

Dietetic Considerations for Supporting Individuals with Learning Disabilities and Avoidant Restrictive Food Intake Disorder (ARFID)

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Executive Summary

People with learning disabilities experience some of the most significant health inequalities in the UK. Additionally, ARFID may be under-recognised in this population due to diagnostic overshadowing, communication differences and gaps in the evidence base. This document provides dietitians with clear, practical and neurodivergent-affirming advice for supporting individuals with learning disabilities and ARFID across all settings. It outlines how ARFID profiles present differently in learning disability contexts and highlights the importance of reasonable adjustments. Furthermore, the document clarifies the essential role of learning disability dietitians within multidisciplinary pathways whilst also addressing stigma, safeguarding and the future research need.

Key Insights

- Feeding difficulties are often misattributed to disability rather than recognised as ARFID.
- ARFID presentations in learning disabilities require adapted assessment - including reliance on behavioural cues, carer insight and accessible tools.
- Sensory, fear-based and low-interest profiles occur in this population but often overlap and present differently due to communication and cognitive differences.
- People with learning disabilities face significant health inequalities, making early nutritional risk identification essential.
- Learning Disability dietitians already hold many of the core skills needed for ARFID care and play a crucial role in multi-professional formulation and intervention.
- Effective care requires reasonable adjustments, accessible communication and trauma-informed, neurodiversity-affirming practice.
- There are substantial research gaps, particularly around prevalence, assessment tools and intervention outcomes for people with learning disabilities.

Document Aims

The aim of this document is to provide dietitians with a clear and practical framework for working with individuals with ARFID and a learning disability. By outlining the nutritional, sensory, cognitive, and safeguarding considerations the document seeks to support safe and effective clinical practice. It offers practical approaches for assessment, communication, and specific considerations for dietetic interventions. Each of these is grounded in the evidence base, clinical consensus and is adaptable across settings and ages.

The document aims to ensure that dietitians feel supported in this clinical area and that individuals with ARFID and learning disabilities receive the skilled, compassionate and well-coordinated care they deserve.

Context

Terminology

In United Kingdom (UK) health and social care, the terms **learning differences**, **learning difficulties**, **learning disabilities** and **intellectual disabilities** are often used interchangeably. However, they each describe distinct concepts that carry important clinical and legal implications. Establishing clarity at the outset is essential for consistent dietetic practice, accurate communication across multidisciplinary teams (MDT) and in the reduction of diagnostic overshadowing.

- **Learning differences** - a broad term that acknowledges natural variation in cognitive processing, communication styles and sensory profiles. It is commonly used within neurodivergent-affirming frameworks to describe differences rather than deficits. It is often applied in relation to autism, attention deficit hyperactivity disorder (ADHD), dyspraxia and other neurodevelopmental conditions. The term does not imply impairment in intellectual ability or adaptive functioning. Rather, it highlights that individuals learn, process or engage with information in ways that diverge from neurotypical expectations.
- **Learning difficulties** - used in UK education and health contexts to describe identified challenges with specific areas of learning (such as reading, writing, numeracy or information processing), while overall intellectual ability remains within the typical range. Dyslexia, dyscalculia and dyspraxia fall within this category. Learning difficulties do not meet the criteria for a learning disability alone, and do not imply global impairment, although they can co-occur with a learning disability. Learning difficulties may influence how individuals engage with dietetic assessment, written information or food-related tasks.
- **Intellectual disabilities** - the international clinical term used in DSM-5 and ICD-11 to describe significant limitations in both intellectual functioning and adaptive behaviour, originating during the developmental period^{1,2}. While conceptually aligned with the UK term “learning disability”, it is used more commonly in research and global health contexts. In UK services, “learning disability” remains the preferred terminology but dietitians working across systems or reviewing international literature will encounter both.
- **Learning disabilities** - a legally and clinically defined term in the UK. It refers to a lifelong condition characterised by significantly reduced intellectual ability and impaired adaptive functioning, with onset before adulthood^{3,4}. Learning disabilities affect understanding, communication, daily living skills and decision-making, and are associated with markedly higher rates of health inequality, multimorbidity and premature mortality. In UK practice, the identification of a learning disability carries defined legal and service responsibilities. Individuals are protected under the Equality Act 2010, requiring reasonable adjustments to ensure equitable access to care, and decision making must be supported and, where appropriate, assessed in line with the Mental Capacity Act 2005⁵. The presence of a learning disability should be clearly recorded and include the use of digital flags where available to facilitate recognition across services. This should prompt proactive consideration of accessibility,

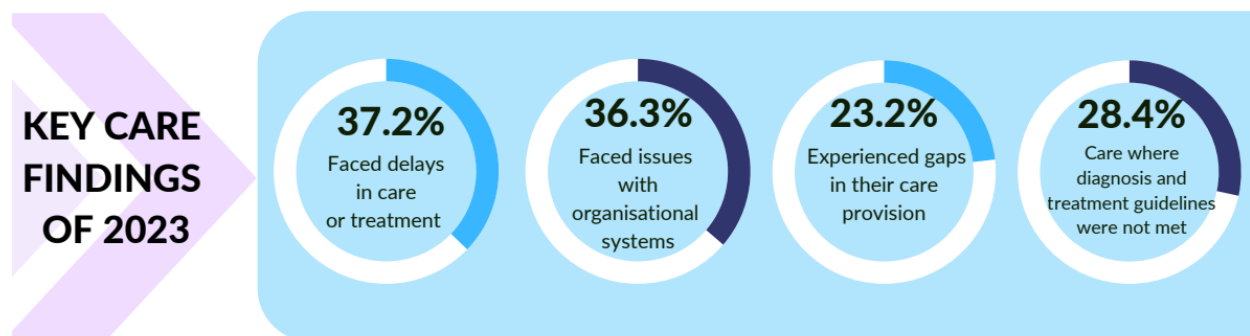
communication needs, mental capacity, safeguarding and the requirement for adapted or specialist dietetic support.

Learning disabilities vary in presentation and are commonly described across levels of severity (e.g. mild, moderate, severe, profound) based on overall functioning. While standardised measures of intellectual functioning may contribute to assessment, current frameworks place greater emphasis on adaptive functioning in determining support needs. A diagnosis of learning disability does not describe the individual's strengths, preferences or specific needs. It should therefore be understood as one component of a holistic, person-centred assessment.

Inequalities

People with learning disabilities experience some of the most notable health inequalities in the UK. The median age of death is just 62.5 years which is only just under 2 decades younger than the general population, and avoidable mortality is almost twice as high⁶. These are not the consequences of disability itself, but of systemic failures in access, recognition and appropriate response.

Crucially, more than a quarter of people with learning disabilities in the “Learning from the Lives and Deaths of people with a learning disability and/or autistic people”⁷ report required at least one reasonable adjustment that was not provided. When adjustments are missing, individuals may be unable to communicate symptoms, tolerate environments or engage with treatment, leaving gaps in the information needed for the early risk identification.



Research and gaps in the evidence base

ARFID is increasingly recognised as a heterogeneous eating disorder, with strong associations with neurodevelopmental conditions, particularly autism and ADHD⁸. However, people with learning disabilities are rarely the primary focus of ARFID research. Most studies either exclude them altogether or subsume them within broader “neurodevelopmental” or “autistic” samples, which obscures learning disability-specific patterns, risks and service needs⁹.

Current epidemiological data provide some insight into incidence and prevalence in children and adolescents, but do not reliably disaggregate by learning-disability status or severity¹⁰. As a result, the true prevalence of ARFID in people with learning disabilities across the spectrum of cognitive ability, communication profiles and medical complexity remains largely unknown. Large, population-based studies with clear learning disability stratification are a key gap.

Assessment tools for ARFID (e.g. structured interviews and questionnaires) have evidence for reliability and validity in general and autistic populations, but formal validation in people with learning disabilities is limited⁹. Questions remain about accessibility (e.g. language and format), the need for informant-report adaptations, and how best to capture ARFID presentations in those with limited verbal communication or high support needs.

Treatment evidence is also constrained. Most intervention studies involve small samples, case series or uncontrolled designs, and very few report outcomes specifically for people with learning disabilities⁸. This limits the ability to determine which approaches (e.g. cognitive behavioural therapy for ARFID (CBT-AR), family-based interventions, multidisciplinary models) are effective and acceptable in learning disability services. It is also difficult to distinguish what reasonable adjustments are required. This is because they are not standardisable and should be individualised to reflect the person's cognitive profile, communication needs and wider context.

These gaps reflect structural and methodological challenges:

- **Population heterogeneity:** Wide variation in cognitive ability, communication, co-occurring autism, physical health and support environments makes standardised research design and outcome measurement more complex⁹.
- **Ethical and legal considerations:** Issues of capacity, consent and assent (particularly for those over 16 with impaired decision-making) can limit inclusion in research protocols and trials⁹.

Overall, the evidence base for ARFID in people with learning disabilities is emerging but incomplete. This document therefore draws cautiously on general ARFID research and combines this with specialist learning disability specific clinical expertise and clinical consensus in current practice.

Diagnosis

ICD-11 Diagnostic Criteria for ARFID

In ICD-11², ARFID is defined as:

Persistent failure to meet appropriate nutritional and/or energy needs associated with at least one of the following criteria:

- Significant nutritional deficiency
- Significant weight loss or failure to gain adequate weight
- Dependence on oral supplementation or tube feeding

And/or

- Marked interference with psychosocial functioning

The eating disturbance is not driven by concerns about body weight or shape, and it cannot be better explained by a lack of available food, culturally sanctioned practices, or another medical or mental disorder. The diagnosis requires that the severity of the eating disturbance

exceeds what would be expected from any co-existing condition and that it meaningfully impairs health or functioning.

ARFID Diagnosis in the Context of Learning Disabilities

Diagnosing ARFID in people with learning disabilities requires a nuanced and context-sensitive approach. Many standard diagnostic cues (such as self-reported symptoms, psychosocial impairment, typical growth trajectories) may present differently or be more difficult to assess.

This population often faces substantial barriers to routine health monitoring, which can delay identification of nutritional risk. Obtaining blood tests, for example, can be challenging due to sensory sensitivities, communication differences or procedural anxiety. As a result, micronutrient deficiencies or markers of medical instability may go undetected for longer. Similarly, individuals may be unable to reliably recognise or report symptoms such as nausea, abdominal pain, early satiety or fear-based avoidance, meaning clinicians must rely more heavily on behavioural observation, carer reports and objective nutritional and physical indicators.

Growth and weight trajectories also require careful interpretation. Many people with learning disabilities have atypical body composition or growth patterns¹¹. What appears to be “stable” weight may mask deviation from an individual baseline, while weight loss may be misattributed to their learning disability or behaviour. Access to appropriate weighing equipment can further complicate assessment. This is particularly true for individuals who require hoist-assisted or wheelchair scales which may not be consistently available across services or care settings¹¹.

Psychosocial impairment can be difficult to objectively assess or define using standard benchmarks. Expectations of social eating, independence, or mealtime participation may not be appropriate comparators. Clinicians must determine what constitutes meaningful impairment for that specific individual and their family or support network. Distinguishing between selective eating and unsafe intake can also be challenging, particularly when sensory sensitivities, rigid routines or communication differences are present. Educational and social participation may also be affected when eating difficulties limit access to school, college or community activities. Without careful formulation, ARFID may be overlooked, or conversely, neurodivergent eating patterns may be misinterpreted as pathology.

Comorbidities add further complexity. People with a learning disability often experience a range of co-occurring conditions, including gastrointestinal conditions (e.g. constipation), epilepsy, dysphagia, and anxiety all of which can influence feeding behaviour and nutritional status, and can influence appetite regulation¹². Multimorbidity is highly prevalent, with UK cohort data indicating an average of 11 physical health conditions per person¹³. This increases the risk of diagnostic overshadowing, where feeding difficulties are attributed to the learning disability itself, or other co-occurring condition, rather than recognised as a potentially treatable and distinct disorder¹⁴. A thorough, multidisciplinary assessment is therefore essential to determine whether the severity and nature of the eating disturbance exceed what would be expected in the context of the individual’s underlying needs.

In this context, ARFID diagnosis is less about rigid application of criteria and more about understanding change, risk and functional impact. A holistic formulation should consider

developmental profile, sensory needs and contextual factors, working closely with families and carers.

Sensory based ARFID profile in learning disabilities

Sensory sensitivities are a well-recognised driver of ARFID¹⁵, and are especially common in people with learning disabilities, particularly when autism or sensory-processing differences are present¹⁶. The underlying patterns mirror those seen in the general population (aversions to certain textures, temperatures, smells or visual qualities) but require nuanced and careful interpretation.

For many individuals, sensory input around food is overwhelming rather than merely unpleasant. Anxiety and distress may present behaviourally and may be subtle or easily misinterpreted. Some people display clear signs such as gagging or pushing food away, while others use quieter strategies like turning their head, closing their mouth or withdrawing from the eating environment altogether. As communication differences are common, these behaviours may be the only available expression of discomfort.

Without a sensory-informed lens, such responses risk being dismissed as behavioural, oppositional or simply “part of the disability”. Instead, they often reflect a genuine sensory threat that makes eating feel unsafe. Understanding these cues is important. This can include questions and/or pattern recognition of regarding what foods trigger them, how the environment contributes, and how the individual responds before and after exposure. Supporting individual sensory needs is an essential component to supporting nutritional change and reducing distress and arousal.

Key dietetic assessment considerations:

- Determine whether the individual's food range has always been restricted or has narrowed over time. Long-standing selectivity suggests a stable sensory profile, whereas a shrinking range indicates present or emerging risk.
- Develop an understanding of sensory food preferences (e.g. taste, texture, temperature, appearance, smell) and include changes to sensory preferences over time.
- Check whether food preferences and refusals are consistent across settings and carers; they may be variable across environments.
- Explore sensory responses beyond food (e.g., noise, touch, movement) to distinguish global sensory-processing differences from food-specific aversions.
- Consider pain as a contributing factor - gastrointestinal discomfort, dental issues or reflux can heighten sensory defensiveness and lead to avoidance.
- Recognise that sensory-based ARFID typically arises from the interaction of sensory processing differences, communication needs and lived experience, requiring a holistic and comprehensive assessment approach.

Where available, wider members of the MDT (such as Occupational Therapists and Speech and Language Therapists) can further support the dietetic approach by assessing oral-motor skills. This can help develop clinical understanding about challenges such as difficulties with

chewing or swallowing. Furthermore, challenges with proprioception/coordination may mimic sensory refusal but reflect motor-based challenges.

Fear of aversive consequences ARFID profile in learning disabilities

Fear of aversive consequences ARFID profile is less clearly described within learning disability populations and may be under-identified in clinical practice. This may reflect the subtle, cumulative or difficult-to-communicate nature of triggers.

In this profile, food avoidance develops in response to a perceived risk of harm. This is typically associated with experiences such as choking, vomiting, reflux, allergic reactions, or witnessing such events. Gastrointestinal conditions or symptoms (e.g. dysphagia, gastroesophageal reflux disease, constipation, *Helicobacter pylori* infection or recurrent nausea) may also contribute, reinforcing learned associations between eating and discomfort or distress.

In many cases, restriction begins after a specific event or period of illness making the timeline of change a key diagnostic clue. Trauma histories (including forced feeding, repeated medical procedures or distressing hospital experiences) may further reinforce avoidance, particularly when the individual has limited capacity to understand or contextualise what happened.

As communication differences are common, fear is often expressed behaviourally rather than verbally, through refusal, withdrawal or distress around specific foods or textures. Behaviour should therefore be seen as a helpful communication tool.

Key dietetic assessment considerations:

- Establish whether food restriction began after a specific trigger (e.g., choking, vomiting, illness). These sudden restrictions can occur following a direct experience, witnessing a challenging experience, or developing a thought-based concern of consequences.
- Consider whether identified medical issues represent the original trigger, an ongoing driver of avoidance, or an alternative explanation for reduced intake.
- Assess the individual's ability to understand, process and contextualise frightening events, as cognitive or communication differences may prolong or intensify fear responses. This should be done in conjunction with appropriate members of the MDT.
- Recognise that fear may be expressed behaviourally rather than verbally, requiring careful interpretation of avoidance patterns and mealtime behaviours.

Referring the individual for a thorough medical review to identify or rule out ongoing contributors can support the dietetic assessment and understanding. This includes exploring potential issues such as pain, dental issues, swallowing difficulties, reflux or other gastrointestinal conditions.

Disinterest ARFID profile in learning disabilities

Low-interest ARFID presentations are characterised by a reduced drive to eat rather than active avoidance. This profile is frequently observed in people with learning disabilities with the core features typically consistent with those of the general population. These include:

- Forgetting to eat unless prompted
- Eating very slowly
- Stopping eating after only consuming small amounts (early satiety/disinterest)
- Showing minimal initiation of food-seeking behaviour
- Eating is easily displaced by competing interests or activities, where mealtimes often require a sustained external structure to maintain adequate intake.

Key dietetic assessment considerations:

- Assessment should focus on the mechanisms that suppress appetite or reduce internal cues to eat, rather than assuming low intake is disability-related.
- Interoceptive differences are common, particularly in autistic individuals, and these differences may reduce awareness of hunger, thirst or early signs of medical deterioration.
- Medication side effects (including psychotropic, anti-seizure and ADHD-related medications) may reduce appetite, alter gastrointestinal function (e.g. constipation or nausea) and/or reduce energy levels and alertness, contributing to reduced drive to eat.
- Mood and mental health can influence intake - depression, anxiety and low arousal states may reduce motivation to eat. Reduced intake and undernutrition may also adversely affect mood and emotional regulation.
- Executive functioning should be assessed across domains, as difficulties with planning, sequencing, initiation or task-switching can impair the ability to begin or sustain eating. For some individuals, the primary difficulty is not appetite, but the cognitive steps required to start or return to eating.
- Identifying whether similar initiation or sequencing difficulties appear in other daily-living tasks helps clarify whether reduced intake reflects low interest, executive-function challenges or another ARFID driver.

ARFID and Learning Disability Profile Comparisons:

ARFID Profile	Key Features	Primary Assessment Questions	Additional Considerations in Learning Disabilities
Sensory-Based	Avoidance driven by sensory overwhelm (texture, smell, temperature, appearance)	Has the food range always been restricted or has it narrowed? Are patterns consistent	Check for sensory responses beyond food (noise, touch, movement). Patterns often reflect interaction of sensory processing and communication differences. Consider multi-professional

ARFID Profile	Key Features	Primary Assessment Questions	Additional Considerations in Learning Disabilities
		across settings and carers?	assessment of oral-motor skills and any underlying physical symptoms (such as pain, gastrointestinal discomfort, reflux etc.)
Fear-Based	Avoidance due to fear of harm (choking, vomiting, pain, allergic reactions)	Did restriction begin after a specific event or illness? What medical or procedural experiences preceded the change?	Refer for a full medical review (pain, dental issues, dysphagia, reflux). Consider trauma history (forced feeding, repeated interventions). Assess (within scope / refer for assessment) the ability to understand and process frightening events; fear may be expressed behaviourally
Low-Interest	Reduced drive to eat rather than active avoidance. Forgetting to eat, slow eating, stopping early, minimal initiation	Are hunger cues recognised? Is intake displaced by competing interests? Are there patterns of low initiation in other tasks?	Consider interoception difficulties, medication effects, mood and mental health. Evaluate (within scope) executive functioning such as planning, sequencing, initiation. Determine whether cognitive steps rather than appetite are the primary driver

Additional ARFID assessment considerations in people with learning disabilities

- ARFID drivers often overlap rather than occur in isolation¹⁵. Therefore, assessment should consider how sensory, fear-based and low-interest mechanisms interact.
- Interoceptive differences have been described in neurodevelopmental conditions and may affect awareness and interpretation of internal cues such as hunger, fullness and discomfort, which may limit the reliability of self-reported symptoms.
- Weight status is not a dependable indicator of risk¹⁷. Individuals with ARFID may present as underweight, within a typical weight range or with overweight/obesity due to atypical growth patterns, medication effects, reduced activity or oral-motor hyposensitivity with a variety-restricted high-calorific intake.

Multiprofessional members of the MDT, such as Speech and Language Therapists (SALT), can assess oral-motor behaviours. Behaviours such as chewing, mouthing, repetitive eating patterns or seeking strong flavours may reflect sensory-seeking or developmental differences and should be interpreted within the broader clinical picture.

Impact of stigma and assumptions

Diagnostic overshadowing is defined as “the tendency to attribute all behavioural, emotional, physical and social issues to a person's learning

disability or a pre-existing condition, while overlooking the possibility that they could be symptoms of other conditions or difficulties”¹⁸

Stigma and assumptions can significantly distort how ARFID is recognised and managed in people with learning disabilities. Learning highlights how diagnostic overshadowing can present a significant risk⁷. Feeding difficulties may be attributed to the learning disability or autism rather than explored as a potentially treatable eating disorder. In our collective clinical experience, common assumptions include beliefs that the restrictive eating is “just part of the disability”, that the individual is simply “picky”, or that they “will not tolerate or engage with intervention”. These assumptions can lead to under-assessment, delayed diagnosis, and missed opportunities for early support.

Stigma does not operate only at the level of individual attitudes - it also shapes the systems around the person. When professionals assume that feeding difficulties are behavioural or inevitable, decisions may be made about the person rather than with them, and reasonable adjustments may not be offered. This reflects inequitable access to healthcare and failure to meet statutory duties under the Equality Act 2010¹⁹. Caregivers may be discouraged from seeking help where concerns are dismissed or not acted upon⁶. Healthcare teams may overlook nutritional risk or fail to investigate medical contributors, leading to ongoing or worsening health concerns.

The consequences of these assumptions can be significant. Nutritional risk may continue unchecked, resulting in faltering growth or, conversely, increasing weight trajectories that mask underlying nutritional risk leading to micronutrient deficiencies that go unrecognised. At an individual level, repeated dismissal of concerns can affect self-esteem, trust in healthcare and willingness to engage with services – leading to an inequitable acceptance of negative health impacts.

Tragic cases such as Alfie Nichols²⁰, Owen Hinds¹⁴ and Joshua Allcock²¹ highlight the serious implications of unrecognised or minimised feeding difficulties for both adults and children in people with learning disabilities and/or autism. These examples underscore the need for clinicians to approach assessment without assumptions, to recognise the legitimacy of caregiver concerns and to ensure that feeding difficulties are explored with the same clinical curiosity and rigour.

Working effectively with this group requires an active effort to challenge stigma, avoid diagnostic overshadowing and ensure that assessment and intervention are person-centred, evidence-based and respectful of the individual’s communication and support needs. It’s essential that dietitians challenge assumptions and ask better clinical questions.

Stigma and assumptions impact clinical decisions, access to treatment and ultimately impact health outcomes. The latter of which can, and has, lead to avoidable deaths.

The role of the learning disabilities dietitian in ARFID care

The task is not to adopt an entirely new clinical identity, but to apply existing LD dietetic skills through an ARFID-informed lens.

Learning disability (LD) dietitians are already equipped with many of the core competencies required to contribute meaningfully to ARFID assessment and intervention. Their established expertise in nutritional risk, complex health needs and communication-adapted practice provides a strong foundation for supporting individuals with ARFID, even without prior specialist training.

LD dietitians routinely work with individuals whose nutritional needs are shaped by cognitive, sensory, behavioural and medical factors. This positions them well to recognise early signs of nutritional compromise, interpret complex feeding presentations and contribute to multidisciplinary formulation. Their experience in assessing faltering growth, arising risks from overweight and obesity status, micronutrient deficiency and the long-term consequences of restricted diets is directly relevant to ARFID care. In addition, LD dietitians are skilled in adapting communication, using accessible information and working collaboratively with families, carers and support teams. These are an essential component of effective ARFID interventions.

Dietitians in learning disability services also bring a nuanced understanding of the interplay between disability, health and environment. They are familiar with the impact of co-occurring conditions such as epilepsy, gastrointestinal disorders, dysphagia and medication-related appetite changes, all of which may influence feeding behaviour and nutritional status. Their routine involvement in mental capacity assessments, best-interest decision-making and multidisciplinary care planning further strengthens their ability to support individuals whose ARFID presentation intersects with complex support needs.

Where gaps in ARFID-specific knowledge exist, these can be addressed through structured professional development. Clinical supervision with colleagues experienced in ARFID, eating disorders or paediatric feeding can provide essential support and reflective space. Onward referral pathways should be used when presentations exceed the dietitian's scope of practice, such as in cases of severe phobia, trauma-linked feeding avoidance, high medical risk, or multiple co-complexity requiring a broader multiprofessional makeup. Targeted continuous professional development (including ARFID-focused training, webinars, case discussions and participation in professional forums) can help LD dietitians build confidence and competence in this area.

Further reading and resources:

- [The British Dietetic Association \(BDA\) ARFID Toolkit](#) outlines the importance of nutritional risk assessment and monitoring across ARFID profiles, as well as extensive other ARFID specific dietetic knowledge
- [The BDA ARFID Position Statement](#) clarifies the role of non-specialist dietitians, including when to support, when to consult and when to refer.

- [The BDA ARFID Dietetic Competencies](#) describes the knowledge and skills expected at different levels of practice, enabling dietitians to identify their current position and plan their progression.

Understanding and using existing resources (those created for a general audience)

Many ARFID resources have been developed for the general population or for individuals with typical cognitive and communication profiles. When applied to people with learning disabilities, general materials can present significant barriers to understanding, engagement and therapeutic progress^{22,23}. The language used in mainstream ARFID resources is often complex, abstract or heavily reliant on written text, making it inaccessible for individuals who require simplified communication or visual supports. Concepts such as interoception, anxiety cycles or cognitive reframing may be difficult to grasp without substantial adaptation. Many resources also assume a level of reflective capacity, insight into internal experiences and ability to articulate risk that may not align with the communication profiles of all people with learning disabilities.

Furthermore, resources designed for general audiences often rely on self-directed learning, independent completion of worksheets or written exercises and include the ability to generalise ideas across contexts. Individuals with higher support needs might require concrete examples and may benefit from more repetition and modelling. Current formats may be unsuitable to meet this need. Healthcare professionals have a legal duty to provide reasonable adjustments for disabled people²⁴. Without adaptation, there is a risk that the resource is perceived as irrelevant, overwhelming or inaccessible, which can undermine engagement and reinforce feelings of failure or frustration²⁵.

That said, developing bespoke or adapted resources is not without its own difficulties. Creating accessible materials requires a detailed understanding of the individual's cognitive profile, communication needs and sensory preferences. Without this, there is a risk of making generalised assumptions about ability, oversimplifying content or producing materials that do not resonate with the person's lived experience. Clinicians may also worry about age-appropriateness, particularly when using visual supports or simplified language with adolescents or adults and may hesitate to adapt resources for fear of appearing patronising.

These challenges highlight the importance of thoughtful, person-centred adaptation rather than relying on generic ARFID tools. Effective resource development requires collaboration with the individual, their carers, and the wider multidisciplinary team to ensure that materials are meaningful, respectful and accessible. It also highlights the need for ongoing professional development, supervision and shared learning to build confidence in adapting resources for people with learning disabilities. [The BDA ARFID Position Statement](#) recognises the need to include resource development into dietetic job plans within non-contact-care time.

How to tailor and use existing ARFID dietetic resources:

- **Start with accessibility:** Identify what formats the person can understand and engage with (e.g., visual supports, simplified text, objects of reference, modelling).

- **Meet the person where they are:** Pitch information at their cognitive, communication and sensory level rather than expecting them to adapt to the resource.
- **Use personal interests:** Incorporate preferred characters, themes or activities to increase engagement and make concepts more concrete and meaningful.
- **Seek guidance from people who know them well:** Carers, family and support staff can advise on communication style, attention span, motivators and what has worked previously.
- **Check readability:** Use tools such as Hemingway Editor, the NHS Medical Document Readability Tool, or other similar readability checkers to simplify language and ensure materials are accessible.
- **Condense information:** Reduce content to the essential points where needed, avoiding unnecessary detail or abstract explanations that may overwhelm or confuse.
- **Deliver content gradually:** Consider spreading information across multiple shorter sessions to support processing, repetition and consolidation.
- **Collaborate with SALT:** SALT colleagues can support communication adaptations, symbol use, visual sequencing and accessible explanations.
- **Think creatively:** Use role-play, modelling, photos, videos, real-life examples, sensory exploration or hands-on activities to convey ideas in concrete, experiential ways.

Examples of adaptive resources that can be developed in clinical practice:

- **Social Stories™ (or social narratives) for food exposure activities** - Structured, concrete narratives that explain what will happen, why it is happening, and what the individual could do, supporting predictability and reducing uncertainty during graded food exposure. Social narratives may also be used to reinforce positive engagement and effort during food exploration and exposure-based work.
- **Talking Mats® or sorting activities** - Visual communication tools that support individuals to express preferences, understanding, worries and opinions without reliance on verbal explanation. They can also assist in breaking down complex information into manageable components, reducing cognitive load, supporting task structure and facilitating engagement or redirection during sessions.
- **Visual food-exposure ladders** - Step-by-step graded hierarchies using photos, symbols or real objects to support gradual desensitisation and build confidence.
- **“Food explorer” passports** - Personalised booklets where the individual records foods they have looked at, touched, smelled or tasted, reinforcing progress and motivation.
- **Food hierarchies using pictures or food models** - Concrete, hands-on tools to help the person categorise foods by familiarity, sensory qualities or confidence level.

- **Anxiety thermometers** - Simple visual scales to help the person communicate their level of worry or discomfort before, during and after food-related tasks.
- **Stop buttons** - A visual or physical cue the person can use to pause an activity, supporting autonomy, safety and trust during exposure work.
- **Videos** - Short clips modelling food exploration, cooking steps or mealtime routines, offering predictable, repeatable demonstrations.
- **Predictable scripts for modelling** - Repeated, consistent phrases used by staff or carers to support routine, reduce ambiguity and scaffold new skills.
- **Carer education sessions** - Structured sessions to help carers understand ARFID, adapt communication, support exposure tasks and maintain consistency across environments.

These resources should be individualised and used within a broader formulation-led approach. They should also be used alongside consistent communication, environmental adaptations and behavioural support strategies.

Learning Disability Specific Dietetic Intervention Considerations

Food exposure considerations

Food-exposure work can be highly effective for individuals with ARFID, but in learning disability services it requires careful planning, developmental sensitivity and a strong understanding of the person's communication, sensory and regulatory needs. LD dietitians are well placed to support this work, if exposure is approached safely, collaboratively and within a clear formulation. The key considerations include accounting for:

- **Developmental appropriateness and familiarity** - Exposure activities are most effective when they match the person's developmental stage and take place in environments where they feel safe, supported and regulated. Familiar settings reduce cognitive load and help maintain predictability.
- **Nutritional risk** - Before initiating exposure, dietitians should assess whether the individual is medically stable and whether nutritional risk requires prioritising safety, supplementation or stabilisation before sensory or behavioural work.
- **Timing and readiness** - Exposure is not appropriate during periods of acute distress, instability or major life changes. Assess whether the person is regulated enough to engage, and whether the wider system (family, carers, school) is ready to support the process.
- **Opportunities for choice** - Offering choices (such as which food to explore, how to interact with it, or when to pause) supports autonomy, reduces anxiety and increases engagement.
- **Careful preparation** - Exposure requires thoughtful planning. Identifying the goal, preparing materials, anticipating sensory triggers, and ensuring that carers understand their role is central. Predictability and structure are essential.

- **Calm and regulated moments in the routine** - Exposure is more successful when embedded into times of day when the person is typically settled, rather than rushed or overstimulated.
- **Special interests** - Linking exposure tasks to the person's interests (e.g., favourite characters, themes, colours or activities) can increase motivation and make unfamiliar foods feel safer and more engaging.
- **Pacing** - Progress should be slow, steady and responsive to the person's cues. Overly rapid progression risks distress, withdrawal or loss of trust.
- **Using safe edible alternatives in play** - For individuals who benefit from sensory play, exploring safe edible materials (e.g., edible "playdough" (melted marshmallows with icing sugar), edible sand (blended biscuit crumbs), edible mud (chocolate spread), or liquorice root) allows exploration without risk and builds foundational sensory tolerance. Using different preparations of already accepted foods in ways that are engaging for the person in play settings can be helpful in exploration and build resilience within the range of foods that are accepted.

Interpreting responses to food exposure

Understanding how a person responds to a new food is a crucial part of exposure work. For individuals with learning disabilities, a negative or unexpected reaction does not necessarily mean the food itself was the problem but misinterpreting this could stall progress unnecessarily. Dietitians need to consider the full context of the exposure, including how the activity was set up, what was happening in the environment, and how the food was presented. Detailed, objective recording helps clinicians distinguish between food-specific reactions and responses driven by sensory overload, communication difficulties, anxiety, or disruption to routine. Some critical thinking examples include asking the following questions -

How was the exposure set up?

- **Predictability:** Did the person receive advance notice, or did the activity occur unexpectedly? Predictability can significantly influence regulation and willingness to engage.
- **Transition support:** Were they given time to finish their current activity, or were they interrupted abruptly? Smooth transitions reduce distress.
- **Clarity of expectations:** Was the activity explained in a way they could understand, including what would happen and what they were being asked to do?
- **Environmental factors:** Consider noise, lighting, smells, people present, and whether the setting was familiar. Even small changes can affect tolerance.

What was the food and how was it presented?

- **Food characteristics:** What exactly was the food? Was it familiar or completely new?
- **Preparation method:** How was it cooked? Were the cooking times consistent? Was it served hot, warm or cold?

- **Presentation:** Was it whole or cut up? What size were the pieces? What plate or bowl was used?
- **Utensils:** Did the food require cutlery, and is this something the person can manage confidently? These details matter because small variations can dramatically change sensory experience.

What was the response and what might it tell us?

- **Objective description:** Record what happened without interpretation. For example - “said no,” “turned head away,” “pushed bowl,” “left the table,” “pulled hair,” “cried,” “smelled food but did not touch.”
- **Recovery time:** How long did it take for the person to return to baseline arousal? What strategies helped them regulate?
- **Proportionality:** Was the response consistent with the level of challenge, or did it suggest overwhelm, fear, pain, or sensory overload?
- **Patterns across attempts:** Over time, responses should help build a clearer picture of whether the barrier is sensory, cognitive, emotional, or related to routine, communication or environment.

Developing communication skills throughout the process

Exposure work should not only focus on food tolerance but also on helping the individual develop ways to communicate their preferences, discomfort and needs. Doing so helps to reduce distress, increase autonomy and strengthen trust in the process. Examples may include:

- Offering choices
- Modelling simple communication scripts
- Using visuals or gestures
- Reinforcing any attempt to express “stop,” “finished,” “different,” or “help”

This work should be done in line with support from other appropriate professionals such as Learning Disability nurses, occupational therapists, and SALT.

Dietitians working with education settings

Education settings can play a central role in supporting children and young people with ARFID. In the UK, many individuals with learning disabilities remain in education or specialist college provision beyond the age of 18, often up to 25, increasing the relevance of these environments for intervention. Schools, colleges and day centres offer daily structure, predictable routines and opportunities for social learning that can complement dietetic intervention. Mealtimes in these environments provide natural opportunities for social modelling, where observing peers can help build confidence, curiosity and familiarity with a wider range of foods. Staff can also support the development of practical skills (such as sitting at the table, using cutlery or tolerating the sensory aspects of the dining environment) which are often essential foundations for progress in ARFID. Education settings may be

particularly valuable where there are competing demands within the home environment, offering a more consistent context in which to implement and reinforce strategies.

However, dietitians must also recognise the realities and constraints of education and care settings. They often manage fluctuating levels of need, with staff responding to behavioural, medical or safeguarding priorities that may limit their capacity to implement consistent feeding plans. Rigid timetables, limited staffing and competing demands can make it difficult to create the calm, regulated conditions that some individuals require for exposure work. These challenges reflect the complexity of the environment rather than a lack of willingness, and dietitians need to work collaboratively and realistically to ensure that plans are achievable.

Building strong relationships with education staff is therefore essential. Involving education settings early in the process helps ensure that everyone understands the goals, the rationale and the level of support required. Sharing copies of plans, offering brief education sessions and contributing to annual reviews can help embed ARFID-informed approaches within the wider support system. Mealtimes observations are particularly valuable, offering insight into the sensory, social and practical factors that shape the young person's eating in school. Equally, staff often hold detailed knowledge about what helps the child regulate, transition or engage, and their insights can meaningfully shape intervention across settings.

Education, Health and Care Plans (EHCPs), or local/nation-specific equivalents for children and young people, provide a formal, legally binding mechanism for outlining feeding-related support needs. Dietitians can use these documents to advocate for reasonable adjustments, such as adapted seating, quieter eating spaces, visual supports or staff training. Clear, specific recommendations help ensure that support is consistent across settings and that feeding needs are recognised as part of the child's broader educational and health profile.

Education and care settings can also offer valuable opportunities for sensory and play-based approaches. Activities such as messy play, cooking sessions or structured sensory exploration can help individuals engage with food in a non-pressured, developmentally appropriate way. When integrated thoughtfully, these activities can support gradual exposure and build confidence without framing food as a source of stress.

Dietetic considerations for supporting adults with learning disabilities and ARFID

Adults with learning disabilities who present with ARFID require a clinical approach that reflects the complexities of adulthood, including long-standing patterns of eating, and the wider social and support systems around them. Many adults will have lived with restricted diets for years, often without formal recognition of ARFID, and may have entrenched sensory preferences, rigid routines or anxiety-based avoidance that require sensitive, paced intervention.

A key consideration is that of long-term nutritional risk. Adults may present with gastrointestinal complications, dental issues, constipation, or weight trajectories that mask underlying restriction²⁶. Some may have co-occurring conditions (such as dysphagia, epilepsy, or mental health difficulties) that influence appetite, food safety or mealtime routines. Dietitians must therefore take a holistic view, ensuring that medical stability and nutritional adequacy are prioritised before attempting exposure or dietary expansion.

For adults with learning disabilities who rely on family or support staff for shopping, meal preparation and mealtime routines, the consistency and quality of support is a critical factor in intervention success. Dietitians may need to provide training, modelling and clear written guidance to ensure that staff understand the rationale for recommendations, avoid unhelpful pressure, and create predictable, low-demand mealtime environments. High staff turnover, variable knowledge and skill levels, and competing priorities can pose challenges. Dietitians will need to work flexibly and revisit plans regularly to adapt to the needs of the individual and their support network.

Opportunities for social eating may be limited for people with a learning disability. Observational research indicates that meals are frequently eaten alone, and that shared eating is often restricted to structured settings with limited choice over dining companions²⁷. Reduced social networks and community participation can restrict exposure to new foods, opportunities for modelling, and reduce motivation for change²⁸. Dietitians may need to work with day services, supported-living teams or community groups to create safe, structured opportunities for social modelling and skill development. Equally, some adults may experience sensory overload in communal settings, requiring careful planning and environmental adjustments.

Interventions should also consider long-standing routines and identity. Adults may have strong attachments to specific foods, brands or preparation methods, and changes can feel threatening or destabilising. Pacing is therefore essential, with small, achievable steps that respect the person's autonomy and avoid undermining trust. For some adults, the goal may be nutritional adequacy and safety rather than broad dietary expansion, and dietitians should feel confident in setting realistic, person-centred aims.

Finally, adults with learning disabilities often have limited access to specialist ARFID services, meaning LD dietitians may be the primary professionals supporting them. This underscores the importance of clinical supervision, peer discussion, and ongoing continuous professional development to ensure safe and effective practice. [The BDA ARFID Toolkit](#), [Position Statement](#) and [Dietetic Competencies](#) provide a framework for understanding scope, identifying development needs and accessing appropriate support. Utilising the wider LD multidisciplinary team in addition to dietetics allows more holistic support with elements of ARFID care e.g. occupational therapists, LD nurses, SALT.

Comparison: ARFID in Children/Young People vs Adults with Learning Disabilities

	Children and Young People with Learning Disabilities	Adults with Learning Disabilities
History of ARFID behaviours	Often emerging or evolving; may be identified earlier through school, paediatrician or family concern.	Frequently long-standing, entrenched patterns that have persisted for years without formal recognition.
Developmental context	Feeding skills, sensory tolerance and autonomy still developing; opportunities for early intervention.	Established routines, fixed preferences and strong attachments to specific foods or brands; change may feel threatening.
Nutritional risk profile	Risk often linked to growth, micronutrient deficiency, faltering weight or selective diets.	Risk may be masked by stable weight or overweight; long-term deficiencies, constipation, dental

	Children and Young People with Learning Disabilities	Adults with Learning Disabilities
		issues or GI complications more common.
Co-occurring conditions	Autism, ADHD, sensory processing differences, epilepsy, GI issues.	Higher prevalence of long-term medication effects and chronic disease, alongside conditions seen in childhood.
Capacity and consent	Parental responsibility for decisions common; child's voice still central.	Formal capacity assessments and best-interest processes may be needed; autonomy and rights must be prioritised.
Support environment	Parents, carers and school staff provide structure and reinforcement; education settings offer modelling and routine.	Reliance on paid carers for shopping, cooking and mealtime support; variable staff skill, turnover and consistency.
Opportunities for exposure	School, home and community activities offer natural exposure and social modelling.	Fewer social eating opportunities; may require intentional planning with day services or supported living teams.
Communication needs	Developing communication; visuals, modelling and play-based approaches often effective.	Communication profiles vary widely; may require accessible information, SALT input and structured communication systems.
Intervention focus	Building foundational skills, reducing anxiety, expanding variety, supporting growth and development.	Ensuring nutritional adequacy and safety, improving quality of life, supporting autonomy, and making realistic, paced changes.
Service access	More likely to access paediatric feeding teams, CAMHS or school-based support.	Limited access to specialist ARFID services; LD dietitians often lead intervention with MDT support.
Goals and expectations	Often broader dietary expansion and skill development.	Goals may be narrower and more pragmatic — e.g., ensuring safe intake, preventing deficiencies, improving mealtime anxiety.

Oral Nutritional Supplements (ONS), vitamin and mineral support and enteral feeding considerations

Various documents already explore these topics in detail for individuals with ARFID and can be extrapolated to a learning disability audience:

- [ARFID Dietetic Toolkit](#)
- [BDA ARFID Sub-Group Vitamins and Minerals Resource](#)
- [BDA ARFID Sub-Group '5-a-day-a-different-way' Resource](#)
- [BDA ARFID Sub-Group Clinical Considerations for Gastrostomy Feeding](#)

- [Practice Suggestions for Supporting Acute Re-feeding Admissions for Sensory Eating Disorders](#)) and the patient/carer facing [Practical Tools version](#)

Safeguarding considerations for Learning Disability dietitians

Safeguarding is an essential component of clinical care for both children and adults with learning disabilities and ARFID. Restrictive eating, nutritional compromise and mealtime distress can interplay with wider vulnerabilities, including dependence on others for care, communication barriers, and reduced visibility of risk. Dietitians and wider MDT members need to hold safeguarding in mind throughout assessment and intervention. This includes recognising when ARFID is part of a complex picture that may include neglect, abuse, coercion or systemic failure.

For children, safeguarding considerations include the impact of ARFID on growth, development, school attendance and participation, as well as the capacity of caregivers and services to meet nutritional and emotional needs. Persistent non-attendance at appointments, inconsistent implementation of agreed plans, or significant discrepancies between reported and observed mealtime practices should prompt reflection and, where appropriate, escalation. At the same time, it is essential to distinguish between families struggling within an under-resourced system and neglect. Dietitians should understand when it is appropriate to offer support, education and coordination before moving to more formal processes.

For adults, safeguarding must be understood within the context of autonomy, mental capacity and human rights. Dietitians must assess whether the individual can understand, retain and weigh information about food-related interventions, and support decision-making using accessible communication. When the person does not have mental capacity to make a specific decision, best-interest processes must be followed, ensuring that the person's preferences, values and sensory needs remain central. This often requires close collaboration with families, paid carers and advocates. Adults with learning disabilities may be at risk of neglect in supported living or residential settings. Examples could include inadequate access to preferred safe foods, inappropriate restriction, lack of support at mealtimes, or failure to respond to clear signs of nutritional deterioration. Individuals may also be vulnerable to coercion around food, including pressure to eat beyond their tolerance. Self-neglect should also be considered, particularly where reduced engagement with support places the individual at risk of malnutrition or dehydration. Dietitians should be alert to patterns such as unexplained weight change, missed health checks, or staff narratives that minimise risk, particularly when conflicting with observations or objective data.

Safeguarding is a shared responsibility. Dietitians should know local safeguarding procedures, thresholds and routes for advice, and feel confident to raise concerns, document clearly and contribute to multi-agency discussions. They must also have a knowledge and awareness of the legal frameworks in place to support individuals with a learning disability. Furthermore, dietitians also have a role in prevention. This includes advocating for reasonable adjustments, ensuring that feeding plans are realistic and understood, and highlighting when system-level issues (e.g. staffing, training, access to appropriate food) place people at risk. For both children and adults with learning disabilities and ARFID, good safeguarding practice means holding risk and rights together, protecting from harm while respecting autonomy, dignity and the person's lived experience.

Priority areas for future research include:

- **Large-scale prevalence and incidence studies** that explicitly identify and stratify people with learning disabilities (including by severity and co-occurring neurodevelopmental diagnoses)
- **Validation and adaptation of ARFID assessment tools** for learning disability populations, including accessible formats and robust informant-based measures
- **Treatment studies that report learning disability-specific outcomes**, including those with overweight or obesity status, where nutritional risk may be masked by higher weight status, but micronutrient deficiency and functional impairment remain significant
- Qualitative and participatory research exploring **lived experience** of ARFID in people with learning disabilities, including sensory, emotional and social dimensions of eating
- Co-produced research to define **what constitutes acceptable, accessible and effective support**, including outcomes that are meaningful to individuals and their families and carers.

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Glossary of terms

ADHD	Attention Deficit Hyperactivity Disorder
ARFID	Avoidant Restrictive Food Intake Disorder
BDA	British Dietetic Association
CAMHS	Child and Adolescent Mental Health Service
CBT-AR	Cognitive Behavioural Therapy for ARFID
EHCP	Education Health and Care Plan
GI	Gastrointestinal
GORD	Gastroesophageal Reflux Disease
LD	Learning Disability
MDT	Multidisciplinary team
OT	Occupational Therapy
SALT	Speech and Language Therapy
UK	United Kingdom

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