Managing Complexities Eating, Nutrition and Meal-time Risk

Ensuring safe, appropriate, and individualised food, fluid, and care practices

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Today's Agenda

What we'll cover today

- Introduction
- Key concepts
- Strategies & interventions
- Case studies / scenarios

About Me

Senior Dietitian and Director

- Working with clients for 17 years
- Managing Clinical Teams for last 12 years
- Working in people with Disabilities for 16 years
- Adults, Children and Families
- Clinical Strengths - managing complexities across teams
- Enhanced Clinical Training in Behavioural Therapy, Feeding & Swallowing and Incontinence
- Education, Training and Advocacy - Committees & Reference Groups

INTRODUCTION TO FEEDING, EATING AND MEALTIMES

- Eating, feeding, and mealtime routines are fundamental human rights, central to dignity and autonomy.
- Individuals should have the freedom to choose what, how, and when they eat.
- Dietitians traditional role - support people to modify these choices to achieve a goal.
- This role encompasses biopsychosocial model — acknowledging the factors influencing eating behaviour.

INTRODUCTION TO FEEDING, EATING AND MEALTIMES

- In the disability and ageing sectors, reduced understanding, awareness, or capacity can impair self-management of these rights.
- The complexity of these choices - personal/familial biases, multiple agendas of teams, prioritisation/deprioritisation of goals, skills-capacity.
- Without appropriate support, these situations can pose safety and health risks, requiring professional oversight that balances autonomy with duty of care.

How do we navigate this?

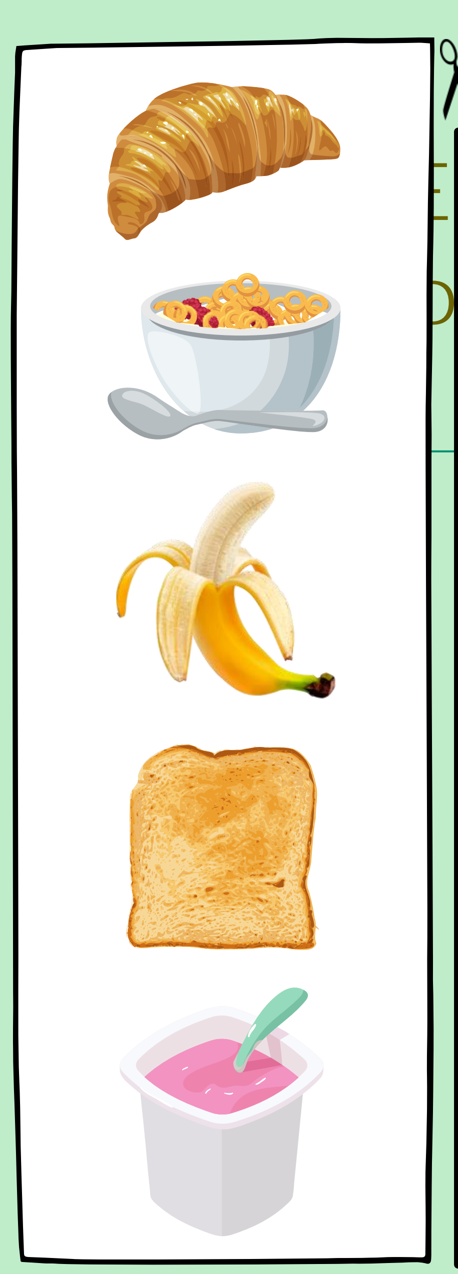
Under NDIS, people with disability have rights to dignity, choice, independence, participation, and freedom from abuse.

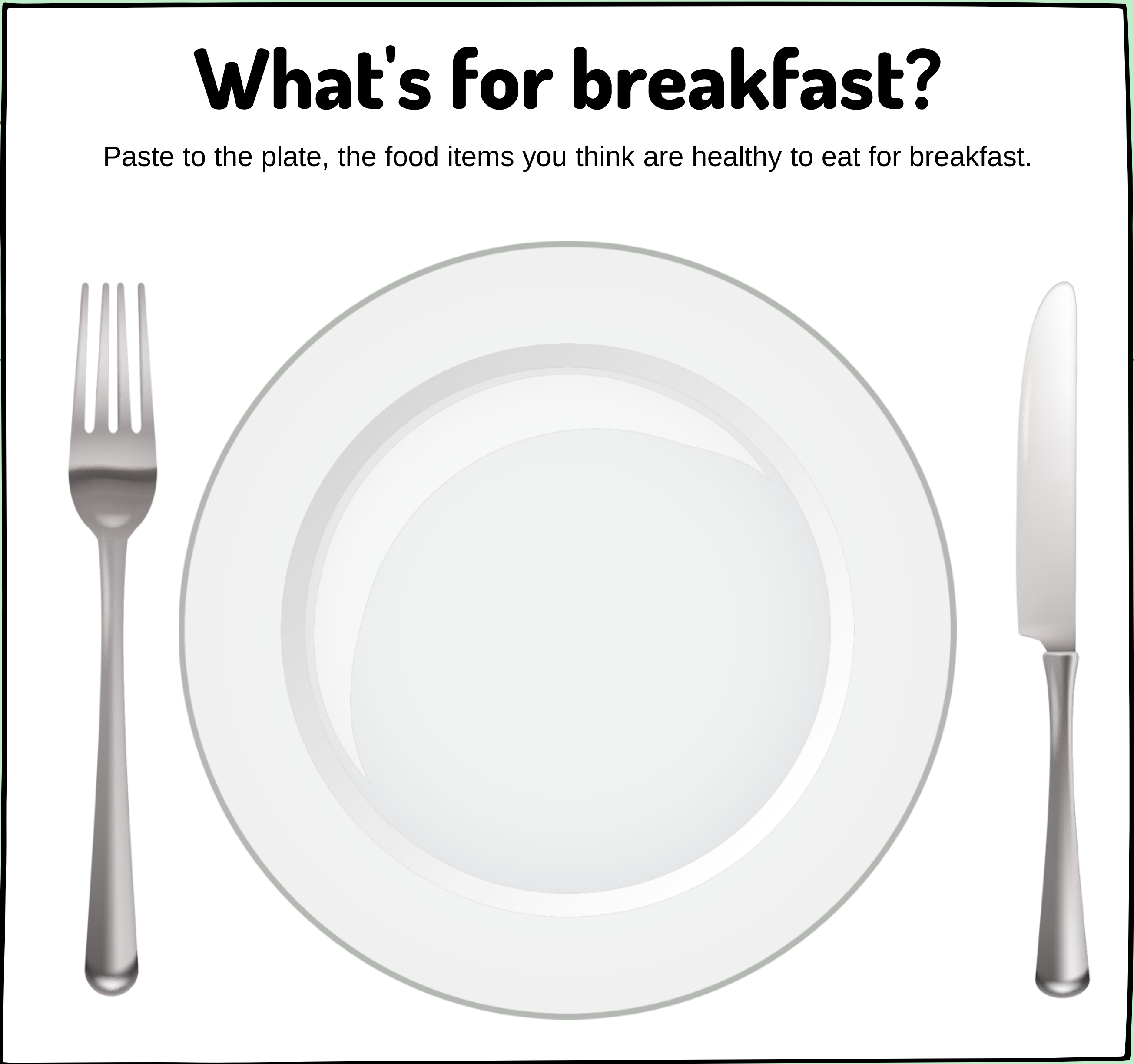
Key Principles

- Rights-based approach to mealtimes
- Distinguish between support vs restriction
- Manage high-risk food situations under “least restrictive” principles

1 RIGHTS BASED APPROACH TO MEALTIMES

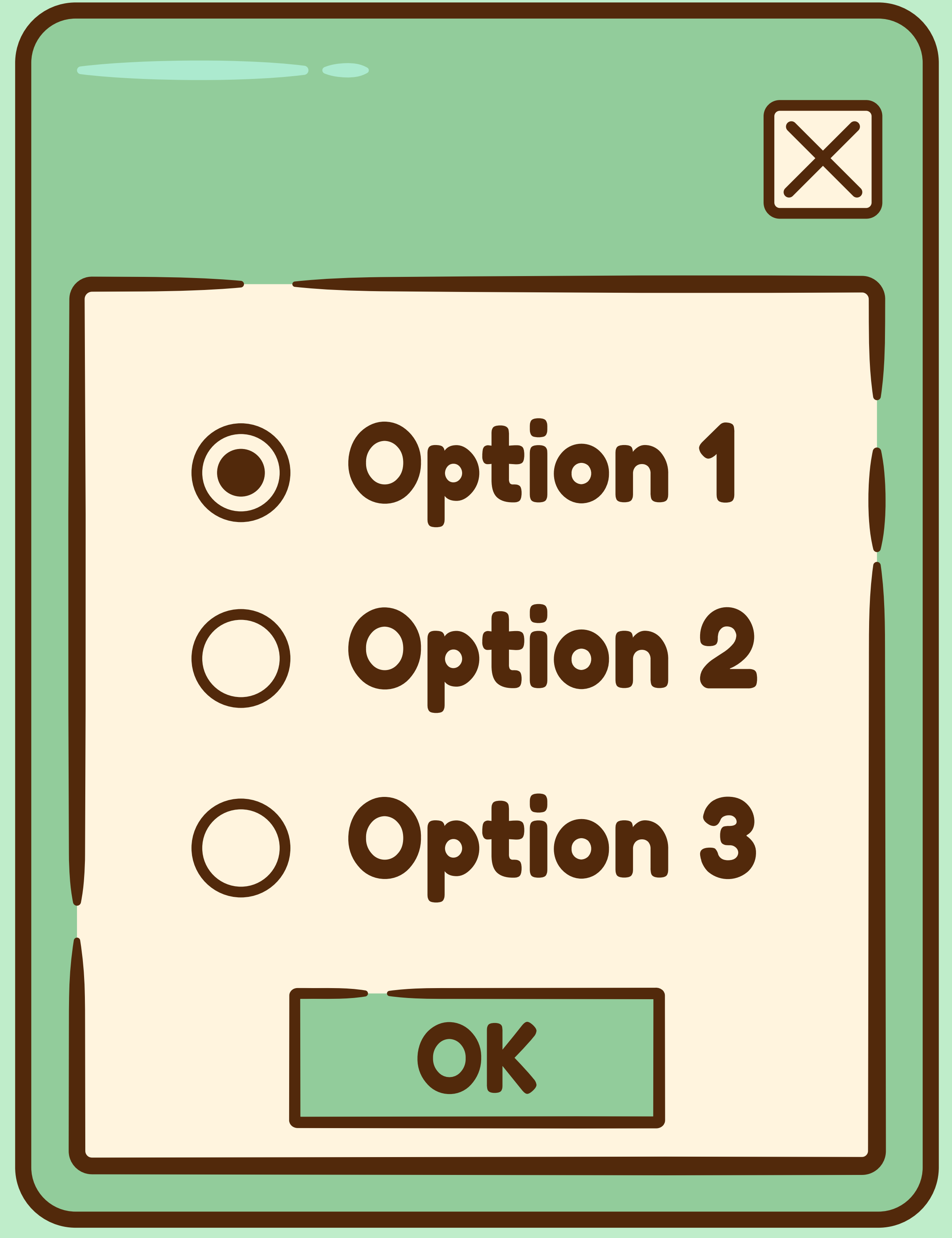
- Recognise that food, eating, mealtimes are part of human dignity. Choices about "what, when, how" are core rights unless overridden for safety.
- Ensure choice and control as much as possible: offer options, permit preferred foods safe for their condition, allow pacing, etc.
- Use supported decision-making, communication aids, visual cues so the person can express preferences to the best of their ability.
- Inform the person (in accessible language) and family or guardians about the supports, risks, and reasons for modifications.





2 DISTINGUISH BETWEEN SUPPORT VS RESTRICTION

- A meal plan, texture modification, or food substitution is a clinical support tool, not inherently a restrictive practice (so long as choice remains).
- It becomes a restrictive practice if it is forced, coercive, limiting access without consent or options, or removing autonomy.
- E.g. locking a fridge to prevent access to dangerous foods could be an environmental restraint, a regulated restrictive practice, unless clearly authorised



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LEAST RESTRICTIVE APPROACH TO CHALLENGES > STRATEGIES

Challenge	Least Restrictive Strategies (Dietitian)
Poor food choices despite risk (e.g. diabetes, dysphagia)	Use visual cues (safe vs risky foods), offer alternatives, schedule supervised eating windows, reinforce safe choices, collaborate with behaviour support to develop understanding of cause-effect
Nonverbal / limited comprehension	Use picture menus, social stories, youtube videos, communication aids, consistent mealtime and shopping routines, redirection
Food hoarding / unsupervised intake	Reorganise environment (safe storage, visibility), reduce access to high-risk foods, only supervise during high-risk times, gradually reduce supervision
Weight gain from excessive intake	Low energy fillers - front loading, swaps and alternatives, consistent structured eating schedule, positive reinforcement for any habit, swap or edit to food intake
Food refusal / minimal intake	Gradual exposure, sensory desensitisation, flexibility in preferred textures / flavors, work with behaviour support to reduce extinction of eating
Texture-modified / swallowing risk diets	Collaborate with speech pathologist, clearly communicate to staff, use consistent measurement tools, train staff, monitor compliance and safety

Case Studies

Real-World Cases

- Background
- Problem & risk
- What was assessed
- Strategies implemented
- How restrictive practices were considered and how these were managed
- Outcomes and lessons

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CASE 1 -ARFID IN A TEENAGER WITH ADHD, OCD, DYSPRAXIA AND LOW BMI

Background (Diagnosis, Context, Environment)

- Diagnosis: Avoidant/Restrictive Food Intake Disorder (ARFID), with comorbid ADHD, OCD, and dyspraxia
- Environment: Lives at home with parents; supportive family, studying criminology/psychology at university; occasionally lives independently
- History: Lifelong picky eating and strong aversions (texture, smell, contamination fears). Limited to <20 foods. Underweight ?disordered eating and dizziness due to poor OI.
- Medications: Vyvanse 40 mg (previously ceased then restarted); Ritalin 10 mg TID; supports focus but can suppress appetite

CASE 1 -ARFID IN A TEENAGER WITH ADHD, OCD, DYSPRAXIA AND LOW BMI

Problem & Risk

- Nutritional Risks: Energy deficiency, low food variety, inconsistent meal timing, reliance on Ensure supplements
- Behavioural Risks: Extreme avoidance of food textures, rigid rituals around food cleanliness, distrust of food freshness
- Physical Symptoms: Historical dizziness and fatigue; now resolved with partial improvement in intake
- Functional Risks: Skipping meals, reduced participation in social eating, and limited ability to self-prepare meals at university

CASE 1 -ARFID IN A TEENAGER WITH ADHD, OCD, DYSPRAXIA AND LOW BMI

What the Dietitian Assesses

- Dietary diversity and food exposure hierarchy (safe vs challenge foods vs safety behaviours)
- Nutritional adequacy (Overall energy status, micronutrients (excess and deficiencies, hydration)
- Weight stability and medical parameters (affected or affecting intake)
- Psychological barriers: anxiety, OCD triggers, ADHD-related forgetfulness, food hierarchy
- Environmental barriers (food access at uni, cooking confidence)
- Motivation, readiness for change (intrinsic & extrinsic motivators, antecedents) and social supports

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CASE 1 -ARFID IN A TEENAGER WITH ADHD, OCD, DYSPRAXIA AND LOW BMI

Strategies Implemented

- **CBT-AR therapy:** Structured exposure to new foods through sensory sessions (taste, texture, temp)
- **Incremental food trials:**
  - Early: chicken nuggets, sausages, spinach, croissant, shortbread, noodles
  - Later: snow peas, grapes, orange/apple juice, salami
- **Nutrition education:** Food safety, use-by vs best-before, storage hygiene, flavour pairing, and portion scheduling (alarms at 12-3-7 pm)
- **Meal structure:** Regular breakfast, snack introduction and dinner
- **Positive reinforcement:** Celebrating progress, increasing autonomy, encouraging cooking and tasting sessions with peers and sister
- **Appetite & mood:** Encouraged gym activity for appetite stimulation and mental health

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CASE 1 -ARFID IN A TEENAGER WITH ADHD, OCD, DYSPRAXIA AND LOW BMI

🚫 Restrictive Practice Considerations

- Potential Restrictive Risks: Forcing exposure to aversive foods, controlling food environment, or removing safe foods.
- Mitigation:
  - Adopted choice-based exposure hierarchy guided by CBT-AR principles.
  - Used motivational interviewing and neutral environments to promote autonomy.
  - Avoided coercion; instead fostered confidence, education, and social support.
  - Expanded support network; language redirections to encourage, not pressure, food experimentation

CASE 1 -ARFID IN A TEENAGER WITH ADHD, OCD, DYSPRAXIA AND LOW BMI

Outcomes & Lessons

- Expanded food repertoire > 50 foods over 8 months (small – rapid change)
- Improved medical, psychological and relationships
- Increased self-efficacy in meal prep and social eating contexts
- Improved psychological flexibility—less distress during exposure tasks
- Habit stacking behaviours in meals – planning intergrated with other life activities
- Reinforces the importance of consistent, non-restrictive, exposure-based support integrated with behavioural support.

CASE 2 - 40 YR OLD LADY WITH ID, AUTISM, DYSPHAGIA - PICA + COMPULSIVE DRINKING + HYPER-HYPONATREMIA + ADHERENCE TO MTMP

Background (Diagnosis, Context, Environment)

- *Diagnosis*: Kleefstra Syndrome; Severe Intellectual Disability; Autism Spectrum Disorder (Level 3); Dysphagia; Bipolar Disorder; Anxiety Disorder; Epilepsy (in remission), Incontinece
- *Living Situation:* Shared supported accommodation with three other residents. Requires full assistance with activities of daily living including meals, toileting, and hygiene
- *Support Team:* GP, Behaviour Support Practitioner, Speech Pathologist, Occupational Therapist, Support Coordinator, and support workers.
- *MTMP and Fluid Restrictions in Place*: Minced and Moist (IDDSI Level 5) diet, FR 1.5 L/day (heart failure)

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CASE 2 - 40 YR OLD LADY WITH ID, AUTISM, DYSPHAGIA - PICA + COMPULSIVE DRINKING + HYPER-HYPONATREMIA + ADHERENCE TO MTMP

⚠️ Problem & Risk

- Constipation and Faecal Incontinence
  - Chronic use of osmotic and stimulant laxatives (Movicol, Lactulose, Coloxyl/Senna).
  - Previously on clearance therapy → Type 6–7 stools, electrolyte imbalance, dehydration risk
- Urinary Incontinence:
  - High frequency (≈20 pad changes/day) and urge pattern due to frequent sipping and poor bladder control
- Fluid-Seeking Behaviour:
  - Excessive thirst leading to overconsumption and ingestion of unsafe fluids;
  - Fluid restriction implemented as a restrictive practice

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CASE 2 - 40 YR OLD LADY WITH ID, AUTISM, DYSPHAGIA - PICA + COMPULSIVE DRINKING + HYPER-HYPONATREMIA + ADHERENCE TO MTMP

⚠️ Problem & Risk

- Hospitalisation:
  - Admitted for leg swelling, electrolyte losses, and toxic fluid ingestion due to polydipsia.
  - Faecal Impaction and hysteria; resulting in further exacerbation electrolytes +/-

- Behavioural/Medical Risks:
  - Refusal to toilet;
  - Anxiety/fear-related night time waking
  - Withholding behaviour after hospital trauma

CASE 2 - 40 YR OLD LADY WITH ID, AUTISM, DYSPHAGIA - PICA + COMPULSIVE DRINKING + HYPER-HYPONATREMIA + ADHERENCE TO MTMP

What the Dietitian Assesses

- Adequacy of bowel management regimen: frequency, stool consistency, and hydration balance.
- Risk of electrolyte imbalance from fluids and laxative overuse and diarrhoea.
- Urinary output patterns and continence aid usage.
- Weight trends and signs of dehydration or oedema.
- Mealtime safety: supervision level, IDDSI compliance, swallowing issues, and texture tolerance.
- Communication and behavioural responses related to mealtime or toileting routines.
- Coordination with GP, nursing, and behaviour support regarding medication titration and restrictive practice governance

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Strategies Implemented

- **Medical & Nutritional Management**
  - Revised bowel management plan: ongoing revision of BM Plan with GP
  - Implemented PRN protocol: Movicol and Enemas only if no bowel motion for 4–5 days.
  - Encouraged GP review for glucose testing, urinalysis, and electrolyte monitoring.
- **Education for Support Staff**
  - Training in bowel chart recording, stool classification (Bristol Scale), and hydration cues.
  - Education on osmotic laxative effects and fluid balance.
  - Practical guidance on fluid timing to reduce urinary urgency.

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CASE 2 - 40 YR OLD LADY WITH ID, AUTISM, DYSPHAGIA - PICA + COMPULSIVE DRINKING + HYPER-HYPONATREMIA + ADHERENCE TO MTMP

🧠 Strategies Implemented

- **Behavioural & Environmental Supports**
  - Adjusted fluid access to ensure safety while maintaining autonomy (monitored access rather than deprivation).
  - Use of night lights, calming sensory tools, and bedtime adjustments to improve sleep and reduce anxiety
- **Multidisciplinary Coordination**
  - Collaboration with GP, Behaviour Support, and Speech Pathology.
  - Discouraged unnecessary medical procedures (e.g., stoma insertion, unnecessary inpatient monitoring).
  - Ongoing reviews and written communication to all stakeholder

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CASE 2 - 40 YR OLD LADY WITH ID, AUTISM, DYSPHAGIA - PICA + COMPULSIVE DRINKING + HYPER-HYPONATREMIA + ADHERENCE TO MTMP

🚫 Restrictive Practice Considerations

- **Restrictive Practice In Place as Per BSP:** Removal of unsafe fluids and supervised bathroom access to prevent overconsumpion of unsafe/excess fluid intake.
- **Risks Considered:** Safety vs dignity, risk of dehydration vs fluid intoxication, autonomy vs supervision
- **Dietitian's Mitigation Strategies:**
  - Promoted capacity-building: educating staff on gradual reintroduction monitored access.
  - Reinforced positive hydration (e.g., measured bottles, supervised refills, limited tap drinking).
  - Ongoing review of MTMP: document acceptance, refusal or behaviours of concern
  - Supported non-restrictive environmental strategies (education, positive reinforcement, structured fluid and food routines).

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CASE 2 - 40 YR OLD LADY WITH ID, AUTISM, DYSPHAGIA - PICA + COMPULSIVE DRINKING + HYPER-HYPONATREMIA + ADHERENCE TO MTMP

🌱 Outcomes & Lessons

- Clinical Improvements:
  - Bowel function stabilised (Type 5, 1-2 times daily), no documented hysteria.
  - Sleep and anxiety improved with environmental and sensory supports.
  - Fluid-seeking behaviour reduced; safe fluid intake achieved.
- Team Outcomes:
  - Enhanced staff knowledge and coordination.
  - Reduction in unnecessary medical interventions.
  - Improved use of data (bowel & bladder charts, hydration monitoring) for decision-making.
- Key Lessons:
  - Restrictive practices must always be clinically justified, time-limited, capacity-building focused.
  - Dietitians play a pivotal role- safeguarding safety and dignity through education, collaboration, and data-led monitoring

CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

Background (Diagnosis, Context, Environment)

- Diagnosis: Type 2 Diabetes Mellitus (insulin-dependent), secondary brain injury post-brain cancer (in remission), toe amputation, hyperlipidaemia, depression, nerve pain, No -Teeth
- Living Environment: SIL environment with daily support workers assisting with meals, medications, and daily routines
- Cognitive/Behavioural Profile: Mild cognitive impairment, trauma-related anxiety, emotional lability, low motivation, regular verbal aggression, strong-overt traits of racism and sexism 2* TBI.

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CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

⚠️ Problem & Risk

- Clinical Risks:
  - Persistent hyperglycaemia (BGLs often >10–18 mmol/L).
  - Weight gain with increased visceral adiposity.
  - Elevated cardiovascular risk (waist circumference 120–123 cm).
  - Nocturia (3–4 × nightly) impacting sleep
- Behavioural Risks:
  - Impulse control difficulties and verbal aggression re food
  - Forgetfullness and reduced short term memory - affects recall
  - Skipping walks due to mood and support staff inconsistency

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CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

⚠️ Problem & Risk

- Environmental/Social Risks:
  - Limited support-worker consistency in meal prompting and physical activity engagement.
  - Mid Meal snacking, compulsive eating and forgetfullness ^^^^ BGL
  - Emotional stressors—financial frustration, change of living circumstance and trauma memories (triggering cortisol >insulin > glucose)

CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

What the Dietitian Assesses

- Medical and Clinical parameters - Blood glucose tracking with meals and snacks.
- Weight and waist trends for cardiometabolic risk tracking.
- Eating habits & patterns, meal time behaviours (hoarding, overeating), behaviour change w hypo/hypers
- Psychosocial readiness and motivations towards positive change or maintainence
- Support worker engagement and adherence to meal planning.
- Literacy and comprehension of diabetes self-management tools (Libre/Dexcom).
- Emotional drivers of overeating and low activity (stress, isolation, trauma).

CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

Strategies Implemented

- **Medical Nutrition Therapy**
  - Replace/exchange alternatives with protein-based options and low GL meals
  - Reduce Red Traffic light foods and replacing with Low Energy Fillers and Protein Rich Snacks
  - Food and BGL data - accurately adjust Diabetes Mgt plan with informed consent and shared decision making.
  - Adjust food textures in conjunction with food acceptability / preferences
  - Shopping List developed in positive moods to support improved food choice

CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

🧠 Strategies Implemented

- **Behavioural & Environmental Supports**
  - Cooking Demonstrations and Meal Prep Days to support positive food experience.
  - Visual Aids: Picture menus, traffic-light systems, visual recipes, food safety cue cards.
  - Easy Materials: Short sentences, one idea per line, simple fonts, large print on resources
  - Routine-Based Support: Consistent meal times, familiar environments and positive redirection
  - Reinforced peer modelling with social stories of friends and story telling of positive change.
  - Environmental and Kitchen redesign: placing healthy snacks at eye level, and clear containers for food storage.

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CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

🧠 Strategies Implemented

- **Psychosocial & Emotional Strategies**
  - Encouraged journaling as a self-regulation tool and weekly social worker engagement
  - Promoted the goal of dog ownership to encourage walking and companionship.
  - Use of CBT- technques to explore beliefs and values relating to health, relationship with food and others, to explore change resistance and stress-eating triggers
- **Multidisciplinary Coordination**
  - Weekly Updates to all stakeholders informing data and reveiwing behaviour management

CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

🚫 Restrictive Practice Considerations

- Limiting access to discretionary foods could risk autonomy or create food control.
- Creating meal plans, and strict Diabetes Protocol could risk the right to choose to be "treated"

- Mitigation Strategies:
  - Implemented structured choice approach in collaboration: suggest and offer planned healthy snack first, redirect if wanting to choose alternative, but allow right to choose.
  - Educated staff on positive reinforcement over negative reinforcement; to encourage healthy behaviours
  - Ongoing data monitoring (food, BGL, Insulin) - client centred choices.
  - Aligned with positive behaviour support framework — used routine, visual prompts, and self-monitoring to build intrinsic control.

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CASE 3 - 55 YEAR OLD - 2*TBI, INSULIN D. DIABETES WITH MEMORY LOSS, BLUNTED INTEROCEPTION AND OVEREATING

🌱 Outcomes & Lessons

- Clinical Improvements:
  - Improved meal structure and less hypos (less insulin correction)
  - Weight stability and waist circ losses
  - Consistent engagement with Diabetes - enhanced monitoring and self-management
- Behavioural Outcomes:
  - Increased food awareness and mindfulness
  - Shift from reactive insulin correction to proactive meal planning.
  - Improved emotional regulation and self-reflection through journaling and reflections.
- Key Lessons:
  - Nutrition education for clients with cognitive and psychosocial complexity must emphasise autonomy, reinforcement, and practicality.
  - CB activities and consistency across teams minimises RP risk and collaboration.

Positive Client Outcomes

- Customised client plans with automony and independence at forefront
- Safe and supportive food environments result in least restrictions
- Education & training - consistent communication b/n teams
- DATA + DATA = accurate interventions
- Supported decisions with BSP, Client and Teams
- Document + communicate and rinse repeat

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