NDIS Amendment (Securing the NDIS for Future Generations) Bill 2026

Response to consultation
May 2026

Recipient

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Senate Standing Committees on Community Affairs
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Dietitians Australia acknowledges all traditional custodians of the lands, waters and seas that we work and live on across Australia. We pay our respect to Elders past, present and future and thank them for their continuing custodianship.

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About Dietitians Australia

Dietitians Australia is the national association of the dietetic profession with over 9000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve.

The Accredited Practising Dietitian (APD) program is the credentialling program of Dietitians Australia. It provides an assurance of safe and quality dietetic practice and is the foundation of self-regulation of the dietetic profession in Australia.

This submission was prepared by members of the Dietitians Australia Disability Sector Expert Reference Group following the Conflict-of-Interest processes approved by the Board of Dietitians Australia. All content has been reviewed, verified, and endorsed by the contributors. Contributors include APDs that are NDIS registered providers, with a full list detailed at the end of this submission.

Summary

Dietitians Australia thanks the Community Affairs Legislation Committee for the opportunity to provide a response to the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 ('the Bill').

We understand the importance of ensuring the National Disability Insurance Scheme (NDIS) is sustainable for future generations. However, without adequate safeguards in place, we are concerned that participants rights to access and receive high-quality nutrition support will be compromised by cost containment.

Accredited Practising Dietitians support one of the most fundamental activities of daily living, eating and drinking, for people whose disability directly impairs their capacity to do so safely, adequately, and independently. The therapeutic support APDs provide enables and equips participants living with disability to engage in therapy, education, employment, family routines, and community participation. Nutrition and dietetic supports are functional, capacity-building, and disability-specific. When removed or reduced, the consequences extend across every domain of a participant's daily life, negatively impacts the success of allied health therapies and will likely increase, not decrease long-term scheme costs.

Dietitians Australia perceives the proposed changes will narrow eligibility, move away from individualised approaches and reduce access to capacity building supports at the discretion of the Minister of the day. This departs from the fundamental principles of the scheme and raises questions about participant choice, control, access and ultimately safety due to underfunding supports.

We are deeply concerned that the proposed migration of support needs from the Commonwealth to the jurisdictions and from the NDIS to other areas of the care economy. Rather than cost-contain, this will potentially increase health system costs and result in poorer outcomes for people living with a disability, their reduced participation in education and engagement in employment, and further reduce the productivity of those with caregiving roles.

Below outlines detailed feedback from members of the Dietitians Australia Disability Sector Expert Reference Group relating to five of the proposed amendments to Schedule 1 of the Bill that carry significant risks for participants whose disability directly impairs their ability to eat (nourish), drink (hydrate), prepare food, and sustain the nutrition required for daily function and participation. Also included are case studies from our members who are NDIS registered dietitians that demonstrates how nutrition and hydration support is directly linked to functional capacity, safety, participation, and avoidance of escalation into acute or higher-cost systems of care.

Detailed feedback

Schedule 1 – Access and planning measures

Part 1 - Defining Functional Capacity

Item 4 — New Section 9B: Functional Capacity Assessed Without Environmental Context

The definition of functional capacity as assessed without regard to environmental and personal circumstances creates risks for participants whose functional feeding impairment is only expressed, or only manageable, within specific environmental contexts.

The proposed amendment defines functional capacity as the ability to undertake an activity without assistance and excluding environmental and personal circumstances. The stated intent is to improve consistency and objectivity in assessment.

For functional feeding, nutrition and hydration supports, this creates a practical tension. Nutrition support in disability settings is often gradual, functional and heavily influenced by the participant's environment and daily supports.

Many participants' real-world functional capacity is not separable from their environment or the supports available to them. For example, a participant with autism spectrum disorder (ASD) whose restrictive eating patterns are triggered or mitigated by specific sensory environments, or a participant with acquired neurological disability who can only eat safely with modified textures and caregiver assistance, may present very differently when assessed in isolation from those conditions.

For participants with cognitive and/or psychosocial disability, meaningful progress may require extended time for relationship building, establishing trust, communication, understanding and sustainable behaviour change. These interventions do not always align with short-term or easily measurable outcome frameworks.

While the intent of standardisation is understood, there is a risk that removing environmental context from assessment may underestimate functional need in practice, particularly where disability impacts are only observable through interaction with supports, routines, and physical access to appropriate care.

Dietitians Australia recommends that the definition of functional capacity be revised to align with the World Health Organization International Classification of Functioning, Disability and Health that recognises the functioning and disability of a person is shaped by their context[i].

Disability does not exist in isolation and needs to be captured holistically with accompanying guidance clarifying that environment-dependent and caregiver-dependent functional feeding impairments remain valid expressions of disability-related functional capacity, rather than being discounted because performance varies depending on support conditions.

We are also concerned about the updated definition of permanence in relation to participants with lower financial resources or limited geographic access. Under the proposed legislation, the NDIA will be able to deny a person access to the scheme regardless of their level of functional need, if they have not exhausted all appropriate treatment options, with no consideration for them being unable to afford or even geographically access it. This would further widen existing disparities between metropolitan and regional participants, and between those with and without the means to privately supplement supports. This must be more carefully considered. We recommend a provision is added to also consider the socio-economic position and geographical location of a participant.

Part 3: Strengthen link between impairment and need for support

Item 28 — New Subsection 32K(3A): Direct Link Between Impairment and Support

The requirement to link supports directly to impairment risks excluding functional feeding and hydration supports where the impairment affects eating and drinking indirectly, through cognition, sensory processing, motor planning, or behavioural regulation.

The proposed legislation introduces a requirement that NDIS supports arise directly from the primary disability/impairment for which a participant meets the disability or early intervention requirements.

The Explanatory Memorandum illustrates this on page 27 with the example of 'Josephine', who has intellectual disability and Type 2 diabetes. This case study confirms that supports arising from intellectual disability (including support for eating, drinking, cooking, and shopping) remain fundable, but that supports arising solely from the diabetes do not.

Dietitians Australia supports the intent of this provision. However, it raises a significant risk in its application to participants whose disability affects eating and nutrition through indirect but causally linked pathways.

Consider participants with:

- Intellectual disability, where cognitive impairment directly impairs the ability to understand nutritional needs, make appropriate food and hydration choices, regulate intake, manage a therapeutic diet, prepare meals, or access food safely.
- Cerebral palsy or acquired neurological disability, where oromotor dysfunction, spasticity, fatigue, and reduced fine motor function directly impair the ability to self-feed and hydrate, prepare food, or manage oral food and hydration intake safely.
- Autism spectrum disorder, where sensory processing differences directly restrict dietary variety, cause significant distress at mealtimes, and impair the capacity to eat and drink safely and adequately in educational, social, and community settings.

In each of these cases, the functional feeding and hydration impairment is directly caused by the disability. It is not a downstream health condition. The risk is that a narrow interpretation of "directly arising" will confine dietetic support to participants with frank dysphagia or structural swallowing impairment; while excluding participants whose feeding capacity is impaired through cognition, sensory processing, motor planning, or behavioural regulation despite these being equally direct impairments of their disability. If not distinctly addressed or clarified that it includes functional feeding and hydration indirectly caused by the disability, the participant's safety may become at risk and hospitalisation may be required.

Dietitians Australia recommends that the Committee seek clarification in The Bill or Explanatory Memorandum that functional feeding and hydration impairments arising through cognitive, sensory, behavioural, or motor pathways are recognised as directly arising from the primary disability, and that dietetic support addressing these functional impairments is within scope.

Case Study: Rory
Rory is a 4-year-old with ASD Level 2, ADHD, global developmental delay, and oromotor dyspraxia. He presents with extreme dietary restriction, very high anxiety at mealtimes, and sensory aversion to food textures. Rory's restricted intake directly reduces his energy levels, engagement in preschool,

capacity for physical activity, and ability to participate in physiotherapy, speech therapy and occupational therapy. Dietetic intervention focuses on ensuring nutritional and hydration adequacy and expanding safe participation in eating, not treating nutritional conditions. Under a narrow interpretation of "direct link," this support risks being excluded despite arising unambiguously from his disability. The success of Rory's physiotherapy, speech therapy and occupational therapy interventions are therefore dependent on Rory's nutrition and hydration status.

Part 6- Reasonable and necessary supports

Item 68 — New Subsections 33(2EA) and (2EB): Maximum Intensity Caps for Therapy Supports

The power to set maximum intensity caps for therapy supports risks applying uniform limits to dietetic care despite evidence that functional feeding and hydration needs are often complex and lifelong.

The proposed Bill grants the Minister power, by legislative instrument, to determine maximum funding amounts, maximum intensity, and maximum worker-to-participant ratios for supports or classes of supports.

The Explanatory Memorandum provides the example of 'Marco' on page 51 where a maximum of 25 hours per therapy discipline per year is applied, regardless of clinical recommendation. The Explanatory Memorandum notes the intention is to specify maximums even when research shows that additional intensity provides benefit. This raises several concerns for APDs.

Dietetic support in disability is already frequently under-funded relative to clinical need. Many participants currently receive approximately 10 hours per year of dietetic support, despite clinician reports clearly demonstrating that safe and effective management of complex feeding and hydration needs, particularly enteral nutrition, dysphagia, feeding disorders, and the functional feeding and hydration impacts of neurological disability, requires significantly more engagement. A uniform 10 or 25-hour cap applied without disability-specific evidence would further entrench this under-funding.

1. The functional feeding needs of participants with complex disability are often lifelong. They therefore require ongoing monitoring, adaptation to changes in ability and function, and multidisciplinary coordination. A participant with cerebral palsy and gastrostomy feeding, or a participant with progressive neurological disease and dysphagia, does not have a need that resolves within a fixed annual intensity cap. These minister-imposed caps undermine the clinical judgement and care planning provided by experienced, accredited dietitians, despite there being no evidence to justify such restrictions.

2. The large majority of participants are informed by NDIS planners that their allied health funding is not intended to be inclusive of travel fees (despite its inclusion in the NDIS price guide). In most cases, Dietetic assessment and capacity building is most effective in the home environment for numerous reasons including; assessment of eating in natural environment, assessment of food supply and household menu systems, collaboration with multiple support workers in a single appointment, and trial of interventions in the environments where eating/feeding/mealtime challenges occur (home, school etc). This increases the likelihood of positive outcomes, is value for money, and reduces the risk of eating/feeding skills not transferring from a clinic space to the 'real world'.

3. Additionally, for many NDIS participants, accessing an unfamiliar clinic environment can be physically challenging or impossible, be dysregulating (sensory/behavioural challenges), and becomes a significant drain on their social and community hours.

4. If maximum funding amounts are implemented, such as 10 hours/year, in reality, face to face therapeutic hours will be as little as <5 hours/year, accounting for travel, and non-face to face services, such as multi-disciplinary communications, report writing, assessments and attendance at multi-disciplinary case meetings. This directly undermines the capacity of the Dietitian to implement meaningful interventions that target the NDIS participants goals and aspirations.

We recommend that determinations for therapy supports be:

- Preceded by mandatory consultation with Dietitians Australia and relevant peak allied health bodies prior to commencement.
- Accompanied by published, disability population-specific evidence, where available, justifying the proposed limit, including its impact on functional capacity and participation outcomes.
- Subject to an individual needs pathway where a registered allied health professional documents that a participant's functional support needs exceed the determined maximum.

Item 70 / insertion after 34 (1)(f)

The proposed addition to the bill states that, as part of assessment of a reasonable and necessary support, consideration of other appropriate schemes and existing government services must be considered. Whilst we agree with this practice in theory, in practice we have observed NDIS participants being referred to Dietetic services under Medicare (Chronic Disease Management Plan) by the planner inappropriately.

For example, a NDIS participant, with a primary disability of dementia, causing both cognitive and physical impairment, is denied funding for Dietitian support under NDIS, with the planner citing ‘Health services’ to be a more appropriate referral pathway. This is despite the NDIS participant experiencing dementia-related inability to plan, prepare and initiate meals, inability to understand their nutrition and hydration needs, and mealtime challenges including food refusal, taste changes and evidence of decline in strength and participation in social and community activities, due to a decline in oral intake.

Referring NDIS participants to Medicare for allied health services disregards the NDIS Bill (current, 2013, and amendment 2026), which stipulates that it is reasonable and necessary to fund supports for functional impairments directly arising from a participants primary and/or secondary disability. Medicare Chronic Disease Management Plans are also constrained in that allied health clinicians not funded to attend home or school environments to perform mealtime assessments in the participants natural environment. This discriminates participants who have mobility, cognitive or behavioural impairments, that limit their ability to attend clinic environments and/or effectively participate in an unfamiliar, often dysregulating clinic space. They also aren’t funded to prepare capacity building resources for the participant, family or carers, or reports to demonstrate progress and challenges/barriers, in relation to Dietitian therapy and the NDIS participants NDIS goals.

The out-of-pocket gap fees to access private allied health practitioners including dietitians will also present as a financial barrier for accessing necessary health care. This directly excludes NDIS participants who do not have the financial means to access this type of support from quality Dietetic care. The limit of up to 5 appointments per year across allied health disciplines is not designed for individuals with permanent disability and life-long impairment.

In the public health care setting such as hospital outpatient clinics, other barriers to accessing dietetic and allied health supports include not meeting the eligibility criteria, ssignificant wait lists, limited ability to facilitate home/school visits due to significant clinical caseloads and knowledge gaps regarding NDIS systems and documentation.

We recommend that, when considering if Dietitian support is more appropriate to be funded by 'other' schemes or government services, the decision makers acknowledge the unique limitations that need to be considered, when deciding if referral to 'health services' for Dietitian and other allied health services is accessible and practical for the NDIS participant.

Item 73 — New Subsections 34(1E) and (1F): Evidence Hierarchy for "Effective and Beneficial"

The evidence hierarchy for "effective and beneficial" supports risks disadvantaging disability-specific dietetic intervention, which is under-represented in generalisable research but well-supported by functional evidence and expert clinical consensus.

The proposed amendment to The Bill introduces a ranked evidence framework for assessing whether a support is effective and beneficial, prioritising published, peer-reviewed, generalisable research. The CEO may decline a support where such research is limited or absent, even where there is individual evidence of effectiveness and or where expert clinical consensus is available.

Dietetic research in disability populations is characterised by small sample sizes, heterogeneous participant profiles, and significant under-representation in generalisable trials, not because the interventions are ineffective, but because these populations are under-researched. High-quality evidence exists for specific presentations (dysphagia management, enteral nutrition in cerebral palsy, feeding therapy in ASD), but it may not meet the threshold of "generalisable" as defined in the Bill.

The risk is that supports producing clear functional gains such as increased participation in therapy, improved energy and endurance, expanded dietary capacity, and reduced carer burden will be declined because the evidence base favours published research, not individual circumstances.

We recommend that the evidence framework be adjusted to ensure it is appropriate for disability-specific practice where population-level research may be limited but clinical need and functional outcomes are well established in practice. The evidence framework could be strengthened by:

- Recognising that the absence of generalisable research for a specific disability population does not indicate that an intervention is ineffective or inappropriate.
- Equally ranking demonstrated functional outcomes for individual participants (consistent with subsection 34(1E) (c)) with generalisable research where population-level evidence is limited.
- Requiring the NDIA to maintain clear guidance on disability-specific populations where the evidence base is acknowledged to be limited, but where there are strong clinical consensus and established practice supporting intervention.
- Require mandatory consultation with Dietitians Australia and relevant peak allied health bodies prior to commencement to avoid unintended consequences.
- Ensuring review and oversight by the Evidence Advisory Committee.

- Removing reliance on an open-ended discretion such as "any other matters the CEO considers appropriate," to ensure transparency, consistency, and clinical accountability in decision-making frameworks.

Recommendations

Provision from Schedule 1	Our concerns	Our recommendations
Part 1: Defining Functional Capacity Item 4 / s.9B	Functional capacity assessed without environmental context may underestimate disability-related feeding and hydration impairments that are context-dependent or support-dependent.	Align with the WHO definition[1] that environment-dependent and caregiver-dependent functional feeding impairments remain valid expressions of disability-related functional capacity and are not excluded from assessment due to contextual variation.
Part 3: Strengthen link between impairment and need for support Item 28 / s.32K(3A)	A narrow interpretation of "directly arising" may exclude feeding impairments arising through cognitive, sensory, behavioural, or motor pathways.	Clarify that functional feeding impairments arising through cognitive, sensory, behavioural, or motor pathways are considered to arise directly from the participant's disability and remain eligible for support.
6—Reasonable and necessary supports Item 68 / s.33(2EA)	Uniform maximum therapy caps may restrict clinically necessary dietetic input without disability-specific evidence.	Consultation with peak allied health bodies; ensure exemptions for ongoing clinical risk and complex care needs; and allow clinician-led variation or override where functional need is demonstrated.
6—Reasonable and necessary supports Item 70 / insertion after 34 (1)(f)	Referring NDIS participants to Medicare for allied health services disregards the NDIS Bill and overlooks the limitations faced by hospital outpatient clinics and Medicare Chronic Disease Management Plans.	Consider the unique limitations faced by NDIS participants when deciding if referral to 'health services' is accessible and practical for the NDIS participant.
6—Reasonable and necessary supports Item 73 / s.34(1E)	The limited evidence base may disadvantage people with a disability; the migration of care to Medicare Chronic Disease Care plans is not fit-for-purpose for people with a disability.	Call for more research and consultation to fill in gaps where population-level evidence is limited.

NOTES

[i] World Health Organization. ICF. https://www.who.int/standards/classifications/international-classification-of-functioning-disability-and-health

ADDITIONAL CASE STUDIES

The following case studies have been de-identified from NDIS registered APDs to demonstrate how functional feeding, hydration and nutrition supports sit at the intersection of disability, health, and daily living. In each case, dietetic support is not ancillary or optional, but directly linked to functional capacity, safety, participation, and avoidance of escalation into acute or higher-cost systems of care.

Case Study: Sam

Sam is a NDIS participant with cerebral palsy who experiences chronic gastro-oesophageal reflux as a direct consequence of neurological impairment and reduced mobility. Without effective dietetic management, his condition progresses over time to Barrett's oesophagus, followed by an acute gastrointestinal bleed requiring hospitalisation. Acute care involves a multidisciplinary inpatient response, followed by ongoing rehabilitation input. Following discharge, dietetic intervention is essential to stabilise intake, manage reflux risk, and support nutritional recovery through texture modification, reflux-aware dietary strategies, and meal structuring.

Functional impact if dietetic supports are reduced or absent:

- Increased supervision required during meals due to choking and reflux risk
- Reduced independence in eating and meal management
- Increased assistance required for ADLs involving food preparation and safe intake
- Reduced participation in daily activities due to fatigue, discomfort, and hospital recovery periods
- Increased reliance on support workers for feeding-related tasks
- Reduced consistency in participation in rehabilitation and allied health therapy due to fluctuating health status
- Increased long-term reliance and intensity of support services following functional decline
- Increased risk of further hospitalisation

In this scenario, the cost of acute hospitalisation and ongoing multidisciplinary care significantly exceeds the cost of preventative dietetic input. Without ongoing support, there is a foreseeable escalation in care needs and reduced functional independence across daily living domains.

Case Study: Tom

Tom is a 47-year-old man with a complete T6 spinal cord injury and a chronic Stage 4 pressure injury, with recurrent hospital admissions due to wound infection. Nutrition is a direct determinant of wound healing in this context. Inadequate protein and energy intake contributes to delayed recovery, increased infection risk, and prolonged hospital stays. Dietetic intervention includes individualised high-protein nutrition planning, supplementation, and support worker training to ensure consistent implementation of nutritional strategies.

Functional impact if dietetic supports are reduced or absent:

- Reduced mobility due to worsening wound status and pain
- Increased reliance on physical supports for transfers and mobility tasks

- Increased assistance required for ADLs, including dressing and personal care
- Escalating support needs across multiple domains due to prolonged recovery periods
- Reduced participation in therapy and rehabilitation activities
- Increased supervision requirements due to medical instability and infection risk
- Increased long-term reliance on high-intensity supports, including wound care and nursing input

Reducing or removing dietetic input does not reduce overall system cost. It shifts cost from preventative community-based care into repeated hospital admissions and higher-intensity ongoing NDIS support requirements.

Case Study: Anna

Anna is a woman in her early 50s with advanced Huntington's Disease, presenting with progressive dysphagia, significant unintentional weight loss, and a recent choking episode. Her husband is her primary carer. Dietetic intervention includes energy-dense meal planning, supplementation, and carer education to support safe and adequate oral intake.

Functional impact if dietetic supports are reduced or absent:

- Increased supervision required during all meals due to choking risk
- Reduced independence in eating and daily routines
- Increased assistance required for all ADLs involving feeding and hydration
- Increased falls risk and reduced mobility due to unintentional weight loss and muscle wasting
- Reduced participation in daily activities due to fatigue and progressive decline
- Escalating support needs across personal care, mobility, and household tasks
- Increased reliance on physical supports and carer input for all nutrition-related care
- Increased intensity of NDIS support workers due to carer burnout and reduced functional capacity

Without dietetic support, the trajectory is accelerated functional decline, carer burnout, and higher costs to the NDIS. This represents a significantly higher long-term cost compared with preventative and ongoing dietetic input.

Case Study: Mark

Mark is a 32-year-old man with Down syndrome living semi-independently. He presents with significant weight gain, reduced energy levels, and increasing behavioural dysregulation related to food access, particularly following work and community participation activities. Dietetic intervention includes structured eating routines, environmental modifications, support worker training, and behaviourally informed nutrition strategies to support consistent intake and regulation of food-related behaviours.

Functional impact if dietetic supports are reduced or absent:

- Reduced independence in daily routines, including meal planning and food choices.
- Increased supervision required across the day to manage food-related behaviours.
- Escalating support needs across domains, including behaviour support and daily living assistance.
- Reduced capacity for ADLs and daily routines due to fatigue and reduced physical stamina.

- Inconsistent participation in therapy, work, and community activities due to behavioural escalation and energy variability.
- Reduced participation in employment due to difficulty sustaining routines and managing post-work fatigue and food behaviours.
- Increased reliance on physical and behavioural supports from staff and carers.
- Increased long-term reliance on funded supports due to functional decline over time.
- Increased risk of restrictive practices if behaviours escalate without preventative nutritional intervention.

These outcomes directly affect Mark's ability to maintain employment participation, independent living skills, and social participation. Without dietetic input, there is a foreseeable progression to chronic disease, reduced mobility, increased behavioural escalation, and greater reliance on restrictive practices and high-intensity NDIS supports. These outcomes carry significant long-term costs to both the individual's independence and the broader scheme.

Case Study: Ruby

Ruby is a 41-year-old woman with moderate intellectual disability, acquired brain injury, schizophrenia, and musculoskeletal mobility impairment, living independently with disability support. While she also has Type 2 Diabetes Mellitus, her primary difficulties with eating, meal preparation, blood glucose management, and nutritional self-care arise directly from disability-related impairments affecting comprehension, planning, organisation, behavioural regulation, motivation, and independent living skills associated with her intellectual disability.

Nutrition and dietetic support focused on improving functional capacity and supporting independent living through:

- Adapted visual meal planning.
- Simplified education.
- Support worker training.
- Behavioural strategies.
- Structured food routines.
- Environmental supports.
- Multidisciplinary coordination.

Nutrition therapeutic support required extended timeframes, repetition, relationship building, and highly individualised approaches due to cognitive and psychosocial disability impacts. Following sustained dietetic input over 12 months, Ruby demonstrated meaningful functional improvements across daily living and community participation:

- Approximately 50% reduction in severe hyperglycaemia
- 25% reduction in excessive carbohydrate intake
- Improved structure and consistency around meals and food routines
- Increased engagement and confidence in meal preparation tasks
- Improved understanding of basic nutrition and diabetes concepts
- Reduced reliance on takeaway foods
- Increased capacity to participate in daily activities and therapy sessions
- Reduced reliance on support workers for meal preparation, with greater independence in basic meal assembly and routine planning

- Reduced need for NDIS-funded nursing intervention related to diabetes instability and monitoring escalation
- Improved mood stability and reduced behaviours of concern associated with blood glucose variability, hunger regulation, and routine disruption
- Nil hospital admissions for hyperglycaemia during 12 months of dietetic input (previously frequent admissions)

Importantly, these outcomes reflect improvements in functional capacity and participation, not simply biomedical markers. This also reduced pressure on other funded supports, including nursing escalation, intensive support worker input for meal management, and crisis-driven interventions during periods of metabolic instability or behavioural escalation.

ACKNOWLEDGEMENTS

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