State Disability Plan and Victorian Autism Plan 2027-2031

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Recipient

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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 9,000 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.

Autism: Dietitians (APDs) play a pivotal role in supporting Autistic children and adults to eat in a way that supports their health and wellbeing. By offering nutrition therapy throughout the continuum of care, APDs address challenges such as restrictive diets and gastrointestinal concerns, ultimately enhancing the person's capacity to learn, engage, and fully participate in life.

Disability: APDs are uniquely trained to provide essential support for people with disability by assessing and managing swallowing difficulties, ensuring safe mealtime practices, addressing tube feeding and complex nutrition needs, and preventing malnutrition. They also guide families in managing allergies, intolerances, and specialised diets that can affect growth, learning, and participation. Recognising dietitians as part of the disability workforce will ensure children and adults receive safe, timely, and holistic care. APDs are also uniquely trained to provide one-on-one medical nutrition therapy to people with disability in a clinical context across a broad range of disease and health conditions. Dietitians must hold the APD credential and meet continuing professional development and recency of practice standards annually to access Medicare, Department of Veterans Affairs, National Disability Insurance Scheme, worker's compensation schemes and most private health insurers. Dietitians are essential providers of functional capacity-building supports in disability and mental health.

Members of Dietitians Australia contributed to this submission, following the Conflict-of-Interest processes approved by the Board of Dietitians Australia. Contributors include APDs who are NDIS registered providers.

Part 1: Victorian Autism Plan

Recommendations

1.	**The Victorian Autism Plan should raise awareness of and address the food and nutrition issues experienced by people with Autism.**
2.	**Nutrition and hydration must be embedded across all four domains and the systemic reforms and must be explicitly recognised as a distinct priority and outcome area under Pillar 2: Health, housing and wellbeing**
3.	**Pillar 1: Inclusive Communities** **Eating and drinking should also be incorporated into actions on community access and participation. This would recognise that eating and drinking are critical parts of social connection, cultural participation and community inclusion, not only clinical health matters.** This could include: • accessible and sensory-inclusive eating environments • availability of suitable food and drink at public events, recreation facilities and cultural venues • accessible information about food, nutrition and available supports • reasonable adjustments in community programs • support for participation in shared meals and community activities.
4.	**Pillar 2: Health, Housing and Wellbeing** • **Add a new outcome area: Nutrition and hydration** • **Add a distinct priority: Equitable access to nutrition and hydration** • **Add proposed Commitment:** people with Autism and people with disability have an equal and practical opportunity to achieve adequate nutrition and hydration in ways that respect their autonomy, health needs, culture, sensory preferences and communication requirements. Increase timely access to appropriate and adequately funded nutrition and dietetic support based on assessed need. At present, the health priorities focus on items such as healthcare access, autism assessment, health workforce capability, mental health, housing, sport and recreation, NDIS, and children and families, but do not include healthy eating and drinking, a basic human need, as a priority.
5.	**Pillar 3: Fairness and Safety: Complex needs** **Engage Dietitians Australia in future twice-yearly *'complex needs'* forums and other consultation mechanisms to provide advice to the Victorian government that will allow current and future policy to take in the circumstances and needs of people with Autism with complex feeding and hydration needs.**
6.	**Pillar 3: Fairness and Safety: Diverse Communities** **Engage Dietitians Australia in future twice-yearly 'autism diversity' forums and other consultation mechanisms to provide advice to the Victorian government that will allow current and future policy to take in the circumstances and needs of people with Autism with diverse needs, including *rural and regional Victoria*.**

7.	**Pillar 4: Opportunity and disability pride**[1] **Scope models of success to require schools and educational institutions to make reasonable adjustments to food, mealtime and drinking environments for Autistic students, with input from students, families and appropriately qualified Accredited Practising Dietitians, where needed.**
8.	**Pillar 4: Opportunity and disability pride** **In Table 4.4 (p37)** [2] **Strengthening individualised support for Autistic students:** • **Replace**: "Invest in student health and wellbeing including by employing more allied health service staff such as speech pathologists and psychologists in the education system" **with "Invest in student health and wellbeing including by employing more allied health service staff such as dietitians, speech pathologists and psychologists in the education system"** • **Add 'Funding dietitians in every Victorian government secondary school campus.'** to align with funding mental health practitioners.
9.	**Support the health and mental health of people with Autism by enhancing access to Accredited Practising Dietitian services through the following measure:** • **Integrate dietetic services in dedicated autism services, mainstream programs, and mental health services.**

Why food and drink matter for people with Autism

To support people with Autism throughout their lives, the pivotal role of food and nutrition in addressing their health and mental health needs must be recognised.[1, 2] Although people with Autism share the same nutritional requirements as people without Autism, they often encounter unique challenges that can make fulfilling these needs more complex.[3, 4] Within the context of multidisciplinary teams, APDs are instrumental in supporting children and adults with Autism to navigate these challenges.[5-7]

The Victorian Autism Plan 2027-2031 provides an opportunity to amplify the importance of nutrition, hydration and the critical role of APDs in ensuring people with Autism live fulfilling lives.

Gaps in the plan

Nutrition and hydration must be explicitly recognised as a priority in the Victorian State Disability Plan and Victorian Autism Plan

While the Plans comprehensively address several factors impacting the health and mental health of people with Autism, they overlook and lack the consideration of food, nutrition and hydration requirements and the specific needs of people with Autism.[8, 9] Heightened sensory perceptions and certain restrictive or repetitive behaviours may influence dietary preferences and habits.[4] Such patterns can result in health complications, such as food or specific food group avoidance, hyper selection of foods, problematic mealtime behaviours, mealtime anxiety and malnutrition.[10-12] Examples of such eating behaviours include:

[1] Previously called - Contributing lives education and skills in the Victorian Autism Plan 2019.

[2] Victorian Autism Plan 2019

- Strong preferences for - and hyper selection of specific textures, like crunchy or soft foods
- Preferences for particular food brands
- Preferences for specific foods such as “beige foods” e.g. bread or chicken nuggets
- Desire for food to be prepared or presented in specific ways, with potential avoidance if not fulfilled.[8]

Additionally, evidence suggests that people with Autism are more likely to experience other comorbidities[13] including Avoidant/Restrictive Food Intake Disorder,[12, 14] eating disorders[15, 16] and gastrointestinal issues such as constipation, diarrhoea, and bloating.[17-19]

Appropriate adjustments to the eating environment and nutrition and dietetic support[7, 19, 20] are essential to effectively support people with Autism to eat in a way that best meets their individual needs.

The Plan has an important role in raising awareness about the food and nutrition as well as hydration issues experienced by people with Autism and ensuring there is access to appropriate dietetic support.

How can we better support community inclusion, health and mental health outcomes for people with Autism?

Raise awareness about nutrition and dietetic support

It is essential that people with Autism, caregivers, educators, and health professionals are aware of the common nutrition and hydration issues experienced by people with Autism and the avenues for professional support.[21]

Accredited Practising Dietitians are university-qualified experts that are skilled and credentialed to provide person-centred and evidence-based dietary support to enhance the physical and mental health outcomes of people with Autism.[5, 6]

Accredited Practising Dietitians can support people with Autism to align their preferences and nutritional requirements, which are essential for:

- Optimal concentration and learning, and participation in schools and workplaces[22, 23]
- Initiating, planning and completing daily tasks such as planning what to eat, remembering to eat regularly, and learning how to improve eating habits[20]
- Minimising the effects of hunger which can impact on capacity to manage emotions and socialise[24]
- Preserving and improving muscle strength and balance and capacity to participate in physical activity[25]
- Enhancing social participation such as engagement at work, participation in mealtimes and engagement in the community[26]
- Capacity to engage in activities to promote health, self-manage diet, communicate, and undertake physical activity.[5]

By facilitating dietetic referrals and integration within health services, we ensure that the Autistic community has access to dependable and individualised advice to address their unique nutrition needs and to optimise function.

Incorporating these elements into Victorian Autism Plan is essential. By doing so, we can prioritise addressing these issues, facilitate appropriate referrals and foster improved physical and mental health outcomes.

Expand access to Accredited Practising Dietitians services

Beyond raising awareness about nutrition, it's vital to enhance access to evidence-based dietetic support for people with Autism. Currently, the options for people with Autism to see an Accredited Practising Dietitian are limited. There are limited Medicare items allocated for Autistic children or adults to see a dietitian and other allied health professionals:

- Accredited practising dietitians are included in the Medicare Benefits Schedule (MBS) for eligible people **aged under 25** with a complex neurodevelopmental condition, such as autism, or another eligible disability. Medicare provides benefits for up to **eight allied health assessments per lifetime** under these items. Given the complexities involved in the care of people with Autism this provision is insufficient.
- For people with Autism with a co-morbidities such as chronic conditions there are additional restricted access concerns. Limited services are currently available under the MBS Chronic Condition Management Plan with only **up to 5 allied health sessions** across all allied health professionals being made available to an individual. Given the complexity of care requirements this further impacts access for a person with Autism to access the services of an Accredited Practising Dietitian.
- People with Autism who have a diagnosed eating disorder. Whilst eligible patients can access **eating disorders** MBS items through an Eating Disorder Treatment and Management Plan (EDTMP), which provides Medicare benefits for up to 20 dietetic services over a 12-month period, a person with Autism will be required to undergo a specific eating disorder diagnosis which may present significant complexities for families and caregivers and the individuals themselves. This MBS provision is not sensitive to the needs of people with Autism.

Moreover, existing data suggests that the number of hours allocated to dietetic services through the National Disability Insurance Scheme (NDIS) is often inadequate.[27] Consequently, both children and adults with Autism are unable to access the essential dietetic support they need. We advocate for expanded access to APD services through the implementation of the following measures:

- Integrate dietetic services in dedicated autism services, mainstream programs, and mental health services.

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Part 2: State Disability Plan 2027-2031

Recommendations

Dietitians Australia believes it is vital to have Accredited Practising Dietitians, working at the coalface in Victoria to provide **practical and clinical insights** into how the proposed new State Disability Plan will affect people with disabilities' access to safe, effective and disability-specific nutrition, hydration and dietetic therapy supports, including for people with complex feeding, hydration, swallowing, enteral nutrition (tube feeding into stomach or bowel), sensory, behavioural and functional capacity needs.

Dietitians Australia and its members welcome the opportunity to collaborate with you to co-design solutions that will ensure appropriate nutrition and dietetic therapy supports are available to all Victorians with disability and to promote workforce development strategies.

General Recommendations

1.	**The Plan should raise awareness of and address the food, nutrition and hydration issues experienced by people with disability.**
2.	**Explicitly recognise eating and drinking as well as nutrition and hydration as foundations of health, function and participation in the next State Disability Plan.**
3.	**Ensure equitable and timely access to Accredited Practising Dietitians, based on assessed need and with choice of Accredited Practising Dietitian.** Equitable and accessible dietetic services, together with a genuine opportunity for adequate nutrition and hydration, enable people with disability to optimise functioning, manage health conditions, promote fitness and wellbeing, participate in everyday life and experience eating and drinking in positive, safe and personally meaningful ways.
4.	**Establish clear access pathways for dietetic, nutrition and hydration services across the NDIS, Home and Community Care Program for Younger People (HACC PYP), Medicare, community health, hospitals, mental health services and education**, so that people do not fall through service and funding gaps.
5.	**Ensure people with disability have access to their preferred provider beyond dietitians working for community services, including sole traders and private practising dietitians.** This includes expanding the opportunity for people with disability to use HACC PYP funding to see private practising dietitians.
6.	**Ensure people receive the practical changes and support they need to eat and drink safely, comfortably and according to their needs and preferences**, including adjustments to sensory environments, communication, appointments, food presentation, mealtime routines and practical assistance.

7.	**Include nutrition, hydration, food security, feeding, eating, drinking, swallowing and access to dietetic services in:** • **Consultation processes** • **data collections** • **outcomes frameworks.**
8.	**Decisions about nutrition, hydration and dietetic needs of people with disability should be informed by qualified dietitians and must not be displaced by generic tools, automated decision-making, standardised algorithms, or staff without appropriate clinical training.**

Pillar-Specific Recommendations

1.	**Nutrition and hydration must be embedded across all four domains and the systemic reforms and must be explicitly recognised as a distinct priority and outcome area under Pillar 2: Health, housing and wellbeing.**
2.	**Pillar 1: Inclusive Communities** **Eating and drinking should be incorporated into actions on community access and participation. This would recognise that eating and drinking are critical parts of social connection, cultural participation and community inclusion, not only clinical health matters.** This could include: • accessible and sensory-inclusive eating environments • availability of suitable food and drink at public events, recreation facilities and cultural venues • accessible information about food, nutrition and available supports • reasonable adjustments in community programs. • support for participation in shared meals and community activities.
3.	**Pillar 2: Health, Housing and Wellbeing** • **Add a new outcome area: Nutrition and hydration** • **Add a distinct priority: Equitable access to nutrition and hydration** At present, the health priorities focus on items such as healthcare access, autism assessment, health workforce capability, mental health, housing, sport and recreation, NDIS, and children and families, but do not include healthy eating and drinking, a basic human need, as a priority.
4.	**Pillar 3: Fairness and safety** **Add explicit recognition of nutrition and hydration within safeguarding, emergencies, advocacy and justice actions.** This could include: • prevention of choking, malnutrition, dehydration and nutrition-related neglect • safe eating, drinking, mealtime and feeding support • access to appropriate food and fluids (including oral nutrition supplements and enteral tube feeds and enteral tube feeding equipment) during emergencies, evacuation and recovery

	• access to advocacy when nutrition or hydration needs are not met • safeguards against inappropriate restriction of preferred foods or unnecessary coercive feeding practices • nutrition and hydration support for people with disability in hospitals, residential settings, child protection and justice environments.
5.	**Pillar 4: Opportunity and disability** **Nutrition and hydration should be explicitly linked to participation in:** • **early childhood education** • **school and tertiary education** • **vocational training** • **employment** • **sport and physical activity** • **independent living.** Actions could require schools, TAFEs and workplaces to make reasonable adjustments relating to: • food textures and presentation • eating locations • mealtime timing and flexibility • sensory environments • access to fluids • support for planning, preparing and remembering to eat and drink. • Consideration of requirements for individuals relying on enteral tube feeding (gastrostomy or nasogastric feeding) to be able to prepare and administer feeds and hydration safely and hygienically when and if required.

Systemic Reforms Section Recommendations

1.	**Healthy eating and drinking should be incorporated into the systemic reforms.**
2.	**Co-design** **Nutrition, hydration, feeding and mealtime policies should be co-designed with people with Autism and people with disability, including people with restricted eating, feeding or swallowing difficulties.**
3.	**Aboriginal and Torres Strait Islander People self-determination** **Food, nutrition, feeding and hydration initiatives should be culturally safe and developed by First Peoples**.
4.	**Intersectional approaches** **The plan should recognise the interaction between disability, poverty, geographic location, gender, culture and food insecurity.** The midway outcomes report found food insecurity was particularly high among people with disability living in outer regional Victoria.

5.	**Accessible communication and universal design** **Nutrition information, menus, food-service systems and mealtime environments should be accessible and sensory-inclusive through developing policies, guidelines and programs.**
6.	**Disability-confident workforces** **Health, education, disability, justice and community-service workforces should understand disability-related feeding, eating and drinking needs and know when to refer to an Accredited Practising Dietitian or another appropriate professional.** Dietitians Australia can support this workforce development strategy.
7.	**Effective data and outcomes reporting** **The Plans should collect and report data on:** • **food insecurity** • **malnutrition risk** • **hydration** • **restricted eating** • **feeding and swallowing safety** • **artificial feeding (oral nutrition supplements, enteral tube feeding)** • **mealtime participation** • **access to dietetic services** • **unmet need and waiting times** • **reasonable adjustments.** This is particularly important because neither the current consultation snapshot nor the Plans report on any food, nutrition, hydration, eating, feeding or drinking elements, despite the broader outcomes framework showing worsening food insecurity.
8.	**Use available ABS National Health Survey measures, including fruit and vegetable intake, as interim population indicators, while developing disability-specific measures of food insecurity, nutrition adequacy, hydration, mealtime safety and access to dietetic services. Results should be reported separately for people with and without disability.** **Use existing ABS National Health Survey[3] measures to determine adequate food intake**. For example: • Proportion of Victorians with disability who meet the age- and sex-specific Australian Dietary Guidelines for recommended daily serves of fruit and vegetables, compared with Victorians without disability. • Percentage of adults with disability who meet both the recommended daily fruit and vegetable intake.

[3] https://www.abs.gov.au/statistics/health/food-and-nutrition/dietary-behaviour/latest-release

The cost of inaction on nutrition

According to the World Bank (2024), every $1 invested in undernutrition returns $23, while failure to act on undernutrition and obesity is projected to cost $41 trillion over 10 years (Box 1).

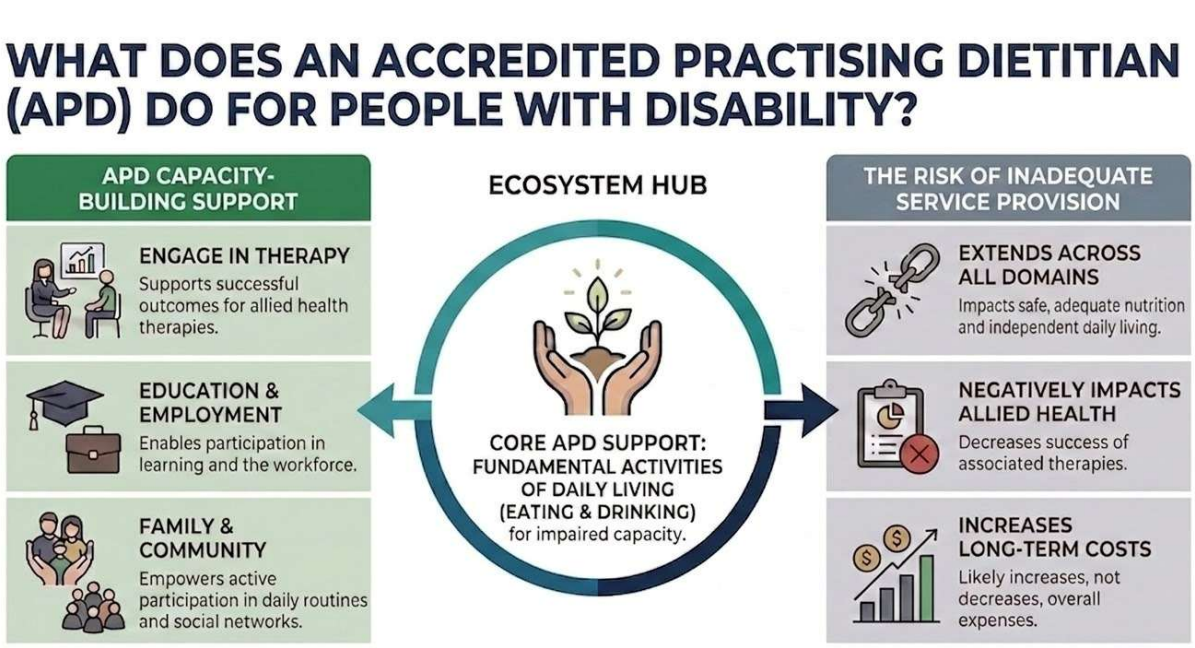
> *"For every $1 invested in addressing undernutrition, $23 are returned, and an estimated $2.4 trillion is generated in economic benefits. The economic benefits associated with these investments far outweigh the costs of inaction, which run around* ***$41 trillion over 10 years****, including $21 trillion in economic productivity losses due to undernutrition and micronutrient deficiencies and* ***$20 trillion in economic and social costs from overweight and obesity."***
>
> **Box 1 '*World Bank Investment Framework for Nutrition 2024*'** [4]

What can an Accredited Practising Dietitian do for people with disability?

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 people 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 person's daily life, negatively impact the success of allied health therapies and will likely increase, not decrease long-term government costs. Figure 1 shows the typical therapy impact of an Accredited Practising Dietitian for people with disability and provides examples of risks associated with inadequate access to nutrition and dietetic therapy supports.

[4] https://openknowledge.worldbank.org/entities/publication/2c0b8b5e-0f67-47fe-9eae-d4707d9ed195

Figure 1 Accredited Practising Dietitians support people with disability



Examples of where Accredited Practising Dietitians can support people with disability are:

- food insecurity and affordability
- restricted eating and sensory-related food avoidance
- malnutrition and nutritional deficiency
- hydration difficulties
- swallowing, feeding and mealtime safety
- gastrointestinal issues
- access to dietetic assessment and intervention
- the functional effects of inadequate nutrition and hydration.

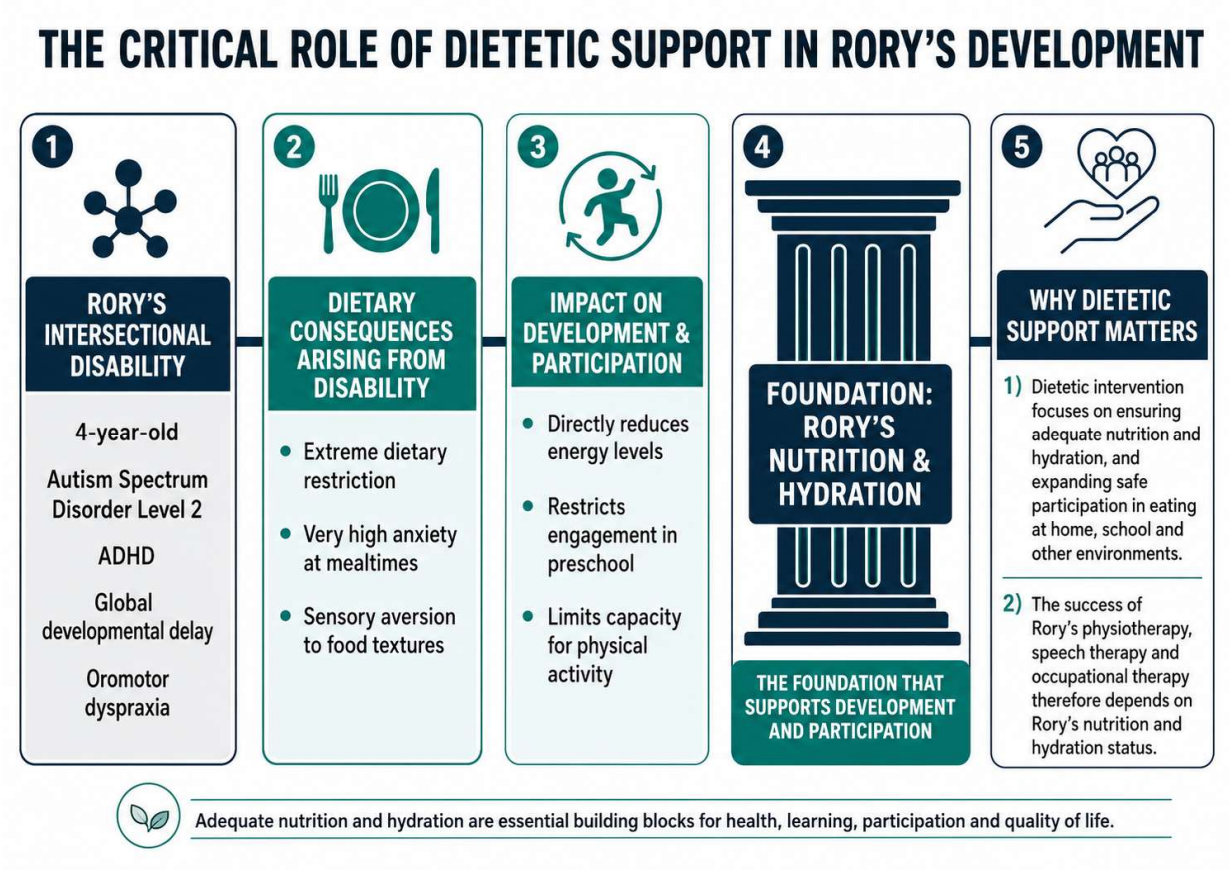
Figure 2 illustrates a case study of a young boy called 'Rory'[5].

Rory's life will be significantly impacted, including his learning abilities, if he does not receive appropriate dietetic therapy to ensure adequate nutrition and hydration and expand safe participation in eating. The success of Rory's physiotherapy, speech therapy and occupational therapy interventions is also dependent on Rory's nutrition and hydration status.

There are **many more such real-life examples to explain the complexity of dietetic care for people living with disability**. This complexity is often ignored or misunderstood. (See extra case studies in Appendix A).

[5] 'Rory' is a real life NDIS participant, however the case was de-identified for privacy purposes.

Figure 2 How Rory's life is impacted by his disability from a nutrition and dietetic perspective



People with disability and provider safety

Dietitians Australia continues to hold serious concerns about the current Disability sector reforms. The current changes create unacceptable risks for people with disability, particularly in relation to safety, access to dietetic supports, and the availability of capacity-building supports (See Figure 1 above)

Further evidence provided by our members reinforced these concerns. The proposed reforms are likely to have wide-reaching harmful consequences for people with disability, allied health providers, families and communities. In particular, they will limit people's ability to develop skills, increase independence, improve daily functioning, and participate more fully in family, education, work and community life. We welcome the further refinement of the State Disability Plan to improve the lives of people living with disability.

Beyond this, Accredited Practising Dietitians hold deep concerns about **the misunderstood functional benefits and risk protections that nutrition and dietetic therapy enable.** The absence or significant reduction of nutrition and dietetic supports reduces the functional capacity of people with disability, their ability to function independently and confidently, and participate in daily activities. The success of other allied health interventions is dependent on a person's nutrition and hydration status and their physical ability to effectively participate in therapy interventions.

For individuals who rely on enteral feeding (via a tube to stomach or bowel) or a combination of oral feeding (with texture modification and enteral tube feeding), it also means their feeding schedules and modifications need to be carefully planned and scheduled to ensure therapy interventions such as physiotherapy or occupational therapy can effectively occur.

More specifically, a person with disability who is undernourished or dehydrated will lack the energy and cognition to respond to therapeutic intervention, activity or instruction.

These safety concerns are not theoretical**. Dietitians Australia's de-identified case studies** describe people with disabilities whose reduced or absent dietetic support can **increase risks of choking, reflux-related deterioration, gastrointestinal bleeding, wound infection, delayed healing, unintentional weight loss, kidney failure, falls, behavioural escalation, restrictive practices, metabolic instability and avoidable hospitalisation**. Providers are concerned because, without appropriate dietetic assessment, planning and support-worker training, people with disability may be left relying on informal or non-clinical feeding, hydration and nutrition decisions in situations where small errors can lead to serious deterioration, acute care escalation, or increased reliance on high-intensity supports.

With a reduction in dietetic therapy supports, APDs have already observed people with disability experiencing significant deteriorations in their physical condition and functional capacity.

It is with this in mind, that Dietitians Australia requests that the Plan should raise awareness of and address the feeding, nutrition and hydration issues experienced by people with disability. It should explicitly recognise, safe eating and drinking as well as nutrition and hydration as foundations of health, function and participation in the next State Disability Plan.

State Disability Plan and Victorian Autism Plan 2027–2031: Survey Findings Snapshot as of 15 June 2026: food and nutrition-related outcomes to be more clearly defined in the Plan and the outcomes framework.

The **survey findings[6] snapshot does not report any specific findings on food, nutrition, eating, drinking, hydration, swallowing, mealtime support or access to dietetic services**. There are no percentages or themes specifically addressing these issues.

The closest, but only indirectly related, findings were:

- Sensory environments not being accommodated - 23%, which could affect eating environments for people with Autism and people with disability, but the report does not make that connection.
- Cost of healthcare - 20%.
- Lack of disability-informed healthcare - 18%.
- Poor coordination between services -15%.
- Respondents valued being listened to, clear communication and Disability Liaison Officers.

This is a **clear gap in** the published survey snapshot. It supports an argument that the consultation findings **may overlook essential daily-living and health issues related to a core basic human function: eating and drinking.**

[6] State Disability Plan and Victorian Autism Plan 2027–2031: Survey Findings Snapshot as of 15 June 2026.

*This gap is particularly notable because the **separate Inclusive Victoria Midway Outcomes[7] work did identify worsening food insecurity among people with disability,** but that issue was not carried through into this survey snapshot. We would welcome the inclusion of **food and nutrition-related outcomes being more clearly defined in the Plan and the outcomes framework**.*

Equitable access to dietetic, nutrition and hydration support to be included in the Plan

Adequate nutrition and hydration are essential foundations for health, functioning, independence and participation. For people with Autism and other people with disability, impairments, environmental barriers and inadequate supports may restrict the opportunity to eat and drink in ways that meet their nutritional requirements, health needs, sensory needs, preferences and cultural circumstances.

Feeding, nutrition and hydration affect a person's capacity:

- to socially participate
- to participate and perform at school, in education and at work
- to focus attention, process information and make decisions
- to initiate, plan and complete everyday tasks
- to engage in physical activity and sustain strength and endurance
- to maintain an appropriate body weight and body composition
- to manage health conditions and support physical and mental wellbeing
- to communicate, socialise and participate in family, community and cultural life
- to engage effectively in other supportive therapy intervention, including physiotherapy, occupational therapy and speech pathology.

Inadequate energy, nutrient or fluid intake may contribute to fatigue, reduced concentration, poor physical endurance and reduced capacity to regulate emotions or participate in therapy. In turn, this can limit progress towards education, employment, independence, mobility and community participation goals. Dietetic intervention should therefore not be viewed narrowly as addressing food intake or body weight. It can be an enabling support that improves a person's capacity to function and benefit from other health, disability and educational supports.

People with Autism may experience sensory-related food avoidance, highly restricted food repertoires, mealtime anxiety, difficulties recognising hunger or thirst, gastrointestinal symptoms, avoidant/restrictive food intake disorder, eating disorders and challenges with food preparation and daily routines.

Reasonable adjustments may be needed to the food, physical environment, communication approach, service model or level of practical support. These adjustments should be based on the individual's needs and preferences rather than an expectation that the person conform to standard eating environments or practices.

[7] Inclusive Victoria: State Disability Plan Midway Report 2022–2024

Ensuring equitable access to dietetic, nutrition and hydration supports regardless of funding source

There is a need for equitable dietetic input (and the right and equal opportunity for good nutrition and hydration based on needs and preferences) not related to a specific funding source (HACC/NDIS/Medicare).

Only 11% of Victorians with disability accessed the NDIS.[8] People with disability may receive support through the NDIS, The Victorian Home and Community Care Program for Younger People (HACC PYP), Medicare, community health, public hospitals, mental health services, education or other mainstream systems. Many people with disability are not NDIS participants, while others may have health and nutrition needs that cross the boundaries between disability and mainstream health responsibilities.

HACC PYP provides one potential pathway for eligible Victorians under 65 who have a disability, chronic illness, mental health condition or other condition affecting everyday living and community participation. Its Linkages program can fund additional HACC PYP allied health services, explicitly including dietetics, for eligible people with complex needs who require case management and support beyond standard service levels. However, HACC PYP is a targeted program delivered within finite resources. It cannot replace inadequate NDIS supports, fund private allied health services or provide services that are the responsibility of another program.

This creates a risk that people with complex nutrition and hydration needs will fall between systems. A person may technically be eligible for support somewhere, but still be unable to obtain timely, sufficiently intensive or appropriately coordinated dietetic care. Access may also be restricted by capped service hours, workforce shortages, geographical availability, co-payments, service eligibility rules or disagreement about whether a need is primarily health-related or disability-related.

The next Plans should therefore establish a **needs-based, system-neutral principle**: every Autistic person and person with disability should have equitable access to nutrition and hydration support and reasonable adjustments, regardless of which government program is responsible for funding the service. This does not require one program to assume another program's responsibilities. It requires governments and service systems to establish clear pathways, sufficient service capacity, coordinated referrals and transparent accountability so that people are not left without support because of funding boundaries.

This approach aligns with the Disability Discrimination Act 1992 (Cth)[9], which makes disability discrimination unlawful in areas including employment, education, access to public premises, the provision of goods, services and facilities, accommodation, clubs and sport. Under the Act, failing to provide a reasonable adjustment may amount to direct or indirect disability discrimination, unless making the adjustment would impose unjustifiable hardship.

[8] Inclusive Victoria: State Disability Plan 2022–2026, p16.

[9] *Disability Discrimination Act 1992* (Cth), ss 4–6, 11 and 15–29A.

Appendix A
Additional case studies explaining the importance of nutrition, hydration and dietetic supports

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.