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An innovative self-catering food service model in a mental health rehabilitation setting

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> Background

Mental health rehabilitation services aim to transition consumers into community living through the promotion of independence in daily living skills, such as health habits. A common service provided is training on healthy eating behaviour and cooking.[1,2,3]

Self-catering food service models are characterised by consumers choosing, preparing and cooking their own food and meals directly prior to consumption. Currently there are no specific nutrition guidelines for the implementation of this type of food service model. Self-catering models aim to encourage high levels of participation and independence by the consumers, posing it as an appropriate model to employ within mental health rehabilitation services.

The University of Canberra Hospital (UCH) **Adult Mental Health Rehabilitation Unit (AMHRU)** piloted a self-catering food service model. This unique model allows consumers to prepare and cook their own meals within a pod kitchen, facilitated by occupational therapy clinicians and allied health assistants (AHA).

A preliminary assessment of the nutritional adequacy and exploration of consumer and stakeholder acceptance of the food service model was undertaken.

> Methods

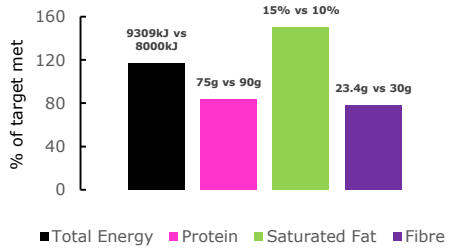
1. Identify relevant literature and nutrition standards for **menu** and **recipe assessment**
2. **Dietary intake** recall of consumers with nutrient and **meal pattern** analysis as well as consumer observations and discussion
3. Semi-structured **interviews of stakeholders** exploring **engagement** and possible **enhancements** of the model

> Results

1. NUTRITIONAL ADEQUACY OF THE MODEL

The **ACI Standards for Consumers of Inpatient Mental Health Services** (Standards)[1] were selected to assess nutritional components of the model.

Test menus were developed from 28 day main menu and assessed for nutrient goals/targets of Total Energy (8000kJ), Protein (90g), Saturated Fat (10%) and Fibre (30g).



High compliance with **minimum menu choice standards** at 78% (15 of 19 standards were met).

ACI Nutrition Standard	Items of non-compliance across the 7 day sample menus
Hot Dish (lunch and dinner): > offer hot dishes on at least two meal occasions per day > at least one hot dish per meal must meet standard for Band 1 or Band 2	▪ ingredients provided to prepare/produce only 1 hot dish option at the dinner meal (from a selection of 2 choices in previous week) ▪ hot option not regularly offered at lunch but was on the menu ▪ 6/14 hot dishes did not meet the Band 1 or 2 standards due to elevated sodium or fat and/or low protein content and/or portion size
One Band 1 Sandwich offered once per day	▪ 1 sandwich option exceeded sodium for Band
One Band 1 or 2 Salad offered once per day	▪ 3 salads exceeded fat content for relevant Band
One Band 1 dessert offered once per day with reduced fat dairy	▪ 6/7 desserts exceeded energy for Band 1 ▪ not currently being made on reduced fat dairy

2. DIETARY PATTERNS

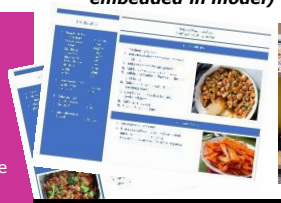
Dietary recall conducted during daily walking group activity.

- Highly **varied intake** for macronutrient and micronutrients due to varied patterns of food intake (n=4)
- **Breakfast** often missed/skipped, sometimes due to consumers being asleep
- **Lunch** often purchased from local café. Low engagement with self-make sandwiches provided in the unit
- Consumers expressed a desire to spend less money on food
- **High participation** and engagement with **evening meal** preparation and cooking
- AHA staff member available during whole evening meal service and provided encouragement

3. STAKEHOLDER PERSPECTIVES & ENHANCEMENTS

Analysis of stakeholder interviews (representing dietetics, occupational therapy, AHA, nursing, management, and consumers) revealed opportunities for enhanced engagement with the model.

- Extension of AHA staffing to breakfast and lunch meals to promote eating within the unit, and minimise expense of purchasing food
- Provision of formal dietetic service for consumers ***(dietitian led healthy eating group education sessions now embedded in the unit)***
- Improve visual quality and labelling of lunch ingredients and meals
- Modification of evening meals to cater for special dietary requirements (e.g. vegetarian)
- Creation of simple, user-friendly and visually appealing recipe cards ***(recipe cards now embedded in model)***



> Conclusion and Significance

The authors believe this innovative food service model to be the first employed within an adult mental health rehabilitation setting that aims to holistically support nutritional outcomes and independent living skills acquisition. It is expected the model will contribute to positive outcomes for consumers, and support good nutrition habits on discharge.

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Acknowledgements
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