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Disability Advocacy Priority Brief

Dietitians Australia position

Dietitians Australia recommends the implementation of greater oversight, accountability, education and support for the provision of food and nutrition for all Australian's impacted by disability to reduce the risk of preventable deaths.

Policy recommendations

1. **Policies and training for NDIA planners**

   NDIA to develop evidence-based policies and training to guide NDIA planners/delegates about what is 'reasonable and necessary' regarding inclusion of Accredited Practising Dietitians (APDs) and nutrition support products in NDIS plans.

2. **Governance and accountability for nutrition in supported independent living**

   Development of legislation and policy to support optimising nutritional intake, healthy eating, food safety and supported decision making in group homes including staff training and accountability mechanisms (governance).

3. **Medicare item numbers**

   I. APDs included in teams for autism, pervasive developmental disorder and disability (M10) and provided with their own unique 800** number for the dietary treatment of people with these forms of disability

   II. Increase in number, duration and rebate of MBS items to support building of relationships, communication, and incremental behaviour change in recognition that individuals with a disability are likely to be more medically complex and higher risk than the general population

   III. APDs available through the Better Access (to mental health) Program

A 1/8 Phipps Close, Deakin ACT 2600 | **T** 02 6189 1200
E info@dietitiansaustralia.org.au
W dietitiansaustralia.org.au | **ABN** 34 008 521 480

Background

The prevalence of disability in Australia is estimated to be around 18% (4.4 million), across all age groups, and 13% (2.9 million) of people under the age of 65 years.(1) Population studies show that people with disability have poorer self-reported general health and higher prevalence of health and behavioural risk factors, compared to people without disability, including insufficient fruit and vegetable intake, higher consumption of sugar sweetened beverages, high blood pressure, insufficient physical activity, high BMI and waist circumference.(1) The presence of modifiable risk factors, such as poor diet and lower levels of physical activity, may contribute to the higher prevalence of diet-related health conditions, such as cardiometabolic disease, diabetes and cancer among people with disability, compared to people without disability.(2-4)

Not only are individuals with a disability more likely to experience diet-related health conditions, their disability, be that physical, intellectual, sensory or psychosocial, may lead to unique food, fluid and nutrition requirements, further placing individuals at higher risk of nutritional problems.(5) For instance, untreated dysphagia may lead to malnutrition, dehydration, aspiration pneumonia and choking.(6) Research shows that people with disability experience higher rates of potentially avoidable deaths, compared to people without disability in Australia.(6, 7) Troller and Salomon(6) synthesised data from reports of reviewable deaths in Australia and found that many potentially avoidable deaths experienced by people with disability in receipt of disability services, were attributable to inappropriate management of the food, fluid and nutrition care needs of people with disability.

Access to healthy food, fluids and person-centred nutrition care are significant factors in promoting both the mental and physical health of people with disability.(8-13) Improved access to nutrition care and Accredited Practising Dietitian (APD) services through policy reform, care coordination, funding and education, will lead to improvements in the health and wellbeing of people with disability, reductions in preventable deaths and increased social and economic participation.

As of August 2020, there were around 400,000 people receiving supports and services through the National Disability Insurance Scheme,(14) representing approximately 14% of all people with a disability. Recognising that individuals with a disability will need to access nutrition supports both within the NDIS and through mainstream community-based services, emphasises the need for a coordinated approach to both nutrition policy and systems of service delivery.

This need for systemic change to support improved access to nutrition supports for all people with a disability aligns with the World Health Organisation definition of capacity building:

> *"the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion...[with] actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organizations, and; the development of cohesiveness and partnerships for health in communities"(15)*

Evidence

National Disability Insurance Scheme

NDIS plans are frequently inadequate to meet the nutrition needs of participants' complex needs. NDIS planners, support workers, carers and allied health practitioners often fail to understand the role of food and nutrition, including dietitians in supporting people with a disability to achieve their goals, stay well and avoid an early – preventable death.

The development of clear guidelines, information and training is needed to identify both opportunity and risk and ensure adequate funding of the right food and nutrition supports.

There is currently a greater demand for skilled dietitians to work across the disability sector than can be met. The barriers to increasing workforce capacity including; cost, risk and administrative burden to register with NDIS. This is compounded by the inability of allied health students to gain disability experience during their degree due to current NDIS policy stipulating only fully qualified practitioners can provide services.

Recommendations

1. **Policies and training for NDIA planners**

   NDIA to develop evidence-based policies and training to guide NDIA planners/delegates about what is 'reasonable and necessary' regarding inclusion of Accredited Practising Dietitians (APDs) and nutrition support products in NDIS plans.

2. **Training opportunities for students and dietitians**

   Change the current NDIA policy so that qualified Allied Health Professionals can supervise students to provide services (with participants consent).

Group Homes

There is currently no legislation or standards for food provision in group homes. This results in a huge discrepancy between the quality, variety, nutritional adequacy and risk an individual may experience. In many homes people with a disability lack any food selection choices and may be impacted by restrictive practices (e.g. locking fridges and cupboards) aimed at limiting their own access or someone else whom they live with. This significantly impacts the quality of life of residents and contributes to preventable deaths of people with disability.

Recommendations

1. **Governance and accountability for nutrition in supported independent living**

   Development of legislation and policy to support optimising nutritional intake, healthy eating, food safety and supported decision making in group homes including staff training and accountability mechanisms (governance).

2. **Streamline and prioritise interface between sectors**
   Adequate funding for care coordination across multi-disciplinary teams from multiple sectors (acute, community and NDIS) is required to effectively reduce health related risks for individuals with a disability – especially when in hospital and then transitioning back to their home.

Mainstream healthcare

There is a lack of specific funding to support access to community based or outpatient dietetic services for people with disability. Most people with disability do not have access to NDIS funding and thus are required to access nutrition supports and APD services using mainstream funding arrangements. Standard Medicare allied health funding is insufficient to meet the needs of people with a disability for a number of reasons; limited to 5 consults per calendar year across all allied health; funding provides for a short duration (20min) consultation or results in often large out of pocket fees (rebate is $53 an average initial consultation with a private practice dietitian fees being $120-$180/hour) and no provision for case conferencing. Large multi-disciplinary disability services often prioritise other Allied Health Disciplines above dietetics, creating barriers to access and further challenges in care coordination. Preventative health or health promotion programs specifically designed for people with a disability are almost non-existent.

Recommendations

1. **Research and malnutrition screening**

   People with a disability, especially those dependant on others for all food and fluids, are at a greater risk of malnutrition (poor nutritional status and associated outcomes) than the general public. Research to identify appropriate screening tools and systematic implementation is required to reduce the risk of preventable deaths in people with a disability.
2. **National Nutrition Policy**

   Australian government to fund the development and implementation of a National Nutrition Policy including specific standards required to meet the complex needs of people with a disability.
3. **Adequate access to funding across health sector**
   - **I.** Australian, state and territory governments to establish appropriate dietetic staff to patient ratios and fund positions for APDs in community, inpatient and outpatient settings.
   - **II.** Government to support ongoing access to Telehealth services across all funding systems.
4. **Medicare item numbers**
   - **I.** APDs included in teams for autism, pervasive developmental disorder and disability (M10) and provided with their own unique 800** number for the dietary treatment of people with these forms of disability
   - **II.** Increase in number, duration and rebate of MBS items to support building of relationships, communication, and incremental behaviour change in recognition that individuals with a disability are likely to be more medically complex and higher risk than the general population
   - **III.** APDs available through the Better Access (to mental health) Program

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