

Dietitians Australia submission to the NDIS Legislation, Policy and Engagement Branch

New Framework Planning Rules NDIS Supports Transitional Rules

Response to consultation 14 October 2026

Recipient

NDIS Legislation, Policy and Engagement Branch
Department of Health, Disability and Ageing

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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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Summary and recommendations

Key recommendation

Dietitians Australia recommends that new framework planning explicitly recognise nutrition, hydration, and safe eating and drinking as foundational to function, wellbeing, and participation. The Department and NDIA should embed a clear pathway to ensure that disability-related nutrition and feeding needs are accurately identified through appropriate APD assessment and met through adequate funding and coordinated support. Rules, assessment tools, and funding methods should be co-designed and tested with people with disability and Accredited Practising Dietitians to protect participant choice, maintain essential supports through transition, and respond promptly when needs change.

Supporting recommendations

Recommendation	Action	Questions
R1 Identify nutrition and feeding needs	- Publish screening and referral triggers, use APD evidence and explain who arranges and funds additional assessment. - Recognise fluctuating needs, maintenance of function and realistic informal support.	12
R2 Complete evidence and explain decisions	- Record missing information, responsibilities, clinical recommendations and reasons for differing findings. - Correct or complete the report; replace an assessment when material problems remain unresolved.	13–14
R3 Explain and individualise funding	- Show calculation methods, quantities, prices, adjustments and exceptions. - Calculate funding on the complete assessed package: dietetic input, products, compatible equipment, daily assistance, monitoring and participant-specific training.	15
R4 Make plans usable and protect continuity	- Link assessed needs to the plan and implementation responsibilities. - Explain funding periods, restrictions and review routes; confirm at plan implementation who supplies, implements and monitors essential nutrition supports, and name an escalation contact for when continuity is at risk.	16, 22
R5 Respond promptly to changing needs	- Publish nutrition-specific variation and reassessment examples, urgent contacts and interim arrangements. - Match the pathway to the change in support needs, not funding size alone. - Plan variations should be approved in 14 days, plan reassessment in 4-6 weeks.	17
R6 Clarify supports and professional roles	- Align categories and funding boundaries. Explain professional and daily-support roles; recognise eligible nutrition products and equipment, including oral nutritional supplements and blended-feeding requirements, without gaps or duplication. - Use a disability-related health supports title and description that explicitly recognise both nursing and allied health roles. - Clarify health, aged care and NDIS responsibilities, confirm practical access and establish handover and escalation arrangements where gaps remain. - Explicit APD recognition in safeguarding, mealtime management and restrictive-practice guidance related to food and nutrition.	18–19; 21, 23

Recommendation	Action	Questions
R7 Build nutrition capability in the NDIS workforce	• Include training for NDIA assessors, planners, support coordinators and the broader NDIS workforce on: ○ recognising and responding to nutrition, hydration and feeding risks and ○ identifying when APD assessment or referral is required • Adapt Dietitians Australia Capacity Building in Disability for Dietitians materials, co-designed with AFDO, for adaptation and testing with disability-led organisations.	26; Appendix C
R8 Test accessible information and the pathway	Co-design linked examples from assessment to implementation; reconcile inconsistent terminology. Test communication, transition arrangements and practical access with participants and relevant professionals.	12, 20; 24–28
R9 Publish minimum requirements tables and health professional forms for dietary/nutrition and dysphagia modules alongside the exposure drafts	The minimum requirements tables and health professional forms for the dietary/nutrition and dysphagia modules should be published with the exposure drafts, so that APDs can test them before the rules are made final.	12, 13, 25
R10 Demonstrate that the adapted assessment identifies nutrition needs	Publish evidence supporting the adapted I-CAN and PECQ across disability cohorts and test, with participants and APDs, whether it captures complex, fluctuating and less visible nutrition and hydration needs and informs appropriate funding.	12, 25
R11 Explicitly include eating, drinking, nutrition and hydration in the proposed therapy supports description.	Include 'eating and drinking, meeting nutrition and hydration needs' in new therapy supports description on p18 in the NDIS Supports Transitional Rule	15

Dietitians Australia welcomes continued engagement on the exposure drafts and implementation testing. The responses below explain these recommendations and the evidence or practical gaps they address.

We note that the question numbering used in our submission Q12 to Q28 mirrors the Department's online response form. The numbering is kept; each heading already carries the question wording.

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 credential is Dietitians Australia's credentialling program. It provides assurance of safe, quality dietetic practice and is the foundation of self-regulation of the profession in Australia. Dietitians must hold the credential and meet continuing professional development and recency of practice requirements each year to provide services under Medicare, the National Disability Insurance Scheme, DVA, private health insurers, and other funded programs.

Accredited Practising Dietitians (APDs) support children, young people and adults with disability and developmental differences by assessing and managing nutrition and feeding needs that affect growth, health, learning and participation. APDs are uniquely trained to provide essential support for people with disability by assessing and managing nutritional needs associated with feeding and swallowing difficulties, working within multidisciplinary teams, ensuring safe mealtime practices, addressing tube feeding and complex nutrition needs, and preventing malnutrition. APDs play a critical role helping families to manage allergies, intolerances, and design specialised diets that can impact growth, learning, functional capacity 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.

This submission was prepared by the Dietitians Australia Policy and Advocacy team following processes approved by the Board of Dietitians Australia. Stakeholder contributions, including experiences from Accredited Practising Dietitians and participants, were provided by Dietitians Australia members and members of Dietitians Australia's Disability Sector Expert Reference Group.

The role and value of Accredited Practising Dietitians

Understanding the role and scope of APDs in disability: critical information for the NDIA and disability workforce (Appendices A and B)

Dietitians Australia's published [Disability Role Statement](#) describes nutrition assessment, diagnosis, intervention, monitoring and evaluation; disability-specific knowledge; and collaboration within interdisciplinary teams. Capability varies with experience and further training. Assessors and support coordinators should understand that experienced disability APDs can mentor and supervise early career dietitians to safeguard participants and the quality of care (Dietitians Australia, n.d.-b).

Specialist disability-related nutrition care

Accredited Practising Dietitians (APDs) provide specialist assessment and intervention where a person's disability affects their ability to eat, drink, meet nutritional requirements or safely and effectively implement nutrition recommendations. Dietetic care in disability can be clinically complex because nutrition needs may be affected by the nature of the disability itself, multiple health conditions, medications, dysphagia, gastrointestinal issues, food aversions, cognitive or communication impairment, behaviours of concern, fluctuating health, dependence on others for food and mealtime support, and the person's living and support environment.

Comprehensive assessment and individualised intervention

APDs undertake comprehensive nutrition assessment and develop individualised interventions that take account of the person's disability, functional capacity, communication needs, preferences, goals and available supports. This may include management of malnutrition or unintended weight change; food fortification; allergies and intolerances; food aversions and restricted dietary intake; mealtime management;

nutrition-related consequences of medications and health conditions; tube feeding and oral nutritional supplements. APDs also assess whether recommendations can realistically be implemented by the person, family, carers or support workers and modify the intervention accordingly.

Enteral nutrition and tube-feeding management

For people requiring enteral nutrition or tube feeding, dietitians play an important clinical role across the continuum of care. This includes assessing whether enteral nutrition is appropriate, determining nutritional requirements and the appropriate feed or formula, developing and adjusting feeding regimens, monitoring nutritional adequacy and tolerance, managing nutrition-related complications and supporting people who receive enteral nutrition at home or in supported accommodation. Enteral nutrition may provide all or part of a person's nutritional requirements and requires ongoing professional monitoring because complications can include choking, aspiration, gastrointestinal symptoms and problems associated with the feeding tube.

Multidisciplinary and implementation support

Disability dietetics is collaborative. APDs work with the person, family and carers, disability support workers, supported accommodation providers and interdisciplinary health teams. They may provide disability-specific recommendations, develop mealtime or nutrition plans, advise residential and respite services, train or support those responsible for implementing nutrition recommendations, coordinate referrals and contribute to multidisciplinary management. More experienced disability APDs also manage people with multiple or complex comorbidities and provide specialist input into disability-related nutrition protocols, service development and policy.

Clinical complexity beyond general nutrition advice

The dietitian's role is not interchangeable with general nutrition information or routine food support. It involves clinical assessment, diagnosis of nutrition-related problems, evidence-informed intervention, monitoring and review, and adaptation of care to the interaction between disability, health conditions, function and the person's support environment. For people with complex disability, effective dietetic intervention may therefore require substantial assessment, liaison, implementation support, monitoring and coordination in addition to direct consultation time.

Autism

Nutrition concerns are also highly relevant for autistic children, young people and adults, who may experience food selectivity, restricted dietary variety and sensory-related eating difficulties (Ferrara et al., 2025). Differences in dietary intake and micronutrient status have also been identified compared with typically developing children (Alhrbi et al., 2025). Support should therefore be based on individual nutrition and feeding needs rather than diagnosis alone.

Counselling and behaviour change aspects

The counselling and behaviour change aspects of dietetic care are essential to helping people with disability, their families and care support teams to apply nutrition knowledge. Accredited Practising Dietitians provide clear, practical advice backed by the evidence and reasoning for recommendations, including examples of nutritious meals and strategies that families or support teams can sustain. Budget allocation should fund sufficient time for this work, rather than relying on brief consultations or the provision of a fact sheet.

Support needs assessment rules

Question 12. What parts of the support needs assessment process need more explanation?

R1 Identify nutrition and feeding needs

Dietitians Australia recommends that new framework planning explicitly recognise adequate nutrition and hydration as foundational to function, wellbeing and participation. Nutrition and hydration support physical function, cognitive performance, communication, mobility, emotional wellbeing, participation in daily activities and engagement in community life. They also help maintain muscle strength, immune function, skin integrity and overall health, reducing the risk of illness, fatigue, functional decline and avoidable hospital admissions. Without adequate nutrition and hydration, participants' capacity to engage in and benefit from other funded supports may be significantly reduced. Identifying and funding disability-related nutrition support needs should therefore be an integral part of assessment and planning. Dietitians Australia recommends a three-step pathway within new framework planning:

Step 1. Screen for disability-related nutrition support needs

The Department and NDIA should explain the screening questions, referral triggers and responsibilities for identifying disability-related nutrition, hydration and feeding needs. Screening should identify participants who:

- Have swallowing risks or an existing Mealtime Management Plan.
- Have difficulty eating or drinking adequately because of their disability, including psychosocial disability.
- Have disability-related changes in nutritional requirements that need individual assessment, including people with progressive conditions such as Huntington's disease.
- Rely on enteral (tube) feeding.
- Depend on others to provide food, prepare meals or assist with eating and drinking, including people receiving supported independent living or 24-hour support in their own home or specialist disability accommodation.
- Have reduced fluid intake, restricted dietary variety, unexplained weight change or difficulty sustaining adequate intake, including when communication, sensory needs or fluctuating capacity affect mealtimes.

Identified concerns should trigger appropriate dietary/nutrition assessment; screening results or diagnosis alone should not determine eligibility or funding amounts.

Step 2. Assess risks and quantify individual support requirements

Assessment should involve the participant, draw on available professional reports and seek APD and other relevant professional input where required. It should identify the type, amount and frequency of supports needed, including:

- **Dietetic supports:** APD assessment, intervention, monitoring, liaison and participant-specific worker training.
- **Consumables:** enteral feeds, oral nutritional supplements and feeding consumables.
- **Assistive technology:** clinically required feeding pumps and compatible equipment, with the applicable funding pathway explained.
- **Nursing supports:** input and delegation arrangements where required.
- **Personal care supports:** assistance with food preparation, eating, drinking and feeding as described in the NDIA operational guideline on nutrition supports including meal preparation (National Disability Insurance Agency, 2026).

Assessment should consider ongoing, recurrent and fluctuating needs, preferences and the support environment. It should identify support needed to maintain function or prevent deterioration, as well as to build skills. Informal support should reflect carers' actual capacity, willingness and sustainability, rather than assumed availability.

Step 3. Translate assessed requirements into funding

Funding for eligible disability-related nutrition supports should be guided by individual assessment and relevant APD reports. Budget decisions should clearly explain how the identified requirements translate into funding across dietetic services, nutrition products, equipment and daily assistance.

This would help ensure that recognising a nutrition need leads to a complete, coordinated support package that enables safe eating and drinking, daily function and participation.

APD expertise must inform dietary and nutrition assessments

The proposed targeted assessments include dietary/nutrition and dysphagia supports (Department of Health, Disability and Ageing, 2026b, Attachment 2, p. 19). These assessments must recognise the clinical expertise of Accredited Practising Dietitians (APDs) and incorporate relevant dietetic evidence.

Participants with complex nutrition needs may require specialised enteral nutrition, oral nutritional supplements, modified diets or additional mealtime support. These needs cannot be reliably determined through standardised questions alone.

The Department's own example shows the risk. The draft support needs assessment report records that the participant has a current mealtime management plan prepared by a speech pathologist and is recorded as needing daily support with eating and drinking, including '*you will eat quickly and need to be reminded to slow down*' (National Disability Insurance Agency, n.d.-b, p. 11). This could be a potential swallowing risk. The disability-related health supports section lists no dysphagia module among those considered, and dietary/nutrition supports were not assessed because the information provided did not meet requirements (pp. 17 and 21). Despite recording daily eating and drinking support needs and an existing mealtime management plan, the example does not explain whether further swallowing or nutrition assessment was considered, or how the missing information required for dietary/nutrition assessment would be obtained.

The NDIA should specify how APD assessments, feeding plans and clinical recommendations inform the type, quantity and frequency of nutrition supports. Assessors need training to recognise nutrition risks and seek specialist advice. Guidance should explain the information required, how current reports can be reused, and who arranges and funds any additional APD evidence so that lack of access to an assessment does not become a barrier to identifying need.

The NDIA should explain how nutrition concerns identified in shopping, cooking, eating and drinking, mental and emotional health, or behaviour-related domains trigger appropriate follow-up. A concern recorded outside the dietary/nutrition module should still be considered when determining whether APD input is needed. Assessment guidance should explain when collaborative input from an APD and other practitioners is required, including where reduced self-care or communication difficulties affect nutritional intake.

Require APD expertise and clinical evidence

Australian and New Zealand research highlights the importance of specialist knowledge in enteral nutrition. Reilly et al. (2025) found that professional development was significantly associated with greater clinician confidence in blended tube feeding. This reinforces the need for NDIA assessors to recognise the expertise of APDs and use dietetic reports when assessing complex nutrition needs.

R10 Demonstrate that the adapted I-CAN adequately identifies disability-related nutrition, hydration and mealtime support needs, including needs that are complex, fluctuate or may not be apparent during a single assessment.

The Department should explain how I-CAN is being modified for the NDIS and publish the evidence supporting its use across different disability cohorts. This should identify what has changed, where validation

is being undertaken, who is represented in testing and where evidence gaps remain. APDs need to validate the final tool in relation to all items that relate to dietetics, nutrition and hydration.

Explain how the I-CAN and PECQ work together and inform funded supports

Participants and practitioners need a clear explanation of how the adapted I-CAN tool and Personal and Environmental Circumstances Questionnaire (PECQ) work together, when targeted assessments are required, and how their findings influence funding. The Department should demonstrate how information from each component contributes to identifying therapy needs and calculating the budget. This must include how conflicting information is resolved and how needs identified in clinical reports are considered when they are not adequately captured by the standard assessment questions.

Require appropriately qualified professionals for targeted assessments

The Department should distinguish the NDIA assessor's role in completing a targeted module from the clinician's role in providing specialist assessment and evidence. Nutrition assessments and feeding regimens should draw on appropriately experienced APDs; swallowing assessment and texture or fluid-thickness recommendations require the relevant swallowing expertise. The rules should explain how clinical evidence informs both the core and targeted assessments.

Dietitians Australia and experienced disability APDs should contribute to the minimum information requirements, health-professional forms, questionnaires and assessor manuals, alongside participants and other relevant professions. Testing should follow nutrition-related needs through to the resulting support categories and budget, including needs that are identified across several assessment domains.

R9: The minimum requirements tables and health professional forms for the dietary/nutrition and dysphagia modules should be published with the exposure drafts, so that APDs can test them before the rules are made.

Provide flexible and specialist assessment pathways

The assessment process should offer reasonable communication and accessibility adjustments, multiple sessions where needed, and access to relevant specialist advice. The updated consultation paper (per 6/10/26) states that participants can request communication supports and accessibility requirements when they book the assessment (Department of Health, Disability and Ageing, 2026b, p. 7). The assessment process should also offer multiple sessions where needed and access to relevant specialist advice. It should accommodate cultural and language needs and the participant's chosen decision-making support. Where the assessment approach prevents an accurate account of need, a suitable alternative or replacement assessment should be available.

Assessment guidance should explain the period over which support needs are considered and how frequency and intensity reflect variation across days and weeks. Being able to complete one task during an assessment does not establish that a participant can sustain all daily activities. APDs raised cumulative demands and changing capacity as issues requiring attention, including the assistance needed to obtain, prepare and consume adequate food and fluids.

Use risk screening to prompt appropriate assessment

The coronial recommendation in Box 1 (Coroners Court of Queensland, 2019) supports attention to nutrition and swallowing risks in disability services. It does not validate a specific screening tool for NDIS planning.

A 50-year-old man with acquired brain injury and intellectual disability died from choking on a food bolus. The Coroner recommended:

"I recommend that National Disability Services note the findings and pass on to its members that they consider implementing as part of their respective policies and guidelines a Nutrition and Swallowing Checklist similar to one in use by Multicap and adapted from a document of the NSW Department of Ageing, Disability and Home Care for use by care providers who are providing disability care services to those who could be considered to be in a risk category for swallowing difficulties."

Box 1 Coronal recommendation following a death from choking¹

This Coronal recommendation reinforces the need for systematic identification of nutrition and swallowing risks within new framework planning. The screening pathway in Recommendation R1 should consider changes in intake, nutritional status and feeding arrangements. The following examples are prompts for professional assessment, not a complete or validated screening instrument:

- Weight history and other appropriate indicators of nutritional status, rather than BMI alone.
- Unintended weight change.
- Reduced food or fluid intake, including restricted dietary variety or difficulty maintaining intake.
- Reliance on enteral feeding or prescribed oral nutritional supplements.

Identified nutrition risks should prompt timely APD assessment; swallowing concerns should prompt assessment by the relevant swallowing professional. Findings should inform support requirements and the appropriate funding or plan-change pathway, as outlined in Recommendations R1, R3 and R5.

Question 13. What questions and feedback do you have about the draft support needs assessment report template?

R2 Complete evidence and explain assessment decisions

The template should show how clinical evidence leads to an assessed nutrition need and record when that assessment remains incomplete. The following changes would make it clearer for participants and delegates.

The template must include structured fields recording the evidence considered, its date, the APD recommendations, the assessor's findings and reasons for any departure from those recommendations. Keeping assessed support needs distinct from the subsequent funding decision is critical.

For enteral nutrition:

- Current APD evidence sufficient to identify nutritional requirements and the feeding regimen should be required.
- Accept a suitable existing report and seek an update only where clinically necessary or where specified information is missing.

¹ https://www.coronerscourt.qld.gov.au/data/assets/pdf_file/0008/609857/cif-davis-j-20190417.pdf

Recommendation R1 addresses how additional evidence is obtained and funded.

The draft example distinguishes dietary/nutrition needs that were considered from needs that were assessed. Dietary/nutrition supports were not assessed because the information did not meet requirements (National Disability Insurance Agency, n.d.-b, pp. 17 and 21). The nutrition outcome does not identify the missing information or explain how it can be provided. This fictional example demonstrates a reporting gap; it does not establish that the person is ineligible or that dietetic support is definitely required. Additionally, although disability-related health consumables levels are recorded on pages 17 and 18, the assessed supports summary on page 31 does not separately identify these supports or explain how those levels inform the subsequent budget calculation. This limits the transparency of the example, although the report notes that flexible funding may cover supports not listed in the summary.

The report template should distinguish an incomplete assessment from a finding of no identified need or a funding eligibility decision. It should specify the missing evidence, who will obtain it, how the participant can respond, and the next step before the relevant funding decision is finalised. The delegate's proposed completeness review should check that these issues have been resolved, with urgent support considered while outstanding evidence is obtained.

For each identified nutrition need, link the relevant core, personal/environmental and targeted findings to the proposed support categories. Record the amount and frequency of assistance, clinical review and products required, any assumptions about informal care, and the participant's comments or disagreement. State the contact, next action and expected process for correcting omissions. A participant should not be left to infer that "not assessed" means "not needed".

Question 14. In what circumstances do you think a replacement assessment should be arranged?

The NDIA should distinguish *correcting or completing a report from replacing an assessment*. Missing APD evidence should first be sought where it can resolve an incomplete nutrition assessment. A replacement assessment should be considered when a material problem with the process or findings cannot be remedied through correction, clarification or additional evidence. Examples include unresolved omission of relevant clinical evidence, an inaccessible assessment process, or failure to account for material fluctuation in support needs. These circumstances are distinct from a later plan variation or reassessment.

Compare newly assessed supports with previous plans

Compare assessed needs with existing support arrangements and explain material differences. An unexplained reduction in essential support should trigger a check of both the assessment evidence and the budget calculation. A calculation error requires correction; it does not automatically justify repeating an otherwise sound assessment. Where material assessment concerns remain unresolved, arrange independent review and consider a replacement assessment.

Enable others to raise assessment concerns

Providers, carers and advocates should be able to raise concerns with NDIA delegates and request consideration of a replacement assessment where participants cannot do so themselves. They should explain why they are raising the concern and why they are appropriate to act, with participant consent or representative authority where required.

Budget method rules

Question 15. Further information and details about the budget method and calculations will be provided later in 2026 after more testing is done. What information would help participants understand how a budget is calculated?

R3 Explain and individualise nutrition funding

Attachment 4 of the New Framework Planning Rules consultation paper (Department of Health, Disability and Ageing, 2026b, p. 23) states that Disability-related Health Supports – Consumables will be funded at “funding levels based on targeted assessment module and benchmark pricing”.

Enteral nutrition costs vary considerably depending on the prescribed product, whether this is standard formula, disease-specific formula or commercial blended tube feeding, as well as the volume required, growth and individual tolerance. If the benchmark is based on standard formula, participants who require more specialised or expensive products risk being underfunded. Box 2 describes examples of complex needs that should be reflected in individual funding calculations.

Brian, a person with cerebral palsy at Gross Motor Function Classification System (GMFCS) Level V, experiences formula intolerance, reflux and vomiting. He needs to transition to a commercial blended feed, which can cost significantly more. Funding calculations should reflect the assessed product and quantity required.

Maria has dystonia; assessment should establish whether associated movement or muscle activity increases her individual energy requirements, and, consequently, the quantity of nutrition support required.

Box 2 Illustrative examples of complex nutrition needs

A shortfall in essential nutrition funding could require participants to divert funds from other assessed needs. The budget should therefore be tested against the complete nutrition support package, rather than assuming spare funds are available elsewhere.

The NDIA should explain how the dietitian-prescribed regimen, feeding plan and relevant product quotes inform enteral nutrition funding, including when individual evidence justifies a departure from a benchmark.

The NDIA should publish what each consumables benchmark covers, including quantities, compatible components and replacement assumptions, and explain how participants can submit APD evidence and quotes where it does not meet individual requirements. APDs described differences between feeding systems that require different accessories. Funding should account for the complete prescribed system and product-specific instructions, rather than the feed or main device alone.

Consumables calculations should also be considered alongside the assistance required to use them safely. A lower allowance for cheaper disposable items may increase preparation or cleaning work. These tasks should be assessed against the product instructions and the participant’s support arrangements, without assuming that participants or informal carers can absorb additional work.

Publish how remoteness adjustments, reasonable access and delivery costs, and informal-support offsets affect the calculation. Explain how participants can challenge assumptions that do not reflect actual service availability or sustainable informal care. Test the resulting package against the work needed to prepare and administer feeds, provide fluids, clean compatible equipment and monitor the plan, without double-counting tasks across categories. Attachment 4 (p22) also applies an aged care offset to disability-related health

supports nursing and consumables; the Department should explain how that offset is calculated and what it means for a participant's enteral feeds or oral nutritional supplements or dietetic supports.

Explain how therapy funding is calculated

The *budget fact sheet* describes therapy funding mainly as a relative estimate of need, while disability-related health supports use direct hours and consumables use quotes or benchmarks. The Department should publish how these methods apply to dietetic assessment, intervention, monitoring and training, including how evidence of complex needs changes the calculation (Department of Health, Disability and Ageing, 2026g, pp. 3–4).

Recognise the time required for complex dietetic care

Complex enteral nutrition care requires sufficient time for assessment, feeding plan development, education and monitoring. Reilly et al. (2025) found that 63.2% of surveyed health professionals identified time commitments as a barrier to blended tube feeding. NDIS budget calculations should recognise the professional time required to safely prescribe, implement and monitor individualised feeding regimens.

Participants should receive an understandable explanation of how their assessed needs lead to the budget. For nutrition supports, this should identify the relevant assessment findings, calculation method, assumptions and any adjustments or offsets, together with how individual clinical evidence was considered. A worked example should show the relationship between dietetic input, consumables, equipment and daily assistance, including how a participant can question an assumption that does not reflect their circumstances.

Funding should recognise clinically justified monitoring and maintenance of function, not only short-term skill gains. Show how review frequency and participant-specific training are calculated, including when a new support team must learn an existing feeding plan. The proposed therapy description already includes maintaining functional capacity (New Framework Planning Rules consultation paper, Department of Health, Disability and Ageing, 2026b, Attachment 3), and the amending rule for therapy supports in the NDIS Supports paper describes supports that 'improve, maintain or reduce the decline in' functional capacity (Department of Health, Disability and Ageing, 2026a, Attachment 1, item 34). Dietitians Australia notes that one of the most basic human functions, eating and drinking, is excluded from the new Therapy Description on page 18. 1. In Q15, replace the sentence saying eating and drinking are "excluded" with:

R11 Include 'eating and drinking, meeting nutrition and hydration needs' in new therapy supports description on p18 in the NDIS Supports Transitional Rules

Current	Change to:
"20. Therapy support: Supports that provide evidence-based therapy to help participants improve or maintain their functional capacity in areas such as language and communication, personal care, mobility and movement, interpersonal interactions, functioning (including psychosocial functioning) and community living. This includes an assessment by allied health professionals for support planning and review as required". (Department of Health, Disability and Ageing, 2026a, Attachment 1, item 34, p18).	"Supports that provide evidence-based therapy to help participants improve or maintain their functional capacity in areas such as eating and drinking, meeting nutrition and hydration needs, language and communication, personal care, mobility and movement, interpersonal interactions, functioning (including psychosocial functioning) and community living. This includes assessment by allied health professionals for support planning and review as required."

Question 16. What questions and feedback do you have about the draft participant plan template?

R4 Make plans usable and protect continuity

The draft participant plan example distinguishes restricted and unrestricted flexible funding. Consumables sit within the unrestricted categories, while in-home and community supports are restricted because of an identified safety risk (draft participant plan, National Disability Insurance Agency, n.d.-a, pp. 2, 4–5). The example does not show a participant's complete nutrition package. It lists no therapy or nursing category in the flexible budget, although the participant sees a speech pathologist and an occupational therapist (p. 11), and it uses 'low-cost assistive technology' where the consultation paper uses 'Assistive technology – other'. A nutrition-specific version should connect assessed requirements with APD input, consumables, equipment and daily assistance, and explain any restrictions without assuming every nutrition support must be restricted. Dietitians Australia does not seek restrictions on how nutrition funding is spent; it seeks plans that make the assessed nutrition package visible so participants can protect it.

For any restriction, show the reason, supports covered, conditions and route for reconsideration. Present funding periods, available amounts, adjustments and escalation contacts together so participants can identify a risk to essential supplies early. The plan or accompanying explanation should show how individual nutrition requirements informed the budget while preserving flexibility in its use.

Offer the optional plan implementation discussion in an accessible format. For complex nutrition needs, use it to confirm who will arrange supplies and equipment, implement the feeding plan, provide training, monitor progress and respond to problems. Explain correction and review routes at the relevant decision stage; page 17 of the draft plan refers to an external review after an internal review, which needs a clearer context for a participant receiving an initial plan.

Plan variation and reassessment rules

Question 17. What feedback and questions do you have about plan variations?

R5 Respond promptly to changing nutrition needs

Enteral feeding regimens may change because of nutritional requirements, tolerance, product availability, a tube change or hospital admission. Growth-related changes will also matter as relevant age groups enter the framework. The variation fact sheet already allows small, targeted or short-term changes, urgent health and safety changes, and changes based on updated quotes or reports (Department of Health, Disability and Ageing, 2026d, pp. 1–3).

The Department and NDIA should publish nutrition-specific examples showing when an updated APD feeding plan can support a targeted plan variation and when significantly changed, ongoing support needs require reassessment. Use a consistent test across resources: the fact sheet says a reassessment is used when 'support needs have changed significantly, and those changes are ongoing' (Department of Health, Disability and Ageing, 2026d, p. 3), whereas the summary paper says a reassessment 'may be used when a participant's support needs have changed a lot or the change is ongoing' (Department of Health, Disability and Ageing, 2026e, p. 3).

The size of a funding increase alone should not determine the pathway. A substantial product or price change may affect only one part of a plan while the underlying support needs remain known. Guidance should explain how such changes can be considered through a variation where a full reassessment is unnecessary, and how urgent nutrition supports will continue while any significant ongoing change is assessed.

Show how the urgent variation pathway applies when a participant leaves hospital with a new disability-related tube-feeding need. Guidance should explain how urgent supplies, APD input, worker training and

coordination are arranged while any significant ongoing change is assessed. Provide a clear escalation contact, risk-based response expectations and progress updates, rather than requiring participants to resolve the administrative classification before urgent risks are addressed.

Clarify how plan changes can be requested

There must be a clear process for requesting plan variations and reassessments. Providers should be able to initiate requests with appropriate participant consent or representative authority, particularly where participants cannot navigate the process themselves.

Changes in living or care arrangements can alter the work needed to implement an existing nutrition plan. APDs described additional documentation, monitoring and training when a new support team becomes involved. Decisions about a plan change should consider these actual support requirements, rather than assume that every move between living arrangements requires the same process.

Guidance should also cover recurrent and fluctuating disability-related nutrition needs and predictable changes in requirements, including growth as relevant age groups enter the framework. It should explain how updated evidence is considered where support intensity changes without permanent deterioration in the underlying condition, while distinguishing health treatment from disability-related assistance.

Distinguish urgent clinical care from a request to adjust NDIS funding. Administrative escalation must not be presented as a substitute for clinical assessment where a participant is acutely unwell. For disability-support changes, identify the responsible contact, information needed, interim arrangements and the next decision, including when a prescribed product becomes unavailable.

Changes to NDIS support rules

Question 18. What feedback do you have about changes to NDIS supports for old and new framework planning?

R6 Dietitians are essential to safe, rights-based daily living

Dietitians Australia supports clearer, purpose-based categories across old and new framework planning, provided the changes preserve access to eligible disability-related nutrition and feeding supports. Guidance should explain the change from current categories and prevent clinically equivalent supports being treated differently because of product form or category labels. It should recognise APDs' contribution to safeguarding, dignity and participant choice and control at mealtime while preserving each profession's scope.

Dietitians Australia recommends explicitly referencing dietitians in policies, guidelines, and incident-prevention frameworks around:

- Choking and aspiration risk
- Malnutrition and weight loss
- Food-related restrictive practices and behaviour support plans
- Dignity in mealtimes and choice and control.

This includes:

- Safeguarding standards and practice guidelines
- Mealtime management and dysphagia frameworks
- Behaviour support and restrictive practice policies.

APDs raised concerns about participants being directed to other service systems without a workable route to support. Guidance should distinguish treatment of a health condition from the disability-related assistance needed to access care or implement a nutrition plan. The presence of a coexisting health condition should prompt consideration of the specific support and functional need, rather than a blanket conclusion about all dietetic care.

Where another system is responsible, decisions should identify the relevant service or product, confirm the participant's eligibility and consider practical access, including cost, transport, communication and service delivery arrangements. The Department and NDIA should work with the relevant agencies on clear handover and escalation arrangements when gaps remain.

Question 19. Are the proposed support categories clear?

The categories are not yet sufficiently clear for nutrition supports. The title "Disability-related health supports – Nursing" does not convey the allied health role already included in its description. Use a title reflecting both nursing and allied health, and align it across the papers, assessment tools and plan templates. The NDIS Supports paper already uses the shorter title 'Disability-related health supports' and describes delivery 'by or under the supervision of clinically trained nursing staff or allied health practitioners' (Department of Health, Disability and Ageing, 2026a, Attachment 1). That title and description should be carried into the New Framework Planning paper, the budget fact sheet and the plan template.

Publish a mapping of APD assessment, intervention, monitoring, liaison and worker training to the relevant categories, and explain how these connect with consumables, equipment and daily assistance. Different categories use different calculation methods; mapping should ensure the full package is considered without counting the same task twice (Recommendation R3).

For the same nutrition task, specify when APD input is funded as Therapy or disability-related health support, when nursing input is separately needed, and where daily implementation sits. An APD recommendation should not be treated as requiring nursing supervision solely because of a category title. Allocation should follow the task and required competence.

Question 20. Are there areas where further explanation, guidance or examples would be helpful?

Use consistent participant examples

Provide linked examples that follow the same participant from assessment to budget and plan implementation. The current examples use different participant profiles, making the relationship between documents harder to follow.

Worked examples should include a person with complex nutrition needs and show the assessment evidence, any request for further information, budget calculation and implementation arrangements. Examples should also show what happens when support needs fluctuate or a feeding regimen changes, and identify the respective responsibilities of the participant, assessor, APD and other providers.

Terminology also differs between resources. The fourth part of the assessment is 'assessed categories of NDIS supports' in the consultation paper and 'instructions to assessors' in the support needs assessment fact sheet. 'Short term accommodation' in the consultation paper is 'short term respite' in the budget fact sheet. The draft plan uses 'low-cost assistive technology' for 'assistive technology – other'. The draft report lists 'daily supports' and 'travel and transport arrangements', which are not categories. The NDIS Supports paper lists 18 categories, while its Attachment 1 numbers the amending rule to 20 and includes 'early intervention supports for early childhood'. One glossary should govern every resource, and the exposure drafts should use it.

Question 21. Are there particular support types where more guidance may be needed?

The current *National Disability Insurance Scheme (Getting the NDIS Back on Track No. 1) (NDIS Supports) Transitional Rules 2024* (Cth), Schedule 1, item 9, specifically includes “modified foods, including for the purposes of percutaneous endoscopic gastrostomy feeding” under assistive products for personal care and safety. In contrast, the proposed Disability-related Health Supports - Consumables category refers more broadly to “nutrition”, without explicitly mentioning enteral nutrition products. The mapping in Attachment 1 sends item 9 to three new categories, assistive technology – assets, assistive technology – other and disability-related health supports – consumables, so a participant or planner cannot tell from the rule where enteral feeds and modified foods will sit. The rules and accompanying guidance should clearly identify where enteral feeds and modified foods sit within the new categories (Department of Health, Disability and Ageing, 2026a, Attachment 1, item 9).

Under Recommendation R6, explicitly identify the following disability-related supports and explain the applicable eligibility, evidence and funding pathway:

- Enteral feeds, including commercial blended tube-feeding formulas where individually recommended by an APD.
- Enteral feeding consumables and compatible accessories, including clinically justified quantities and replacements.
- Texture-modified nutrition products, fluids and thickeners where required, distinguishing swallowing recommendations from APD assessment of nutritional adequacy.
- Clinically necessary feeding equipment, including high-powered blenders where appropriate for an individually assessed blended tube-feeding regimen, under a clearly specified assistive technology pathway.
- Prescribed oral nutritional supplements, including ready-to-drink and powdered forms where clinically appropriate. Guidance should assess clinical purpose, disability-related need and the suitability of alternatives, rather than preparation form alone (see Appendix C).

This is particularly important for blended tube feeding. Some APDs have mentioned that most of their enterally fed caseload in complex disability uses blended feeds. The APDs also report a significant improvement in outcomes for these participants. This also aligns with findings reported in the literature. In an Australian and New Zealand survey of 89 health professionals, predominantly dietitians (84.1%), 63% of respondents reported positive outcomes associated with blended tube feeding, including reduced vomiting (73%) and constipation (73%) (Reilly et al., 2025). These findings reflect clinician reports. A 2023 systematic review of seven studies (n = 267) reported positive outcomes, especially in the areas of growth, tolerance, gastrointestinal symptom control, and medication reliance, with few reports of adverse events (McCormack et al., 2023). Given the potential benefits for participants, blended feeds need to remain clearly recognised as a fundable support where recommended and clinically appropriate.

Fund necessary equipment and protect participant choice

Reilly et al. (2025) found that 81.8% of surveyed health professionals identified limited access to necessary equipment, such as blenders, as a constraint on blended tube feeding. This supports explicitly recognising clinically necessary feeding equipment within the NDIS supports rules, enabling participants to access appropriate feeding options based on individual clinical needs and preferences. Recommendation R6 seeks a clear pathway that distinguishes an ordinary household appliance from a participant’s assessed disability-related requirement; Question 23 addresses removal of the replacement-supports route.

Guidance should distinguish disability-related nutrition products and the additional support needed to prepare or consume food from ordinary grocery costs. Clinical recommendation is necessary evidence where relevant, but does not remove the requirement to meet the applicable NDIS support rules.

Question 22. Are there any practical issues or unintended impacts that need to be considered further?

Competing demands within a flexible budget could interrupt essential nutrition supplies or necessary APD review. Recommendation R4 seeks proportionate safeguards, including clear allocation, information, confirmed implementation responsibilities and an escalation contact when continuity is at risk. A service agreement alone does not establish budget adequacy. Any restriction should be individually justified and reviewable, and safeguards should preserve participant choice. If people do not understand the clinical rationale for dietetic services and move funding to a different therapy support, participants safety may be at-risk, such as choking. The risk is not that participants choose how to use flexible funding. It is that a plan which does not show the nutrition package leaves a participant, or a new support team, unable to see which products, reviews and training keep eating and drinking safe. Clear plan information and the implementation discussion address this (Recommendation R4).

Other implementation risks include unmet evidence requests delaying assessment, local shortages of appropriately skilled APDs, and training or coordination work falling between categories. These risks should be tested during rollout, including in rural and remote locations, and addressed through the access, budgeting and implementation measures in Recommendations R1–R5.

Question 23. What impacts do you think will be experienced as a result of removing replacement supports? What items or services will no longer be available?

Before removing the replacement supports process, the Department should clarify the funding route for clinically necessary food-preparation equipment, including a high-powered blender where an APD recommends blended tube feeding. Guidance should distinguish ordinary household use from the participant's specified disability-related requirements and explain which assistive technology criteria apply. The proposed removal does not by itself establish that every such item will become unavailable, but any gap between replacement supports and ordinary assistive technology pathways should be identified and addressed before implementation.

General questions

Question 24. What information was most useful?

The fact sheets usefully distinguish assessment, budget calculation and plan changes. The targeted assessment domains and draft templates make the proposals more concrete. Explicit recognition of dietary/nutrition needs is welcome. Their value would increase if the examples followed one participant through to funded and implemented nutrition supports, and if terminology were consistent across resources.

Question 25. What questions do you still have?

- How will existing long plans transition, including where essential nutrition products or dietetic input are already funded?
- How can participants question an assessment or budget assumption before it interrupts support?
- When will the detailed nutrition assessment requirements, budget assumptions and individual exception processes be available for scrutiny?
- The published transition timetable does not by itself explain how these safeguards will operate for an individual participant?

- What proportion of participants in NDIA testing have triggered the dietary/nutrition or dysphagia targeted assessments, and how many of those assessments were completed with the required professional evidence?

Question 26. What would help people with disability better understand the NDIS new framework planning rules?

R7 Build nutrition capability in the NDIS workforce

People with disability need clear, accessible information and a knowledgeable workforce to help them understand how the new planning rules apply to their circumstances. Assessors, planners, support coordinators and local area coordinators need to recognise disability-related nutrition, hydration and feeding needs, know when an APD assessment is required, and explain how nutrition supports are funded.

Dietitians Australia recommends adapting its Capacity Building in Disability for Dietitians resource to equip assessors and NDIS workers to explain disability-related nutrition supports, support informed decision-making and guide participants through assessment and planning. Dietitians Australia recommends that the NDIA include these elements in assessor, planner and support coordinator training. Workforce education does not replace individual clinical assessment by an APD.

The CBDD program was co-designed with the Australian Federation of Disability Organisations (AFDO) and informed by people with disability, families and carers. Its education and supervision components provide an established foundation for developing tailored workforce training.

Capacity Building in Disability for Dietitians (CBDD) training resource

Dietitians Australia has developed the [Capacity Building in Disability for Dietitians \(CBDD\) training resource](https://dietitiansaustralia.org.au/advocacy-and-policy/capacity-building-disability-dietitians) to strengthen dietitians' knowledge, skills and confidence in responding to the needs of people with disability and improving access to timely, inclusive, appropriate and high-quality dietetic services <https://dietitiansaustralia.org.au/advocacy-and-policy/capacity-building-disability-dietitians>.

Dietitians Australia recommends adapting this resource to build nutrition-related capability across the broader NDIS workforce, including:

- NDIA support needs assessors
- planners and delegates
- support coordinators
- psychosocial recovery coaches
- local area coordinators
- disability support workers
- supported independent living and accommodation providers
- other allied health professionals
- nurses and other health and community professionals involved in supporting people with disability.

Building on existing Programs to Deliver Cost-Effective Workforce Training

Tailored training could strengthen workforce understanding of disability-related nutrition, hydration, feeding and mealtime support needs, including the early identification of malnutrition, dehydration, swallowing difficulties and other nutrition-related risks. It could also improve recognition of when an Accredited Practising Dietitian (APD) assessment or referral is required, how to interpret and implement dietetic recommendations, and how to appropriately document nutrition-related support needs within the new NDIS planning framework. Training should cover the early identification of malnutrition, dehydration, swallowing difficulties and other nutrition-related risks, when an APD assessment or referral is required, how to interpret and implement dietetic recommendations, and how to document nutrition-related support needs within new framework planning. Appendix C gives a case study and example learning outcomes.

We recommend that the NDIA work with Dietitians Australia to co-design and implement role-specific training, ensuring that nutrition-related needs are consistently recognised throughout support needs assessment, budget determination, plan implementation and ongoing support delivery. This would

strengthen participant safety, support informed decision-making and improve access to appropriate dietetic care, while recognising that workforce education does not replace individual clinical assessment by an APD.

Build on an existing professional education program

The government-funded Capacity Building in Disability for Dietitians program provides introductory and intermediate courses, practical workshops, webinars and supervision. Its public resources address tube feeding, psychosocial disability, communication, supported decision-making and cultural inclusion. The 2026 supervision program involved eight experienced supervisors over six months (Dietitians Australia, n.d.-a). We recommend funding adaptation of relevant material for the broader NDIS workforce, co-designed with people with disability and evaluated for quality and implementation. A qualitative evaluation interviewed 15 participating dietitians and explored reported changes in practice (Thompson & Morris, 2023). The program provides an existing delivery platform that can be adapted and tested.

Question 27. What communication formats would make the information more accessible?

Dietitians Australia recommends providing plain-language and Easy Read information, accessible digital and printable documents, captioned video, audio, Auslan and translated materials. Participants should also be able to obtain an explanation through a trained contact person and involve their chosen supporter. People with disability should help design and test these formats, including people with communication or cognitive support needs and those who cannot readily use digital services.

Question 28. What should we focus on in future communication products?

R8 Test accessible information and the complete pathway

The Department and NDIA should co-design and test a consistent set of accessible resources explaining the route from identifying need to obtaining evidence, calculating funding and using a plan. Priorities include urgent nutrition changes, restrictions and funding periods, review and escalation routes, and continuity during transition. Reconcile the budget fact sheet's description of spending 'across the flexible supports categories' (Department of Health, Disability and Ageing, 2026g, p. 4) with the NDIS supports fact sheet's narrower 'across supports in the same category' (Department of Health, Disability and Ageing, 2026c, p. 5), and resolve the inconsistencies listed under Question 20 in the same pass. Use one linked participant example and make the implications clear for both old and new framework plans.

Conclusion

Dietitians Australia welcomes continued involvement in developing and testing new framework planning. The key recommendation and supporting Recommendations R1–R11 provide a practical route from identifying disability-related nutrition, hydration and feeding needs to adequate funding and implementation. Clear assessment pathways, transparent budget decisions and timely responses to changing needs are necessary to translate recognition of nutrition into practical support. The exposure drafts and implementation guidance should demonstrate how participants will obtain the dietetic care, products, equipment and assistance required to meet their assessed disability-related nutrition and hydration needs. These recommendations build on Dietitians Australia's March 2026 submission on the discussion paper, which asked for the I-CAN to be validated across impairment categories and for dietetic reports to inform support needs assessments (Dietitians Australia, 2026).

References

Alhrbj, A., Vlachopoulos, D., Healey, E. M., Massoud, A. T., Morris, C., & Revuelta Iniesta, R. (2025). Nutritional status of children diagnosed with autism spectrum disorder: A systematic review and meta-analysis. *Journal of Human Nutrition and Dietetics*, 38(4), e70099. <https://doi.org/10.1111/jhn.70099>

- Coroners Court of Queensland. (2019, April 17). Inquest into the death of John Davis: Findings of inquest. https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/609857/cif-davis-j-20190417.pdf
- Department of Health, Disability and Ageing. (2026a, August). NDIS Supports Transitional Rules: Consultation paper. https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/consultation-paper---ndis-supports_final.pdf
- Department of Health, Disability and Ageing. (2026b, August). New Framework Planning Rules: Consultation paper (updated 6 October 2026). https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/consultation-paper---new-framework-planning_updated-20261006-1.pdf
- Department of Health, Disability and Ageing. (2026c). New framework planning: NDIS supports [Fact sheet]. https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/ndis-new-framework-planning---ndis-supports---fact-sheet_final-2.pdf
- Department of Health, Disability and Ageing. (2026d). New framework planning: Plan variations and reassessments [Fact sheet]. https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/ndis-new-framework-planning---plan-variations-and-reassessments---fact-sheet_final-1.pdf
- Department of Health, Disability and Ageing. (2026e, August). New Framework Planning Rules: Summary paper (updated 6 October 2026). https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/summary-paper---new-framework-planning_updated-20261006-2.pdf
- Department of Health, Disability and Ageing. (2026f). New framework planning: Support needs assessment [Fact sheet] (updated 6 October 2026). https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/ndis-new-framework-planning---support-needs-assessment---fact-sheet_updated-20261006-2.pdf
- Department of Health, Disability and Ageing. (2026g). New framework planning: Working out a reasonable and necessary budget for a participant [Fact sheet]. https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/ndis-new-framework-planning---working-out-a-budget---fact-sheet_final-1.pdf
- National Disability Insurance Agency. (n.d.-b). Draft support needs assessment report for new framework planning [Example template; consultation resource]. https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/draft-support-needs-assessment-report-for-new-framework-planning-2.pdf
- National Disability Insurance Agency. (n.d.-a). Draft participant plan and budget for new framework planning [Example template; consultation resource]. https://consultations.health.gov.au/disability-and-carers-group/nfp-ndis-supports/user_uploads/draft-participant-plan-for-new-framework-planning.pdf
- Dietitians Australia. (n.d.-a). Capacity building in disability for dietitians. <https://dietitiansaustralia.org.au/advocacy-and-policy/capacity-building-disability-dietitians>
- Dietitians Australia. (n.d.-b). Disability role statement. <https://dietitiansaustralia.org.au/working-dietetics/standards-and-scope/role-statements/disability-role-statement>
- Dietitians Australia. (2026, March). NDIS New Framework Planning Rules: Response to public consultation on new framework planning discussion paper. <https://dietitiansaustralia.org.au/media/1301>
- Ferrara, R., Iovino, L., Ricci, L., Avallone, A., Latina, R., & Ricci, P. (2025). Food selectivity and autism: A systematic review. *World Journal of Clinical Pediatrics*, 14(3), 101974. <https://doi.org/10.5409/wjcp.v14.i3.101974>
- McCormack, S., Patel, K., & Smith, C. (2023). Blended diet for enteral tube feeding in young people: A systematic review of the benefits and complications. *Journal of Human Nutrition and Dietetics*, 36(4), 1390–1405. <https://doi.org/10.1111/jhn.13143>
- National Disability Insurance Scheme (Getting the NDIS Back on Track No. 1) (NDIS Supports) Transitional Rules 2024 (Cth), Schedule 1, item 9. <https://www.legislation.gov.au/F2024L01257/asmade/text>
- National Disability Insurance Agency. (2026, August 3). *Nutrition supports including meal preparation*. <https://www.ndis.gov.au/media/7802/download?attachment>
- Reilly, C., Ross, N., Watene, S., Lindeback, R., Coelho, T., Krishnan, U., Perez, W. P., Chandrasekar, N., Yap, J., Breik, L., & Arrowsmith, F. (2025). A study of professional practices, attitudes and barriers to blended tube feeding in Australia and New Zealand. *Nutrition & Dietetics*, 82(2), 143–151. <https://doi.org/10.1111/1747-0080.12909>
- Thompson, C., & Morris, D. (2023, September). Evaluation of the Capacity Building in Disability for Dietitians education program: Report on interview findings. Centre for Health Service Development, University of Wollongong. <https://dietitiansaustralia.org.au/media/1081>

Appendix A Disability Role Statement for APDs.²

This role statement was developed by members of the Disability Interest Group.

It lists the knowledge and skills of an Accredited Practising Dietitian (APD) working in the disability area.

Knowledge

- Nutrition-specific evidence relating to a specific disability and implementation of evidence informed practice including regular review and reflection on outcomes.
- Impacts, interactions and side effects of medications, diet modifications, particular foods, fluids, nutritional supplements and thickeners that may be commonly used in the care of people with a disability.
- Popular diets and nutrition misinformation relating to specific disabilities.
- Policies, procedures and guidelines relating to health care in disability in line with the mandatory organisation/site specific, state and federal policy directives (for example, use of restricted or restrictive practice).¹⁻⁴
- Disability-related funding that may impact an individual's access to health and dietetic care (for example, National Disability Insurance Scheme) and requirements of dietitians in relation to this including realistic implementation within community settings.⁵
- Awareness and utilisation of the International Classification of Functioning to inform nutrition assessment, care plans and decision making.⁶

Skills

- Consideration of accurate and relevant data, unique features of the client's disability, and related nutrition impact symptoms, physical and cognitive limitations, and communication difficulties when conducting a nutrition assessment and developing a plan.^{7,8}
- Ability to determine health priorities for complex disability clients with multiple comorbidities using evidence base and clinical experience to inform practice.
- Ability to ethically work with clients with a disability who have intellectual/cognitive/memory impairments, behavioural disturbances and mental health co-morbidities. For example, working within scope of practice as part of an interdisciplinary team, delivering person-centred care using social justice principles, understanding informed consent and supported decision-making, and that behaviours are a form of communication.
- Assess the capacity and capability of people with a disability and/or their carers to follow dietetic recommendations and adjust interventions accordingly.
- Collaboration with clients, families, group homes, client support networks and interdisciplinary disability related health teams working within the person-centred practice paradigm, considering the individual's needs, abilities, preferences, choices and aspirations.
- Confident identification of the most appropriate method to effectively communicate with clients, families and/or support workers with a range of cognitive abilities to deliver disability-specific nutrition recommendations using evidence-based reasoning.

Activities entry level APDs would conduct

- Nutrition assessment utilising the most appropriate methods, intervention and monitoring considering key disability-specific issues (For example, dysphagia, mealtime behavioural issues, menu

² <https://dietitiansaustralia.org.au/working-dietetics/standards-and-scope/role-statements/disability-role-statement>

choice, supports in day-to-day life, cognition, fluctuating health, level of intellectual impairment and client capacity to self-monitor, client access to services, communication or environmental stressors).

- Provide nutrition therapy for individuals with disabilities without complex comorbidities (For example, enteral feeding regimens, food fortification, healthy eating, food aversions, food allergies, mealtime management plans).
- Referral to and coordination with specialist/support services available for people with disabilities.
- Ability to work within scope as part of an interdisciplinary team, and appropriately identify when to refer on and/or be guided by more experienced clinicians (For example, inborn errors of metabolism or management of a ketogenic diet for epilepsy).
- Provide consultation and recommendations for meal planning in disability-related residential and respite facilities.

Activities APDs working at a higher level would conduct

- Provide nutrition therapy for individuals with disabilities who have complex comorbidities (For example, eating disorders, psychiatric illness with behaviours of concern, metabolic conditions including phenylketonuria (PKU)).
- Intuitively utilise advanced nutrition and dietetic skills acquired, and recognise other clinicians' knowledge and skills to successfully problem solve and implement effective interventions.^{7,8}
- Facilitate a transdisciplinary approach when working with individuals with disabilities to implement holistic strategies that promote wellbeing.
- Design, develop and actively participate in research that informs policies and best practice for people with disabilities.
- Ability to confidently communicate at organisation and government levels to advocate for disability-specific nutrition priorities with evidence-based reasoning.
- Act as a nutrition resource to dietitians and members of the interdisciplinary team on application of disability related nutrition protocols and guidelines to an individual client or population. This includes the mentoring/supervision of students or less experienced dietitians as well as other health professionals.^{7,8}

Activities APDs working in this area of practice do not usually undertake

- Assessments of swallowing or making food texture and fluid thickness recommendations.
- Assessments of safety and functioning while cooking.
- Assessments of physical activity capacity.
- Assistance with feeding at mealtimes.

References

1. NSW Department of Family and Community Services and Cerebral Palsy Alliance [Internet]. Cerebral Palsy Alliance; 2017. Dietetic core standards for disability. Available from: https://member.dietitiansaustralia.org.au/Common/Uploaded%20files/DAA/Resource_Library/2020/Dietetic_Core_Standards_Disability_2016.pdf
2. Child Family Community Australia. Australian Government: Australian Institute of Family Studies; 2020. Mandatory reporting of child abuse and neglect; June 2020. Available from: <https://aifs.gov.au/cfca/publications/mandatory-reporting-child-abuse-and-neglect> Australian Government. Australian Government: Department of Social Services; 2013.
3. National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector. Available from: https://www.dss.gov.au/sites/default/files/documents/04_2014/national_framework_restrictive_practices_0.pdf

4. Department of Health and Human Services. 2020. The Allied Health capability framework: disability and complex support needs. Available from: <https://www2.health.vic.gov.au/health-workforce/allied-health-workforce/ahcf-disabilitycomplex-support-needs>
5. National Disability Insurance Scheme. Australian Government; National Disability Insurance Agency: 2018. NDIS. Available from: <https://www.ndis.gov.au/>
6. World Health Organisation. Geneva: WHO; 2001. International classification of functioning, disability & health. Available from: <http://www.who.int/classifications/icf/en>
7. Conway C, Lemons S, Terrazas L. Academy of Nutrition and Dietetics: Revised 2020 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Intellectual and Developmental Disabilities. J Acad Nutr Diet. 2020; 120 (12): 2061 - 2075. Available from: <https://doi.org/10.1016/j.jand.2020.08.094>
8. Ptomey LT, Wittenbrook W. Position of the Academy of Nutrition and Dietetics: Nutrition Services for Individuals with Intellectual and Developmental Disabilities and Special Health Care Needs. J Acad Nutr Diet [Internet]. 2015 Apr 01; 115 (4) : 593-608. Available from: [https://jandonline.org/article/S2212-2672\(15\)00121-5/fulltext](https://jandonline.org/article/S2212-2672(15)00121-5/fulltext)
9. United Nations General Assembly. 2007. Convention on the Rights of Persons with Disabilities, NY; <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

Appendix B Enteral feeding ³

Key points

- Enteral nutrition is used when a person has trouble meeting their nutrition needs orally.
- Enteral nutrition comes in the form of liquid formulas given through a feeding tube.
- Tube feeding delivers nutrition directly into the stomach or small intestine.
- Common reasons for tube feeding include swallowing problems, critical illness, and treatments affecting the ability to eat like radiotherapy to the head and neck area.

Details

Enteral nutrition or tube feeding is a method of supplying nutrition through a feeding tube. This tube goes directly into the stomach or small intestine, bypassing the mouth and oesophagus.

It is an option when adequate nutrition cannot be taken by mouth. But otherwise, a person's gut is still working normally to digest and absorb food.

Enteral nutrition may make up a person's entire nutrition needs or can supplement what they eat and drink by mouth.

Enteral nutrition formulas are a liquid food that are high in energy, protein and other nutrients that complement a person's normal diet. There are commercial enteral formulas available and they can also be homemade.

Interest in blenderised tube feeding (BTF) is growing. BTF is feeding by the use of blended foods and liquids given directly into the feeding tube. The food could be homemade, commercial formula mixed with pureed baby food or any of the variety of commercially available ready-to-use BTFs. There are potential drawbacks to the use of BTF including the increased risk of bacterial contamination, greater risk of clogged feeding tubes and more effort involved in the preparation of the feed. This is where dietitians can help advise on the most appropriate type of food or formula for a person and tailor the advice to the needs of the individual.

If a person can't absorb nutrients because of problems such as blockage or disease in parts of the gastrointestinal tract, then nutrition needs to be given directly into the bloodstream. This type of feeding is called parenteral nutrition.

Reasons for enteral nutrition

A person needing tube feeding usually has a condition or injury that prevents them from eating an adequate regular diet by mouth. Common reasons for using this type of nutrition include:

- stroke or other neurological conditions which impair swallowing
- after some types of operations to the head, neck or stomach
- after radiotherapy to the head and neck area
- being unable to consume adequate nutrients
- severe illness or injury which reduces the ability to eat
- poor growth (failure to thrive) or inability to eat in young children or infants.

³ <https://dietitiansaustralia.org.au/health-advice/enteral-nutrition>

Types of feeding tubes

There are two different groups of feeding tubes.

Nasogastric and nasojejunal feeding tubes

The first type makes use of the nose to pass a feeding tube into the stomach (nasogastric tube) or small intestine (nasojejunal tube). Specialised liquid nutrition formulas or blenderised tube feeds can then be given through the tube. This type of feeding is generally used for short-term situations where the person is likely to return to oral eating within weeks.

Gastrostomy and jejunostomy feeding tubes

The second type delivers nutrition through the abdominal wall into the stomach (gastrostomy tube) or small intestine (jejunostomy tube). This type of feeding is used when it is likely that a person's ability to eat will not recover quickly or may not recover at all.

Feeding tubes are usually inserted during a person's hospital stay. But feeding through the tube may continue after a person returns home or to a nursing facility. If tube feeding support is provided at home, this is known as home enteral nutrition (HEN).

Dietitians are normally involved in all stages of the enteral nutrition process. A dietitian will assess a person to see if enteral nutrition is suitable for them. Dietitians are also involved in the monitoring of the feeding and supporting the person if they return home and still need tube feeding.

Risks to do with tube feeding

Even when it is medically appropriate to use, enteral nutrition is not without its risks. People with a feeding tube are at risk of complications such as aspiration where the feed goes into the airways.

There can also be the risk of infection of the feeding tube at the place it is inserted. The physical presence of a feeding tube can also be a source of irritation or pain. Diarrhoea, constipation, nausea and bloating are also common problems that a person may experience.

When to see a dietitian

Enteral nutrition needs the help and support of a professional. An Accredited Practising Dietitian (APD) can help you meet your individual needs.

We recommend seeing a dietitian if you:

- would like advice on whether you need tube feeding
- need advice to help ensure you're meeting your individual nutrient needs
- are experiencing problems with your current enteral nutrition regimen
- would like personalised advice and support from a professional.

APDs are university-trained nutrition experts. They can help you with personalised, easy-to-follow and evidence-based advice.

Appendix C Use real life case studies reported by Accredited Practising Dietitians for workforce training

Real-life case studies reported by Accredited Practising Dietitians can support training on recognising disability-related nutrition needs, understanding APD recommendations and resolving barriers to care.

The case below illustrates the skills described in Recommendation R7: recognising nutrition risks, communicating APD evidence, supporting participant decision-making and following up unresolved funding or service barriers.

Case study 1: Advanced Huntington's disease and loss of access to prescribed ONS

A 51-year-old man with advanced Huntington's disease has severe dysphagia and malnutrition, with **15.8 kg of unintentional weight loss over three months and a BMI of 16.1 kg/m²**. He has received dietetic support since 2021 and has become progressively more reliant on oral nutritional supplements (ONS) since 2023 to meet his nutritional requirements. Percutaneous endoscopic gastrostomy (PEG) feeding is not being pursued, in accordance with the decision of his Plan Nominee/Guardian.

Following a recent NDIS plan review, the participant's support coordinator was advised that the NDIA would **not fund Fortisip because it was a ready-to-drink preparation and was therefore considered "food"**. The coordinator reportedly advised that the NDIS could fund supports for weight maintenance, but that significant weight loss should instead be managed through a GP prescription and mainstream health pathways.

In contrast, Sustagen was considered fundable because it is added to existing foods and drinks. The dietitian was therefore asked to identify an alternative to Fortisip that could meet the participant's nutritional needs within the funding decision.

Strengthen support coordinators' capability to resolve nutrition support barriers

This case illustrates the need for coordinators and NDIA staff to understand the relationship between disability, functional limitations and nutrition support. This case also illustrates the potential consequences of distinguishing nutritional products according to their **form of preparation rather than their clinical purpose and disability-related need**. Both products were being considered as part of the participant's dietetic management of severe HD-related malnutrition and dysphagia. Coordinators need to be educated to understand the differences. The National Disability Insurance Agency's (NDIA) operational guideline provides that funding for prescribed nutritional supplements may be included in a plan where the supplements relate to the participant's disability-related health support needs (NDIA, 2026).

For a person with advanced HD who is unable to maintain adequate nutrition through ordinary food alone and is not proceeding with Percutaneous Endoscopic Gastrostomy (PEG) feeding, removal of a clinically prescribed ready-to-drink ONS may further restrict the available options for maintaining nutritional status. The case supports the need for developing pathways that coordinators can use, which clearly recognise **clinically indicated ONS on the basis of assessed nutritional and functional need, rather than whether the product is supplied as a powder or ready-to-drink preparation**.

The coordinator's role should be to help clarify the funding decision, communicate the APD's evidence and escalate unresolved barriers through appropriate NDIA processes. Where health and disability funding responsibilities are unclear, coordinators should facilitate communication between the relevant systems and services and identify a workable pathway to care. Referring a participant to mainstream health services should not be treated as resolving the issue without confirming that appropriate support has been accessed by the participant.

Example learning outcomes are described in Figure 1.

Example of possible learning outcomes		
Five nutrition capabilities for SCC and NDIA staff		
Training priorities to support safe, coordinated and participant-centred nutrition care		
1		Recognise and escalate nutrition risks Including reported rapid weight loss, swallowing difficulties and interrupted access to prescribed nutrition support.
2		Seek and communicate APD advice Clarify the disability-related need for ONS and the suitability of any proposed alternative.
3		Distinguish coordination and funding decisions from clinical decisions Product suitability should be assessed by the treating APD, rather than inferred from whether it is a powder or ready-to-drink preparation.
4		Resolve barriers across health and disability services Document actions, responsibilities and follow-up. Confirm an accessible support pathway when referring participants to another system.
5		Support participant choice and decision-making Communicate with the participant and their authorised representative about nutrition care, using appropriate decision-making arrangements.
APD: Accredited Practising Dietitian ONS: oral nutritional supplements SCC: Support Coordination and Connection		

Figure 1. Example learning outcomes for coordinators and NDIA staff