-tech options for communication, I guess I wasn't aware of some of those options. I think I will find that useful (M9).

One thing which was covered well, I think it was in the last module, was doing the reports for the NDIS… I feel that that was helpful because one thing which I've learned through trial and error is I can write the exact same report but just change the date and the name. Depending on who reviews the case, half will get through and half will get rejected. I feel like I've learned some of the tricks for wording to get the plans approved (M15).

Participants provided specific comments about the In Practice session 'Focus on Function' and referred to the value of the biopsychosocial model and learning the language of the NDIS. Participants enjoyed being able to interact in a group setting and hear how others problem-solved issues that had arisen for them when supporting people with disability.

I really loved the live workshops and talking through some cases and I felt like they really focused on that client's quality of life and their wishes and goals and things like that. So that was really beneficial and just I guess reinforcing that and reminding you to keep them front of mind when advocating or coming up with a nutrition care plan and things (NM4).

Few participants of those interviewed attended the supervision sessions, those who did spoke about the benefits of learning from the experience of others which was particularly helpful for early career dietitians. Those who worked as solo practitioners or were the only person in their workplace supporting people with disability valued being able to interact with others in similar professional circumstances.

In terms of the supervision, I think for me personally, the most beneficial part of that was having other people who are in a similar line of work because where I am is quite isolated. I'm the only person that does what I do here. Having other people to listen, to learn from their experiences, to share ideas with, it made me feel a lot more connected (NM5).

What can I say other than it hasn't just been about the supervision, but the interaction with my peers. I've really enjoyed the group setting. We've learned a lot from each other because we all have different styles, of course, and we have different caseloads, different experience, and it's actually inspired me. I'm starting a peer support group with my cohort because of my experiences with that group kind of supervision setting and […] I love the fact that it's a safe space (M7).

3.3.4 Negative experiences

Most participants struggled to find examples of negative experiences with the program. The small number of comments received have been clustered into the two themes: the content and format of program components (modules, In Practice and supervision sessions) and practical application of learnings. Some participants felt the content of the modules was repetitive however, they also commented that they felt they had considerable prior knowledge of supporting people with disability. On occasion participants felt the content was 'a bit dry' (M1).

I don't know if it's because I'd done some of my own research. I found some of that was a little bit repetitive, just from my prior knowledge. But in saying that, I think if you hadn't done any kind of disability work and you were just preparing to start, then it would be really great. So I think it's just because I'd already had that little bit of experience that kind of maybe swayed my view a little bit (NM4).

Another participant did not find the report writing module useful as it was not different to what they were currently doing. Others felt that more templates were needed to guide NDIS reporting.

> *I was very interested in the report writing, but since the fact it was an introduction, I understand they couldn't include everything. But I feel at times it did feel a little bit content heavy, in a sense of it was a lot of information, and maybe not always... There was application towards dietetics but sometimes just a lot of information (M13).*

> *I still, after doing the course was a bit, "can I get some better templates or guidelines?" (NM6).*

Some participants raised the small group size for supervision and felt that a larger group would have contributed to a better experience particularly if groups included dietitians with a mix of backgrounds and experience. One instance was identified where a supervision session appeared to be dominated by one participant and this highlighted the need for skilled facilitators.

> *I think, with the supervision again. It would have been better if we could get more people in the group, so I think that they were set up for eight. But there's only three including me in my group. Of course, the more people in there, the more you kind of learn, the more you grow (M2).*

While few comments were provided about the format of the online course, some modules were felt to be quite time consuming to complete. It was suggested that an indication at the start of each module of the estimated time to complete all components would be helpful. One participant felt that the first two modules could be condensed. Other participants found the online modules were not visually appealing.

> *I guess a negative aspect was that it was not very visually appealing or interactive. I've done other training before where there were more videos and even recordings of people talking and like seeing their face. I think that keeps it engaging rather than just looking at words, or even having two people talking, like a podcast type thing, I feel it gets you more engaged and that would be a more interesting way of learning. Especially when you're talking about people with disability, it's easy just to type it all in and write it and read it. But if you were to listen to it, or have a video, I think it could be displayed in a more useful way (M1).*

3.3.5 Potential program improvements

Two themes emerged in relation to program improvements: enhancements to program content and design, and future developments. Most comments were about program content and design. For example, participants suggested additional content should be provided about communication aids and how best to support decision-making with clients who are non-verbal or have limited verbal ability. More information on report writing, including further examples or templates for NDIS reports, as well as guidance on writing in a manner that effectively advocated for the client, were also requested.

> *I think the biggest thing that helps me is having some really nice templates for my assessments and reviews and reports and things like that because I think once you have the learning in those kind of spaces from either the Dietitians Australia stuff or whether it's other PD. I think once you have those broad kind of prompts and you put them somewhere that you are using regularly, it just helps it, I guess, remind you initially. But then it just becomes kind of habit and practice to just always ask those questions or consider those kind of things (NM4).*

Clinical safety was identified as a gap in content with participants referring specifically to clinical dietetics and supporting people with different disabilities with practices such as tube feeding. Inclusion of information about potential funding sources, in addition to the NDIS, was requested to address the wide-ranging needs of children and adults with disabilities.

Yeah, I think from, and I'm thinking more, I guess safety, clinical safety, I think actually more basic clinical dietetics in different aspects of disability. I know it's such a broad, like how on earth do you cover this all? But I mean, I think that definitely would be... Even if it was an add-on, an optional add-on, and especially if you're seeing patients with tubes, feeding tubes and they don't have that support around them, then yeah, I guess I feel like that's something that should be included (M15).

Participants also felt that any opportunities to further integrate the client perspective into the modules would be extremely helpful, either through more case studies or videos featuring people with disability. Suggestions included additional examples using videos, of how to handle situations and apply the knowledge provided into practice. This included demonstrations of client interactions, and role plays of different consultation scenarios relevant to practice. Examples were provided of other training programs that provided more practical examples of knowledge application; participants felt that the CBDD program would benefit from these inclusions.

I think it might be because it [modules] was done virtually. There are talks that I have attended that were in person and they had role plays. They had a volunteer come up and do an example, for instance. So yeah, I think it might have been because it's online (M1).

Suggestions were also made about making resources used in the online modules printable or downloadable as PDF files. Other proposed design improvements were to use different assessment approaches throughout the modules. Rather than relying on multiple choice questionnaires, different types of questionnaires could be considered as well as case scenarios.

Future developments for the CBDD program could include specialty modules that focus on different client groups for example, a paediatric module or stream.

I think maybe having different streams for paediatrics, adults, that sort of thing. And my biggest challenge is, because I'm seeing kids before they have their NDS funding, it's how to write that first letter to advocate for NDIS funding, especially when a young child doesn't necessarily have a diagnosis (M12).

Participants also saw scope for new modules addressing Autism Spectrum Disorders (ASD), fussy eating and other neurodevelopmental disorders of childhood such as Attention-deficit/Hyperactivity disorder (ADHD). Given the diversity of disabilities, development of specific modules on the most common types of disabilities was identified as a potential program improvement. Participants also raised the possibility of a more condensed version of the program for a generalist working in private practice. A refresher workshop based around case studies was also suggested. Finally, participants spoke of the broader application of the program and felt it contained information relevant to dietitians working with older people with physical disabilities or those receiving end-of-life care.

3.4 Program impacts

The CBDD program aimed to enhance dietitians' knowledge, attitude, skills and confidence in working with people with disability. Program impacts were short-term and thematically analysed in relation to the three groups most frequently mentioned as program beneficiaries: program participants and their organisations, people with disability, and the broader dietetic profession.

3.4.1 Benefits for participants and their organisations

The benefits for participants were captured in three themes: the impact on attitudes and beliefs, knowledge and skills, and adapting practice.

3.4.1.1 Attitudes and beliefs

Participants spoke of a 'shift in mindset' that they attributed to the program and provided examples of how their attitudes and beliefs about supporting people with disability had changed. This included moving toward a strengths-based approach rather than focusing on a person's deficits and more of a client focus.

> *It made me think about not just the barriers but more also about their strengths, like what is happening in their daily life. So I could be a bit narrow-minded and just thinking of all the problems and how I can fix them. So it's really changed my mind set about looking into the person's function and daily life (M3).*

> *Learning how to respectfully support the clients, obviously in the disability sector, and helping to reflect on my own practice and making sure that's obviously done in a respectful manner and involving the client as much as possible, not just obviously their support team. Which is something we tend to do, rather than focusing all the attention on the client. Obviously, the people around them are the ones sometimes taking care of them, but I think after the module I was just a bit more focused on the client, I guess (M10).*

Participants referred to enhancing their understanding of the importance of increasing involvement of and communication with the client, in the consultation and decision-making processes, and several referred to the need to empower the client.

> *For people who are more capable, I have modified my practice to include more choice and control. Say for example, the person has diabetes but also has schizophrenia, so he can be quite rigid in his food choices, and not making changes overnight, so he would take time to make one small change. He is fixated on certain food for after-dinner snacks, and it's non-hungry eating. So I teach him the skills of, if he can't regulate his hunger, he doesn't know whether he's hungry or not, I asked him to check his sugar level, and if he's under six for example, then he can have these kinds of food that can be a bit carby. Or if it's about six, he can have low to no carbohydrate snack options. So it teaches him the skills to make his own choices depending on his situation (M3).*

The introduction to the biopsychosocial model helped participants view the person with disability more holistically and within the context of their environment and supported a focus on functional capacity.

> *It is quite a mindset shift from a clinical public health background going into the more biopsychosocial model. That's what the Focus on Function session really covered. Learning the language that the NDIS uses and wants to see, and understanding, working towards clients' goals and functions rather than nutrition diagnoses and things like that (NM5).*

Participants felt that they now kept the needs of the person with disability front of mind and for some, they now adopted in their practice more of a 'supporting mode' as opposed to their previous 'fixing mode' (NM6). An increased awareness of unconscious bias and how participants' unconscious biases had been challenged through the program was raised.

> *A better understanding on how to approach and how to work with people with disabilities... That understanding and empathy and highlighting our unconscious bias, I guess was good (NM6).*

Some participants with more experience working with people with disability felt that the program reaffirmed their existing attitudes and beliefs and provided them with a stronger foundation for these beliefs.

> *I feel like it's just strengthened or reaffirmed to me my attitudes and beliefs, which was really nice because it's quite different practicing in this disability space than it is in the clinical space (NM5).*

3.4.1.2 Knowledge and skills

Program impacts included acquiring knowledge, building confidence and learning practical skills. Specific examples of new knowledge mentioned were the biopsychosocial model, ICF, NDIS system and the importance of understanding the client's context which could be achieved by branching beyond clinical issues to a more holistic assessment of client needs.

> *I did learn a lot of things which I didn't realise I needed to learn, if that makes sense. Particularly, understanding the different models of how disability can be viewed (M15).*

> *I really like the kind of addition of the functional component into the nutrition assessment. I thought that was really practical. A really good tool and really important. And I've definitely used the ICF document and framework going forward in working, especially when I'm writing reports for NDIS, just really using that kind of functional capacity part (M2).*

> *Right at the start, I definitely felt like a fish out of water because I didn't know where to start. I mean, the NDIS for me, and the Australian health system was a brand-new thing. Having this online course that started from very bare basics, and it was really comprehensive in covering the topics, it was such a good starting point to build up some confidence and knowledge to get started and feeling like I would be useful (NM5).*

Participants built confidence in a broader way of working which was explained as increased confidence in working with other disciplines and advocating for dietetic support for clients in multidisciplinary team meetings. For some, this extended to understanding how best to support the person with disability within the context of their living environment.

> *I think it's maybe allowed me to have a broader way of working with them because I now understand how to justify what I'm doing on a more government non-medically educated basis. But I think it's also really helped me fit in with the speechies and the OTs. Which they loved, because I can actually write a report in the exact same format that they can. Obviously, being more dietetic specific, but it's the exact same presentation regardless of which field we're in. And it shows that real focus on those dietetic impacting factors (NM8).*

> *I work in community health and often the different clinicians, the multidisciplinary team will have a chat about, "Okay, I've got this new client." And I think it gave me more insight in where dietitians can really help in that, not so mainstream context. I think one of the examples was a client with ADHD, maybe ASD, and just the setup of their kitchen and where everything was set up, and I felt like that was really insightful. I guess I hadn't seen my role as a dietitian in that way. And so I could advocate more for dietetics within my team and say, "Well, I think we could really help with X, Y, and Z" (M14).*

Report writing for NDIS clients was frequently provided as an example of participants' development of knowledge and skills in supporting people with disability.

> *I definitely took from it how to write, because I've revised how I write my NDIS evidence letter, although I still would really like some more examples to increase the success rate. But certainly changing that, looking at things from a functional perspective and the day-to-day impacts on the child, to then write that into the report as evidence for the NDIS. I think that hopefully is making a difference, because I've had more success this past couple of months with those letters (M12).*

> *It's sort of new practice to me to think differently, and the wording I used in the report, it equips me with the skills I need to apply for funding and I have changed how I write the report. So instead of talking about diabetes, blood sugar level, and weight, I learned my lessons. I try to*

avoid using those words, and looking at how the way of their eating can impact on their comfort on the wheelchair, ease to transfer in and out of the wheelchair. Do they need two-to-one support? Or if they keep carrying more weight, do they need to increase to three-to-one support for self-care and independence? So it's really practical. I really like it (M3).

Reference was made to practical skills that had been learnt, particularly assessment skills. One participant explained how their interactions with clients with disability and their families had changed.

Now in that initial consult, I'm much more pinpointed like, "Is that impacting your life? How is it impacting your life? What does that look like?" Rather than sort of letting it organically come out over what might take me six months (NM8).

3.4.1.3 Adapting practice

Almost all participants were able to provide diverse examples of how they had been able to apply learnings from the CBDD program and adapt their dietetic practice. These included generalisations about being better equipped to see any client with a disability, focusing on client choice, and thinking more broadly about the client's needs and the barriers they faced.

So I think, once again I did look at those NDIS modules, but it did reinforce a lot of those key messages in regard to client choice and especially respecting their decisions and their ability to make decisions when they can… It just reinforced making sure I'm always talking to the client and asking them all the questions. They might not be able to answer as well as the carers, but it's definitely about them and having their choice as well (M13).

I've certainly become a lot more aware, because I travel between different clinic sites as well, I've been a lot more aware of things like accessibility to the actual clinic rooms and the clinic spaces and how that is protected by law, which I found quite interesting, because some of the clinics that I work from would be very inaccessible. They're difficult for someone with a pram to get through, let alone someone in a wheelchair. And there isn't an option for a disabled toilet, for example, at some of those clinics that I go to, which is quite concerning (M12).

Several participants felt they were integrating more effectively with other members of the health care team because they now had a broader understanding of disability.

I think just understanding how I fit in with the other disciplines and how to actually sell myself to other disciplines in disability because it was really hard because we were so medically model trained. They were like, "Oh, we're not interested, you're only interested in medical model outcomes." Even though that may not have been our goal, we didn't know how else to express that, so it's been really good across the board (NM8).

Specific examples of adaptations to practice predominantly related to the assessment process, and ways of working with clients with disabilities. Participants spoke of using goal setting with the client, monitoring progress and measuring longer-term outcomes.

Really tailoring my support to the client's goals and their function and where they are at in life, rather than me taking the lead and trying to fix their nutrition deficiencies or whatever, it's really listening to what the client is striving for and how I can be there to support their wider goals and improve their quality of life or function and things like that (NM5).

Reference was made to changes in how participants structured their assessments, described as moving from a clinical or medical model to a more person-focused model that embraced quality of life. The templates provided through the program were being used to prompt a more holistic assessment approach.

Feeling connected to other people in the space, being able to practice in a holistic, equitable way, and it just left a bit of a space open to feel innovative because we had discussions with other people. I guess the nature of the biopsychosocial model is broad and left quite open to individualise and be creative about how you offer your support (NM5).

Participants also provided examples of how they had adapted their communication with clients based on learnings from the program.

It made me really analyse my communication techniques and seeing how people may or may not communicate. Sometimes, depending on their [the client's] connection with their support worker, because obviously they spend more time with them, their communication can be a lot more synced. Whereas for myself, I think it's actually taking the time, learning that patient's or person's communication techniques, and really trying to work with that (M11).

I normally would always send a text message and things and I have a mobile number, but being mindful to welcome people to communicate with me through that mode or through email if talking verbally might not be an option (M12).

One participant shared the view that they felt that many of the 'gains' from the program for them were intangible and cumulative. It was difficult to provide discrete examples of how they had adapted their practice and applied lessons from the program.

I think it's a little bit more intangible. So I picked up things from each little module, so the ones that definitely stand out is that recipe book, the ICF and all of the thoughts around functional disability. I think that it was reassuring to me as well in the way that I've had so many reports rejected, and it just didn't feel like it was my fault. I had done the course. I was just like, okay, I'm doing my best, and that's just the NDIA (M2).

Importantly, participants perceived a range of benefits for their organisations arising from their completion of the program. These included access to program resources, the opportunity to upskill, being able to contribute to development or revision of organisational policies, procedures and guidelines, and higher quality report writing which translated into additional NDIS funding for their practice's clients with disability.

I've been able to do all the policies and procedures for dietetics. But also it's allowed for a bit more of a cross discipline discussion (NM8).

It's just helped in terms of in my practice, it'd just be a little bit more thorough and always have the client centre of mind. And I think for the organisation I work for, that just has a flow on effect of hopefully clients enjoying and happy with the outcome and quality of care and things, which obviously positively feeds back onto the organisation that I work for (NM4).

For organisations that supported several staff to attend, benefits such as reduced supervisory demands were reported because of the shared learning that had occurred.

I guess it meant me having to do less supervision, explaining to my staff, someone else has done it for me (NM6).

Only two participants felt that the course had no or limited impact on their practice and they related this outcome to the extent of their previous experience in working with people with disability and prior professional development in this area.

3.4.2 Benefits for people with disability

The benefits for people with disability were captured in two themes: improved access and higher quality care. Improved access was linked to participants (dietitians) leaving the program with stronger advocacy skills that could be used to help people with disability have their dietetic needs met.

> *People with disabilities, I think having an extra profession to advocate for them who are well-informed of not only the NDIS but also practice in a way that really will support them. That can only be a good thing (NM5).*

> *Recently, I've had a client and they wanted me to advocate for more funding for dietitian hours for them. I was a little bit unclear at the time as to what I could actually offer the client. After doing the course, one thing that kept being emphasised was what the client wants and from their perspective. I feel like I did take a lot of time to actually sit down with the client and work out how they felt seeing a dietitian could actually help improve them. Because it wasn't overwhelmingly clear to me at the time, and I was very fortunate that this client was able to communicate very well. That's one application. And then I use the tips from the report, from the training, to try and advocate for more funding. I'm yet to find out though whether it's worked or not, whether they've got more funding (M15).*

Robust reports were also seen as a potential benefit for clients as they were an advocacy tool that may translate to improved access to funding and services for people with disability.

> *In terms of report writing and advocacy for the NDIS, I think that's the biggest benefit. I think as well, just questioning how we approach things as individuals is also really important because if you don't have lived experience, then you are at risk of making the wrong assumptions about what people need and acting on the wrong priorities (M12).*

Higher quality care was identified by participants as a benefit for clients arising from the training. This was because participants felt better equipped to meet the needs of people with disability.

> *I think it's an incredibly informative program for all dietitians, from new grads to those that are simply new to the sector. And I think for clients, I believe they'll receive better quality of care from dietitians that have completed the program (M7).*

> *I think that with the training, the services will be more relevant to families with disabilities and to clients with disabilities if they're adults, and more inclusive, and certainly more based around the day-to-day functioning, what is important to that individual client, so that they receive person-centred care and support that is relevant to their needs (M12).*

> *I think upskilling of any clinician in this space is only going to be a good thing. The whole purpose of NDIS and purpose of these sort of programs is if we're upskilled, then people can be more independent and can be more autonomous, and so their disability becomes less of a barrier and more of something that we're all exposed to working with or having the skills to support them with, versus having to always be specific health services for them (M11).*

Improved professional practice was also explained as ensuring that clients received appropriate services.

> *Clients with a disability, they can present anywhere. I think if you are working in clinical, just full stop in clinical, there is a chance that you are going to encounter a client with a disability. I think absolutely, if it can be offered to all dietitians working clinically, I think that that will be a benefit because yeah, you might go into a job specifically in NDIS where you're like, "Oh, okay, yes, I definitely need to do that." But you could be working on just any general hospital ward, general*

private practice and you could encounter a person with a disability. So I think, yeah, definitely that it should be offered to anyone, to any dietitian (M15).

Well, hopefully we can provide a better service to clients with disability ultimately. And that's really the outcome we want, isn't it? It's to improve health outcomes for everyone through diet. I think that ultimately, that's hopefully how it would help (M9).

3.4.3 Benefits for the dietetic profession

The major benefit of the CBDD program for the dietetic profession was the program's potential to influence public perception of the profession. Participants felt that the program reflected positively on the reputation of Dietitians Australia as it demonstrated a commitment to upskilling dietitians to better support people with disability. This was seen to be an important strategy in strengthening the capacity of mainstream dietitians.

I think it's just going to make more dietitians well-equipped (NM8).

For the profession as a whole the more skilled our workforce, the better we are as a profession, and I think that is it (M2).

I think it'll just help upskill dietitians more broadly, which I think would just be really beneficial... So I think it'll have a flow on effect and help some of those mainstream kind of dive into, might not see them all the time, but just have that better understanding of when they maybe do encounter someone from that space. They just have a few more skills and things and a bit more of a thorough idea of avenues to explore (NM4).

There was also a perception that this would enhance the credibility of the profession with the NDIA. Participants strongly felt that the NDIA did not value dietetic services and that while other allied health services would be funded through NDIS plans, frequently dietitians would provide reports for clients that were rejected. This was a great source of frustration for participants currently working with NDIS clients (further commentary is provided about this issue in Section 3.5.1.2).

I think the fact that we're undertaking such comprehensive training. Offering such comprehensive training will hopefully mean we'll be taken a little bit more seriously by the NDIA. I don't feel we're particularly respected based on the level of funding given for our clients' care. So we can certainly demonstrate that we're taking our participation within the NDIS seriously and we mean to provide quality care and help participants to reach their goals (M7).

Many participants spoke of the poor public perception of the profession as the general public associated dietitians with only weight control. They felt that increasing the engagement of dietitians in disability-related services may shift this perception and illustrate the broader contribution dietitians can make to client care.

It can do our profession good, because sometimes we can be perceived as food police, telling people what not to eat, or just to be put on a diet to lose weight. So if we give meaningful advice, it will change the perception of the public (M3).

I think it probably just reflects that we understand as a profession that there are some intricacies of working with clients with a disability. And that we see the need to upskill in that space and have that kind of knowledge and the skills to support them in the best way. And I think by offering that specific course it shows that we understand that… I think it just reflects positively on the profession that we identify that and we've actioned creating some learning to help those in that space (NM4).

The program was seen to be particularly valuable for new graduates who may have limited experience in this field. It also provided credible educational resources for the profession which had not been readily available previously. One participant also spoke of the dangers of burnout for solo practitioners and how the structure of the program, particularly the supervision sessions, mitigated this risk.

> *Maybe not so much for myself, but certainly for younger, new grads, people without experience in the sector, I think increased empathy and understanding of the challenges faced by clients with a disability and also understanding of the NDIS and disability barriers and facilitators [is important] (M7).*

3.5 Factors influencing access to dietetic services for people with disability

3.5.1 Barriers

The interviews provided an opportunity to explore participants' views about factors that hindered their willingness or ability to provide services to people with disability. Three themes are reported as barriers: limitations of undergraduate training, difficulties in working with the NDIA, and mainstream service delivery settings.

3.5.1.1 Limitations of undergraduate training

Participants spoke about how ill-equipped new graduates felt to support people with disability. Multiple examples were provided of undergraduate training programs that had only one or two lectures, if any, about supporting people with disability. Only one respondent could recall the opportunity to participate in a disability-related clinical placement and this was in a mental health service. Most participants who identified as early career dietitians provided comment about the inadequacy of their university training in helping them support people with disability.

> *There are so many barriers and influences. When I first graduated, my majority of training and placement was in the hospital. The patient really doesn't have much say… But since I worked in the community health service, we need to give practical ideas. If we just give them information here, that is a list of things you can change, and I see you five weeks later for example, it's not helping. So I think more training about how to facilitate change. We got the food knowledge, but how to transfer that knowledge into the person's daily life, that is another layer (M3).*

> *So I think if I'd done this straight out, or potentially as part of my education, it just would've made me feel much more comfortable working with somebody with a disability (M13).*

> *When you leave Uni, you leave with the skills to be competent, but it's not specific for clinical areas. I mean, you might get through your entire clinical placement having never seen a patient with a disability, but then the first job you get is doing home visits (M15).*

3.5.1.2 Difficulties working with the NDIA

Many participants spoke of their difficulties in working with the NDIA and felt that this was a factor that significantly hindered the engagement of mainstream dietitians in the disability sector. Navigating the NDIS system was consistently raised as problematic. Frustrations included the perceived 'red tape' surrounding the NDIS, barriers to accessing the NDIS plan for clients, difficulties with reporting requirements, and a strong perception that dietetic services were not valued. Participants felt that dietitians were not recognised by the NDIA for their expertise in the same way that other allied health roles were.

> *I think it's partly the funding. It can be difficult to advocate for dietetic hours within the NDIS. Their hours are often allocated to other clinicians that maybe it is more imperative, the OT or the physio or something like that. That's probably one difficulty. The other one is probably more in the*

getting to clients' houses and booking appointments and the administration of, "Do you go through the family or the support coordinator?" Yeah, more the administration (M14).

Participants acknowledged that NDIS documentation requirements are important but often conflicting advice was received. For example, participants would be told their reports were too technical, however, on revision they would be told that they were not evidence-based. Reporting requirements were perceived to be time consuming and cumbersome and reduced the time available for direct input with clients. When comprehensive reports were provided there was a perception they were overlooked.

Over the years from NDIS especially, we've had very mixed messages on report writing because early in the days it was very much proof without evidence. And then we were told we're being too technical and you need to dumb it down, and then it has to be easy read, and then it's like, "Oh, and here's a template from the NDIS", which is seven, eight pages long. Actually it's more than that, but they really only want to read one page, and it's like, well, we get very mixed messages from the NDIS to go, "Well, you're asking for more evidence, but then you're saying stop using technical jargon" (NM6).

Multiple service providers may be engaged with a NDIS client and participants spoke of the challenges in coordination of care and balancing the client's available funding. With multiple service providers in addition to family and support networks came multiple views about the client's care. Some participants felt that they faced additional work to communicate and resolve conflict when different views about the client's care were evident.

I guess the only real challenge would be around navigating the system, the NDIS system and also communicating or learning how to resolve conflict between, say, the client, with the disability, their family, or their carer, or their support network (M1).

Access to funding was consistently raised as a barrier to services for people with disability. Participants provided examples of not only difficulties in securing funding for clients but the inadequacy of this if they did manage to have success. Participants felt that there was a fundamental lack of understanding of the long-term nature of dietary change and that for some people with disability with significant nutritional issues, six to eight sessions would not affect behavioural change. The costs of becoming a NDIS registered provider was also raised as a barrier for some dietitians.

Really getting the funding for them. It's a disaster (M2).

100% funding. Yeah, we just don't get enough. So you feel like you just start to make progress and then your participant has a review and you ask for 24 hours, for example, which is reasonable, it's once a month, I don't think that's particularly excessive knowing full well that people like physiotherapists, occupational therapists, speechies are getting weekly and fortnightly funding. I don't think once a month is too much to ask. They come back with eight hours, which is crazy. It's tiny and it's disheartening (M7).

3.5.1.3 Mainstream service delivery settings

Mainstream service delivery settings were often not set up as comfortable and accessible spaces for people with disability.

In my office, I always make sure that I have comfort tools available so like fidget toys and like soft toys and just things to kind of make somebody feel a little bit safer and I do get the feedback all the time that that's really important. Is that, you know, I could focus on our conversation because it was okay to kind of just be in my own body here. So I think that's a really easy thing that

dietitians could do. It's the same as like having size-inclusive furniture and stuff like that, like it should just be something that we do, or anyone who has anyone in their office should do (M2).

Participants also felt that dietitians in mainstream roles were challenged by the time required to appropriately assess and respond to the needs of people with disability. This was attributed to the busyness of the practice setting and, for rural areas, under-resourcing of dietetic positions reducing available consultation time and requiring many competing demands for service delivery to be balanced. A range of comments were made about the increased time required to provide appropriate assessment and consultation with people with disability. Basing assessments around the biopsychosocial model of care and drawing on the ICF was seen to take more time than standard assessments using the traditional medical model of care. Some participants felt that dietitians in mainstream roles frequently had limited understanding of how the NDIS works and concerns about being able to provide appropriate care.

It's probably a time factor I think would be the biggest one [barrier]. I know a lot of mainstream kind of roles, there's a lot of, I wouldn't say fast turnover, but your appointment times and things are a little bit shorter and just higher demand, so maybe more patients per day and that kind of stuff. Whereas I think in the disability space, you do need to have either the time in that initial appointment or know that you're going to see them in a week's time or whatever it is to be able to gather a really detailed assessment and all that kind of social background and insights into their disability. Because even though they might have X condition, they might have... also that might lead to other conditions when they were younger and growing and things. So just getting those intricacies, which I think sometimes time would be a barrier in the mainstream space (NM4).

Maybe a lack of the understanding of how the NDIS works. I think there's a perception among hospital dietitians that there's a lot of extra hoops they have to jump through and if they have to do report writing and things like that. Also, not being able to take the time to really support the client in the way that they need; only being able to see someone in a hospital or outpatient clinic is not suitable for everyone, especially people with disabilities. I think maybe a lack of understanding, but also not feeling like they can provide the care needed for each individual client (NM5).

The level of reimbursement from Medicare for a standard consultation was a perceived as a disincentive for some mainstream dietitians to provide care to people with disability.

I really felt that they needed a different approach that let them have the time required to implement changes required to help them, which I guess mainstream isn't providing because a general Medicare referral is, well, they pay us basically for a 20-minute consult, which I can't even say hello in 20 minutes. Whereas I'm dealing with very complex, intellectually disabled and complex (medically and mentally) patients that 5, 20, 30 minute visits from a dietitian just does not cut it. They need the time and they need people to hear them and actually learn about them, and this whole functional capacity side, that takes time (NM6).

Participants spoke of the impact of the care setting with an example given of how the quality of a group home and its carers influences the dietetic interventions implemented and their subsequent success. Working with people with disability frequently required working with the broader support system around them and this added complexity to the dietitian's consultation. This might include working with disability support workers as well as the client so that the care plan developed with the dietitian could be maintained in their absence.

So sometimes it is the quality of the carers and the group home that does influence my ability to put in interventions and try to work with them and provide that dietetic intervention. So yeah, the quality of the carers, the quality of the home. And I'm also finding sometimes with the NDIS

getting funding, I've been finding a little bit more pushback in regard to the hours I'm requesting. And sometimes you get the odd maybe person working within... Sometimes it's the NDIS, sometimes it's the support coordinators, they're not too sure about dietetics role in regard to disability (M13).

Finally, participants discussed the difficulties of being a sole practitioner and not having other dietetic colleagues working in the field of disability to draw upon. This created stress which some dietitians managed by either not providing services at all, or minimising the number of clients with disabilities they supported.

I suppose, and in a mainstream clinical setting, you've obviously got a multidisciplinary team around you, which is extremely helpful, not only for us as clinicians but for the patient as well because there's way more wraparound support (NM5).

3.5.2 Enablers

The factors most frequently identified as helpful in enabling mainstream dietitians to work with people with disability were professional confidence, accessible training to build skills in working with people with disability, and professional advocacy by Dietitians Australia.

3.5.2.1 Professional confidence

Through improving dietitians' knowledge and skills (and ultimately confidence), participants felt that access to dietetic support for people with disability would increase. Participants felt that there was a perception in their profession that it was difficult to support people with disability and that this 'fear factor' needed to be overcome. This fear was perceived to be driven by stigma and concerns about being professionally competent to deal with the wide-ranging nature of disabilities. For dietitians to invest in upskilling they needed to perceive that NDIS clients were part of their core client group.

The main thing is if we can improve dietitians' confidence to actually see patients with disability, then I think that's going to improve access…So there's definitely a need for more dietitians, NDIS registered dietitians, having two things: I think dietitians need more confidence in themselves to see these patients, but also they need less red tape in a way with the NDIS (M15).

I imagine it must come down to training. It would be similar to anything else. As I mentioned, my other kind of specialities are eating disorders and so many dietitians are scared to walk down that path as well, just because they're so worried that they're going to do something wrong, and that there is kind of high risk involved. But I think that it's probably just a lack of knowledge and a lack of confidence that would be driving that (M2).

Professional confidence was strengthened by the presence of support. Participants related this to the resources available through the CBDD program.

For myself, and it's what we've talked about this whole interview, is having those resources available and being a part of the group and being able to refer back to those online resources and things like that. Then for the clients as well, knowing that they've got a health professional there who understands the system and understands they've got goals they want to achieve and things like that, it's good for both the dietitian and client to know that the support is there (NM5).

3.5.2.2 Accessible training

Participants highlighted the importance of assisting all dietitians to build their knowledge of the NDIS and skills in supporting people with disability. Dietitians Australia was seen to have an important role in providing accessible training in this field.

I just want to reiterate that I think upskilling of dietitians is important, especially if they work within this space. And even if they potentially would work in the space or with clients with disabilities, just having those skills and that confidence ensures that the client does get dietetic services that are appropriate. And potentially it means they do get dietetic services where they wouldn't have if the dietitian wasn't confident (M13).

Several participants spoke of the benefits of offering incentives to workplaces to enrol multiple dietitians in the program. When participants had attended with other colleagues from their workplace they found this added value to their learning experience, as they had a ready network of dietitians to discuss issues arising during the program. Training that helped dietitians adapt resources and provided advice on ensuring appropriate practice environments for people with disability were factors that would enable dietitians to better support people with disability.

I'm pretty willing to make adaptations to things to suit my individual clients, but it is a very time intensive task, and I find with my clients with ASD or ADHD things need to be a little bit more punchy, to the point; if it's a big boring wall of text, you might as well throw it in the bin (M2).

3.5.2.3 Advocacy

Participants felt that Dietitians Australia had a crucial role to play in advocating for recognition of the contribution of dietitians to the health and wellbeing of not only people with disability but society more broadly. The belief was expressed that if there was greater awareness of the professional contribution of dietitians there would be more likelihood of the NDIA recognising their contribution to clients' health outcomes.

I think they [Dietitians Australia] can do more marketing, so that the public know that we don't just put people on diets, how to make it more practical (M3).

Everyone just hears dietitian and goes, "Oh, I don't need to lose weight." So I think we definitely need to advocate for our profession better and what we can add to improve quality of people's lives. I think that we need to do a better job at that, and then putting that forward to the NDIS and support coordinators and things to actually point out our role and how much of a difference we can make in people's lives (NM6).

Section 4 Discussion

4.1 Summary

The Kirkpatrick model has been used to guide the evaluation of the CBDD program and the collection of multiple data sources. This study contributes qualitative data for consideration in tandem with findings from the quantitative data and relates particularly to Level 1 and 2 of the model. Definitive findings relating to Level 3 and 4 were not observed due to the short timeframe of the evaluation.

4.1.1 Level 1 – Reaction

Level 1 of the model focuses on the reaction of the participants and the question "How did participants respond to the training?"

The findings from this qualitative study indicate that overall participants responded positively to the training. Many examples of positive experiences were provided and most participants found it difficult to identify negative elements of the program. The online modules were particularly well received and while the numbers of participants in the In Practice and supervision sessions was small, those who did participate found them valuable. There was support for the CBDD program, particularly the online modules, to be offered on an ongoing basis by Dietitians Australia and at no or low cost.

4.1.2 Level 2 – Learning

Level 2 of the model explores learning by the participants and the question "How much did participants learn from the training and have their skills improved?"

Quantitative data collected through the course evaluation is likely to provide more definitive evidence about the attainment of learning outcomes and skills acquisition. Participants in this qualitative study identified a range of benefits for participants and their organisations which included changes in attitudes and beliefs, enhanced knowledge and skills, and diverse examples of how new knowledge and skills had been applied in the practice setting. Encouragingly, many of the examples of skill development and knowledge acquisition identified by participants align with those outlined in Dietitians Australia's disability role statement (2021).

4.1.3 Level 3 – Behaviour

Level 3 of the model requires a longer interval to effectively assess "Have participants applied what they learned from the training?"

The qualitative data was collected approximately 3 – 6 months post training for most participants. This was a sufficient timeframe to detect early indications of behaviour change, and encouraging examples were provided by several participants of how they were using information from the CBDD program to better support people with disability. Three vignettes based on client stories are presented in Section 4.2 to illustrate practice change. While it is not feasible to state that these changes were directly attributable to the CBDD program, it is reasonable to conclude that the program contributed. Further, the short timeframe limited the capacity to assess whether behaviour change was sustained longer term.

4.1.4 Level 4 – Results

Level 4, the highest level of the model focuses on "What benefits has the organisation experienced as a result of the training?"

A range of tangible benefits were identified. In Section 3.4.1 findings are presented about potential benefits for participants and their organisations arising from their engagement with the CBDD program. Further, while Level 4 of the Kirkpatrick model focuses specifically on benefits at an organisational level, from a wider perspective it is important to note that completion of the program was perceived by all participants to have benefits for people with disability (refer to Section 3.4.2) and also potential benefits for the broader dietetic profession (refer to Section 3.4.3).

4.2 Vignettes

Vignette 1

One of the ways I have applied what I have learned from the program is about really tailoring my support to the client's goals and their function and where they are at in life, rather than me taking the lead and trying to fix their nutrition deficiencies or whatever. It's really listening to what the client is striving for, and how I can be there to support their wider goals and improve their quality of life or function and things like that. An example of this was a client who is a 15-year-old male who clinically has sensory feeding issues and a very limited intake of food, but he wanted to be really good at mountain biking.

Instead of taking the approach that possibly a clinical dietitian would, trying to improve the range of foods he's eating and ensure he's getting enough calcium or whatever, it's really looking at foods that would support his mountain biking because that was his goal. That's what he was striving for. I guess quite different approaches. I know he was nervous at the start because, I don't know, maybe in his mind he thought I was going to try and force him to try all these new foods that he just really didn't want to try. However, once we got talking about mountain biking and things like that, I definitely had a good conversation with him and after that he felt comfortable, so that was good. It's really interesting how that resonated with him, food is fuel for mountain biking.

His Mum has sent me a message since then. He certainly took on my advice, and it was great to hear about little triumphs, it worked not tackling everything at once, and the door is open in the future again if he wants to come back and work on other things.

Vignette 2

I am working with a young boy who is from a refugee background. It’s a non-English speaking family and it is likely that they have experienced trauma. Communication is quite difficult, even when you use an interpreter. And so, since I’ve done the training, I've had a few more sessions with the family and I have followed up the sessions with phone contact, because when you’re face-to-face with the child, the child is presenting with developmental delays and quite strong ASD traits.

So, I’ve had to take extra steps to engage Mum outside of these sessions as well, because during each session she’s quite distracted by the child, and this interrupts the flow of the conversation. I’ve had to take steps to communicate verbally via the phone and through an interpreter, use text messages, and email contact and things like that, but even text and email is quite difficult because they are non-English speaking. What I have found is that it’s really important to follow-up with them to reinforce nutritional messages.

So, with that family, I was hesitant to open the NDIS doorway up because it was going to be another complicating factor, but we have done that, and so basically I’ve had to go significantly beyond what would usually be the amount of time spent in case management. This would not be possible if I was working in a hospital setting, I can definitely tell you that, or an outpatient clinic. However, I have been able to ensure appropriate referrals so that the family is now on the NDS pathway, with social work support to navigate their journey, as well as additional refugee health services for health matters (medical oversight of nutrition plus also mental health support) and a NGO case worker who speaks their home language to support with strategies at home.

Vignette 3

My client is a middle-aged man, and he lives in a disability support house. Initially he was referred because he wanted to develop cooking skills so he could make some better choices and just have more confidence in that sense. So I did an initial assessment and then we did a five-week cooking program together and then we completed a review. Learnings from the education program relating to the ICF and understanding the client within the context of their environment and support network were highly relevant to this assessment and review. Upon the review it appeared that there was a lack of uptake of him actually cooking at the support house, mainly because he was still lacking in confidence. He was happy to give it a go, but he really wanted someone kind of there with him. So in that sense, having that review was really beneficial because I could talk to his support coordinator and see if we could shift the times of the support workers and educate them on actually helping him complete those tasks.

So we were able to explore that further and ensure a support person was available to provide that confidence boost. During the review we also discovered that he was quite frustrated and there were some budget constraints because technically the disability support house should have been providing his meals. They weren't really catering to his likes and dislikes with his autism background. So that was one of the reasons that he'd wanted to start cooking in the first place, so he could eat foods that he enjoys. So it's been a lot of back and forth action. I'm still in the middle of it and I'm trying to have a meeting with the chef and actually put some guidelines in place so they can provide some meals that match his likes and dislikes. I feel like he was kind of just going along with whatever meals were offered as he didn't have the confidence to put his foot down and say, "Well no, I'm paying for this house and this accommodation and it's meant to include my meals and you're not providing me anything that I can eat".

So we are still working through that at the moment, but I do have a meeting finally with the house manager and chef in a couple of weeks. So hopefully we'll be able to iron all that out and he will finally be able to get some meals provided that he actually enjoys and that'll just relieve his financial stress a little bit as well. Hopefully, it will result in him eating some more nutritious foods. We will probably go back to the cooking lessons and just continue to build on his confidence in that space as well so he can still do those activities if he feels like it as well.

4.3 Strengths and limitations

This study explored the dietitians' experience of the CBDD program and the impact of the program on practice. The intended focus was on early career dietitians working in a mainstream role, however recruitment of interview participants meeting this selection criteria proved challenging. Consequently, the criteria were expanded, and as a result 40% of participants were mid- or late-career and 27% were working in non-mainstream roles.

The number of interviews completed was limited to 15 due to resource and time constraints, as such, the views of interview participants may not be representative of other dietitians that completed the program. However, researchers considered the sample size to be appropriate as a satisfactory level of data saturation was obtained. However, further research with additional program participants would increase the generalisability of results.

The use of a videoconferencing application for all interviews allowed participants from across Australia to take part. While videoconferencing has been found to be a suitable tool to engage participants in qualitative research when traditional face-to-face techniques are not possible (Boland et al., 2022), and acceptability to health professionals has been reported (Archibald et al., 2019), face-to-face interviews may have potentially generated richer information.

The rigour of the study was ensured by employing several techniques put forward by Patton (1999) as essential for enhancing the quality and credibility of qualitative research. First, rigorous methods were used to collect and analyse data, and are reported in detail in this report; these were appropriate to develop a comprehensive understanding of the topic of interest and answer the specified research questions. Validity and credibility of findings was further strengthened through: (i) use of verbatim transcription to produce a thick description, with supporting interview notes used in interpretation of findings, and maintenance of an audit trail of data collection and analysis to support dependability and confirmability (Lincoln & Guba, 1985); and (ii) investigator triangulation, achieved through use of a multidisciplinary research team. Second, credibility of the researchers was established through utilisation of experienced, skilled individuals; the team (one female, one male) included researchers with expertise in qualitative health services research and program evaluation. As noted, the researchers documented and then discussed their reflections after core data collection activities. This was a deliberate strategy to minimise investigator bias potentially arising from the researchers' respective philosophical perspectives.

4.4 Conclusion

Dietitians Australia in collaboration with its partner the Australian Federation of Disability Organisations has achieved what it set out to do, that is to develop a client-informed educational program (consisting of an online course, In Practice sessions and supervision) to enhance dietitians' knowledge, attitude, skills and confidence in working with people with disability.

This qualitative study has provided detailed information about how the program has contributed to the capacity of dietitians who work in mainstream and non-mainstream dietetic practice settings to respond to the needs of people with disability. While it is beyond the scope of this study to demonstrate improvements in access to dietetic services for people with disability, findings indicate that the program improved the attitudes, confidence and skills of dietitians and their capacity to effectively support people with disability. Dietitians Australia should continue to offer the online course to dietitians, with consideration of the suggested improvements. As information relating to In Practice sessions and supervision was available from fewer participants, findings about these program components are less conclusive and recommendations are not presented.

Appendix 1 Invitation to interview participants

Good morning

This is an invitation for you to participate in an interview as part of the evaluation of the Capacity Building for Dietitians in Disability (CBDD) education program, an initiative being led by Dietitians Australia and funded by the National Disability Insurance Agency (NDIA). This component of the evaluation is being conducted by the Australian Health Services Research Institute (AHSRI), University of Wollongong. The purpose of the interview is to explore your experience of the education program and its impact on your practice.

As part of the evaluation we would like to get feedback from dietitians who completed the education program. This is why you are receiving this invitation. This is an opportunity for you to provide valuable feedback on your experience with the education program.

If you agree to be involved you will be asked to participate in a **30-45 minute online interview** (Zoom or similar) which will be recorded with your permission.

All participants will receive a $100 electronic gift voucher as a token of thanks for their time.

Your participation is completely voluntary and choosing not to participate will not adversely affect your relationship with Dietitians Australia or the University of Wollongong. If you are interested in being involved **please read the attached participant information sheet** and contact me with any questions you may have.

Sayne Dalton has a dual role as Senior Policy Officer at Dietitians Australia and as Chief Investigator for this research. Sayne has a role in the research design for this study but will not be involved in conducting the interview research or data analysis. Sayne will thus not see who has participated in the interviews.

Appendix 2 Participant interview information and questions

Participant information

What is this research about?

This is an invitation for you to participate in an interview as part of an evaluation of the Capacity Building for Dietitians in Disability (CBDD) education program, an initiative being led by Dietitians Australia and funded by the National Disability Insurance Agency (NDIA). This component of the evaluation is being conducted by the Australian Health Services Research Institute (AHSRI), University of Wollongong. The purpose of the interview is to explore your experience of the education program and its impacts on your practice.

As part of the evaluation we would like to get feedback from dietitians who completed the education program. That is why you are receiving this invitation. This is an opportunity for you to provide valuable feedback on your experience with the education program.

Researchers

Cristina Thompson, AHSRI, University of Wollongong, 02 4221 5095, cthompso@uow.edu.au
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What does participation involve?

If you agree to be involved you will be asked to participate in a 30-45 minute online interview (Zoom or similar) at a time and location convenient to you and recorded with your permission. You will be asked to verbally consent to the interview and this needs to be recorded. During the interview, you will be asked questions relating to your experiences with the education program. This will include questions about the impact of the education program on your attitudes, beliefs and skills, in relation to working with clients with disability. Interview questions will be supplied to you via email before the interview.

What will happen to the information I provide?

The recording of the interview will be transcribed into a written document.

We will treat your personal information as confidential and only members of the University of Wollongong research team (named above) will have access to your information. Your interview recording and transcript will be assigned a randomly generated code immediately upon completion of transcription, and your personal information will be stored securely on the University of Wollongong's data management system (StorageGRID), separately from your interview transcript and audio recording. All data will remain the property of the AHSRI and will be stored for at least five years before being destroyed.

Your interview data will be combined with the interview data from all participants to identify themes and broad lessons regarding the impact of the education program. The analysed data (broad themes and lessons) will be used in various publications, including a report to Dietitians Australia, and potentially journal articles and conference presentations. We will not use any personal identifying information or present information in such a way that you could be identified. Similarly, direct quotations may be used in these publications but will not be attributed to identifiable interview participants, rather a generic code will randomly be applied e.g. Participant 1, Participant 2, etc.

What are the benefits of taking part?

You will have the chance to provide valuable feedback on the education program to support improvements and contribute to the broader evaluation. All participants will receive a $100 electronic gift voucher as a token of thanks for their time.

What are the possible risks and burdens of taking part?

There are no foreseeable risks or burdens apart from the estimated 30-45 minutes of your time taken to complete the interview.

Do I have to take part?

No. Your participation in this project is completely voluntary. You may choose to withdraw from the evaluation and have your data removed any time prior to analysis (end of May 2023). Your decision not to participate or withdrawal from the evaluation will be treated as confidential and will not adversely affect your relationship with Dietitians Australia or the University of Wollongong. Should you wish to withdraw from the evaluation please contact Cristina Thompson (02 4221 5095 or cthompso@uow.edu.au)

What if I have concerns about the research or have a complaint?

This research has been approved by the University of Wollongong Health and Medical Human Research Ethics Committee, study (Ref. 2021/070). If you have any concerns or complaints please contact the University of Wollongong Ethics Officer on (02) 4239 2191 or email uow-humanethics@uow.edu.au.

How can I take part?

Please email Cristina Thompson (cthompso@uow.edu.au) to indicate your willingness to be interviewed. A member of the University of Wollongong team will then contact you to schedule a time for the interview that is convenient to you.

1. What year did you obtain your accreditation as a dietitian?
2. Would you please outline which components of the CBDD program you completed?
3. Would you describe your current dietitian position as a mainstream role?
4. Prior to undertaking the program, as a dietitian what experience did you have supporting clients with disability?
5. Would you tell me about your experience with the CBDD program?
6. Has the program influenced how you think about or work with clients with a disability? If not, why?
7. Are there any challenges for you in providing services to clients with disability? If yes, please describe.
8. Was there anything that you learned through the CBDD program that may help you to deal with some of these challenges? If no, why not? If yes, please describe.
9. Have you applied (or do you intend to apply) anything that you learned through the CBDD program to your practice? If no, why not? If yes, please describe.
    - Is there a brief story you could tell me about an experience you have had with a client with disability since you completed the program?
10. Is there a specific example from the program that you can recall that influenced how you might work with clients with a disability in the future? If yes, please describe.
11. What, if any, benefits do you see this program having for:
    - Clients with disability?
    - Dietitians providing services to clients with disability?
    - Your broader practice or organisation?
    - The profession?
12. Can you share a specific example of how your participation in the program has led to benefits for a client with disability?
13. Is there anything else you would like to tell me about the impact of the CBDD program:
    - For you
    - For clients with disability

Appendix 3 Thematic summary

Domain	Themes	Sub-themes
Participant experience	User interaction with the program	▪ Flexibility ▪ Accessibility ▪ Learning platform
	Motivation for enrolling	▪ Professional interest ▪ Need for more education about disability ▪ Cost of the program
	Positive experiences	▪ Overall experience ▪ Experiences specific to course components
	Negative experiences	▪ Content and format of program components ▪ Practical application of learnings
	Potential program improvements	▪ Enhancements to program content and design ▪ Future developments
Program impacts	Benefits for participants and their organisations	▪ Attitudes and beliefs ▪ Knowledge and skills ▪ Adapting practice ▪ Organisational benefits
	Benefits for people with disability	▪ Improved access ▪ Higher quality care
	Benefits for the dietetic profession	▪ Public perception of the profession ▪ Support for new graduates and solo practitioners
Factors influencing access to dietetic services for people with disability	Barriers or hindering factors	▪ Limitations of undergraduate training ▪ Difficulties in working with the NDIA ▪ Mainstream service delivery settings
	Enablers or helping factors	▪ Professional confidence ▪ Accessible training ▪ Advocacy

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