



Supporting Vulnerable People With Their Dietary Needs

Meals-on-Wheels and Social Support

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Introduction

This paper has been commissioned by Parramatta Council to explore ways in which individuals who experience difficulty in eating, feeding and utilising existing meal on wheels programs may be better supported. The impetus for the paper has come from observations that many people who use Meals-on-Wheels programs do not eat the meals that are provided to them. The current and funding does not allow for extra support to be provided to people to ensure they are actually eating their meals and receiving appropriate nutrition.

The NSW Department of Human Services, Ageing Disability & Home Care have provided Parramatta Council with funding to trial ways of supporting people who currently use the Meals-on-Wheels program but are experiencing difficulties with eating, feeding and utilising the program due to dementia, disability or illness. The aim of this paper is to assist in gaining a better understanding of the issues and to explore models of support that could be implemented as part of the Meals-on-Wheels program or a social support program to better meet the needs of such vulnerable people.

The paper will initially explore the issues and possible solutions to mealtime problems for vulnerable people. Service principles, practices and models that address the issues are explored. The paper concludes with options to be considered in changing the current Meals-on-Wheels programs at Parramatta Council.

Review of the literature

Mealtime Difficulties

'Mealtime difficulties' is an overarching term referring to 'aversive' behaviours, eating difficulties and meal behaviours. Aversive behaviours can actually include swallowing problems, mental status problems, oral ill health, and other physiological problems. They are best known for observable behaviours such as turning the head away, refusing food and medication, clamping the mouth shut, and refusing social interaction with the caregiver.

'Feeding behaviours' are displayed when a caregiver is attempting to assist the person to feed and that assistance is met with resistance. This resistance may be judged to be paranoia and agitation (Aselage, 2010). Again, the observable behaviours may include turning the head away, spitting out food, refusing to open the mouth, leaving the mouth open so food drops out and leaving food on the plate.

'Eating behaviours' include both physical and social aspects of meals. The difficulties the person encounters here may include problems with recognising food, problems transferring food to the mouth and problems with the phases of swallowing. There may be a lack of attention to food, a seeming lack of recognition that this is a meal. Some people appear to forget they have food in their mouth and take another bite, overfilling the mouth. Some may eat and choke on non-food items (Lin, Watson & Wu, 2010).

'Meal behaviours' is a term used to describe a combination of behaviours and postulated causes which include positioning problems, dysphagia, distracting noise levels, poor communication, poor nutritional status and poor staff skills in feeding (Aselage, 2010).

It is important to reiterate here, that aversive behaviours in feeding and eating are not necessarily a psychological problem and don't necessarily mean the person is refusing food. They need to be properly interpreted to affect a better outcome. They may in fact indicate physiological problems such as a swallow problem, discomfort, changes in taste perception, such that the food tastes unpleasant; they may indicate pain or cognitive confusion about meals and eating. Attempts to improve feeding should include consideration of repositioning the person, checking for pain and discomfort, checking for taste preferences, gently touching the spoon to the lips to prompt mouthing, and using gentle verbal prompts (Aselage & Amella, 2010).

The importance of proper nutrition cannot be overemphasised. Poor feeding leads to poor nutrition, malnutrition, dehydration, weight loss and is then followed by other problems such as skin breakdown, delirium, earlier morbidity and mortality. Greater feeding problems and greater dependence on others for feeding assistance, correlates with weight loss and poor nutrition in the disabled and elderly population (Charras & Fremontier, 2010).

Poor nutrition contributes to and/or causes cognitive problems. Lack of certain specific nutrients in the diet causes cognitive decline. Poor nutrition and subsequent malnutrition contributes to weakness, loss of strength, falls, infection, depression and cognitive decline (Charras & Fremontier, 2010).

Mental status is an important factor in mealtime behaviour. Mental decline contributes, along with physiological and psychological issues to feeding problems and then weight loss. Moderate dementia and moderate to severe levels of intellectual disability should be taken as an indication that the person needs assessment for apraxia and dysphagia. Such issues are closely related to subsequent weight loss and malnutrition (Miyamoto, Higashino, Mochizuki, Goda & Koyama 2011).

The literature suggests that early and late stage dementia are periods when eating problems are not so difficult. In the early stages, the person may still be

feeding well and not having significant problems with swallow or confusion. They may still be able to use appliances, cook and eat safely, despite small mistakes. In the later stages, people are more likely to be receiving full assistance with all aspects of daily living and feeding assistance will be part of that. It is the middle stages of dementia that pose the greatest problem. Swallow problems, memory problems, difficulty with appliances, cooking and utensil-use become evident, as people become more confused. Factors which are associated with greater rates of weight loss and poor nutrition are: moderate dementia, being female, elderly, having no assistance at home, fewer friends, and beginning to experience swallowing difficulties (Lin et al 2010).

Addressing meal time difficulties

Meals as a Social Event

Successful efforts to address mealtime difficulties acknowledge that meal times are much more than a refuelling and nutrition exercise and address mealtimes as a holistic experience.

A meal, at its best, is a social event and a form of personal social engagement that enhances well-being and happiness. A task oriented approach by paid staff has been shown to produce a negative outcome whilst a person-centred approach, taking into account the person's history and preferences is more likely to produce a good eating experience with less difficulty for the caregiver (Aselage & Amello, 2010).

Some factors which are considered to improve the mealtime environment include making sure there is less noise, less clutter and distractions. Clinical activity should be minimised, interruptions and disturbances should be minimised. Sufficient and focused assistance needs to be provided. The best

eating environment is a familiar home environment with good lighting and the social aspects of home (Aselage & Amello, 2010; Charras & Fremontier, 2010).

A number of studies indicate that enhancing the social environment of meal time results in better eating, improved skills and communication, and better physiological and psychological outcomes. Charras and Fremontier (2010) demonstrated that creating a home-like meal event in a nursing home, with a small group of residents sitting together with staff (out of uniform) quickly led to greater alertness, improved attempts to eat, and greater levels of communication and assistance to each other amongst the residents.

People were assisted by the familiarity of the meal arrangements, improving their memory of how to behave. They were engaged with each other in passing food around the table and contributed to discussion and conversation in this homely and familiar environment. Their use of utensils and eating skills were improved by the opportunity to model the behaviour of the staff. Weight was improved as well as autonomy, with many residents spontaneously contributing to the cleaning up activities after the meal. Interactions were improved as well as communication skills and previous difficult behaviours were improved.

An unexpected outcome of this experiment was an improvement in the quality of the food prepared by the institution's kitchen. Because staff were eating with the residents, they had their first experience of eating what the residents ate. They complained to the kitchen that the food was bland and unappetising. This caused the kitchen staff to take note and improve the food. This might cause us pause, as we consider the relative power and status of staff versus clients. It speaks to the difficulty of getting one's opinions heard if one is already deemed incompetent, not to be taken seriously, and others assume they know what's best for you.

The use of supplements and tube feeding for people with extreme weight loss has not been found to be very effective. By contrast, attention to social, cultural

and environmental issues has resulted in improved nutrition and weight gain (Aselage & Amella, 2010; Charras & Fremontier, 2010).

Aselage and Amella (2010) report on the positive effects of concentrating on the dyadic interaction of the feeding experience. They cite improvements in people where the staff have provided encouraging prompts, guidance, touch and praise, whilst removing the clinical approach. This involved attention to the environment, with the creation of a home-like setting where noise and other distractions were reduced, and attention given to a warm and encouraging interaction between the staff and resident. Previous to this, staff who were described as noisy, demanding and inflexible were found to increase the stress in the relationship which resulted in poorer feeding.

Aselage and Amella (2010) noticed that residents would help each other when staff were not present but as soon as staff entered the environment, residents stopped assisting and returned to their 'client' role. Fostering independence and autonomy was focused on by removing the clinical aspects of the environment. Buffet and family style meals, with attention to home-like meal timing, locations, settings and utensil styles were also observed to improve resident assistance to each other, independence and communication.

Attention to cultural sensitivities and traditions is also an important aspect of the eating experience. Older people are known to lose their appetite. This may in fact be a problem of memory compounded by different cultural traditions. We may make a mistake in assuming that once a person seems to have lost their memory of eating and meal behaviour, cultural traditions won't matter anymore, however the opposite is in fact true. The adherence to long-standing patterns and cultural norms related to eating and mealtimes are most likely to assist the person to perform more independently.

The job of family and carers is to stay focussed on where the person is at, on a continuum of culture of origin versus mainstream cultural affiliation. Modern foods and food preparation techniques may not be experienced as tasting right

and thus be rejected. Eating traditional foods with associated tastes, textures and cooking methods, has been found to improve acceptance of food. Maintenance of traditions such as a pre-dinner drink or wine with meals is also important to maintaining familiarity and continuity for the person with memory problems (Charras & Fremontier, 2010). In addition to this, the presence of family members and family meals will help delay the loss of skills and encourage that emotionally supportive dyad. Indeed, the same person assisting with eating over time produces the best outcome. (Lin, et al. 2010; Aselage & Amella, 2010)

Eating together and family/friendship bonds

Further to the issue of families eating together, the work of Keller et al (2010) reports on the importance of mealtime in maintaining positive social bonds and emotions in the family of a person with dementia. Mealtime in the family typically includes the preparation, cooking, setting the table, serving and cleaning up activities, as well as sitting at the table together. Sitting at the table involves sitting face to face with each other, talking about the day, sharing thoughts and ideas and helping pass and serve food etc. Couples and family members caring for relatives with dementia at home report on the psychological importance of this as a bonding experience.

Meal time may represent the only time the family get to sit together and talk as other interactions are often taken up with instrumental caring activities and tasks. It may represent the only time the carer gets positive feedback and some reciprocity for their caring role, in that the person with dementia is more likely to compliment them for the food, help with tasks if possible and interact positively in mealtime discussion in their familiar family environment. Social connection and reciprocity are aided by the joint task of meal preparation and eating. Such family norms represent traditions and memories that enhance relationships and aid memory and competence.

In one example, a man who was caring for his wife with dementia was relieved of constant caring by his wife's ability to continue to prepare at least part of each

meal. In this way, she was able to share the tasks of daily living and give back to him for all his care of her. Other couples reported the meal as the only time their partner was able to give thanks and acknowledge their care and support, by complimenting them on the dinner. This concentration on the strong bond between carers and their family member is crucial to the well-being of both. The consistency and frequency of this daily rhythm is also crucial to memory and a sense of safety and certainty. For family members then, meal time means remembrance of important events and relationships, intimacy, familiarity, psychological well-being, social connection and reciprocity.

Eating out is another way that people experience the positive bonding and connection at mealtimes with friends and family members (Cassolato et al., 2010). Considering eating out as a leisure activity, we note that leisure is important in assisting people in stressful times, when difficult life events happen. It provides opportunities to escape from stress, creates a sense of optimism, allows for a reconsidering of the future and can provide transformative experiences (excitement, intimacy, new learning). Leisure time involves social connection and the shoring up or new development of social networks. Maintenance of leisure activities for the person diagnosed with dementia, who is frail and ageing, or who is disabled, is important to maintain companionship and social relations as well as maintaining positive social outings and skills, a continuity of life and normal activities. Eating out is frequently practiced by families as a celebration of important events, an exciting change from the norm and a way of relaxing, free from the drudgery of daily tasks.

For some people with dementia eating out offers an opportunity to eat whatever they want, which may mean returning to older food patterns and cooking styles. A restaurant offers the possibility of catering to divergent tastes. Family bonds are strengthened by the remembrance and celebration of important events such as religious rituals, birthdays and anniversaries. Such events enhance the value and continuing place of the older person within the family. The social meal, including extended family, religious group affiliates, and other friends at local clubs, cafes and restaurants or at each others' homes, is important to maintain

social connections and social value, whilst providing necessary support and assistance (Keller et al., 2010).

Indigenous People

For Aboriginal and Torres Strait Islander people, connection to family, community and country are equally important. This means thinking about the person in a web of social connections that dictate valued roles and relationships founded on the person's identity as a family member, clan member and connected to land. Identity is not individual. Identity is related to one's family and clan affiliation which gives one a connection to particular country.

Relationships may be more complex and dense, as in the example of all people of one's mother's generation being referred to as 'aunty', a term that carries with it respect and deference. Familiarity with, and love of country are not just about enjoying the land you own. Living in one's country is important due to deep spiritual connection, inter-generational obligation and the performance of necessary religious rituals. Ageing in place, person-centredness and social connectedness are all concepts popular in the modern aging and disability literature. Such terms are truly the underlying values in Aboriginal culture where mutual responsibility and social obligation through complex kin relations have always dictated how vulnerable people should be supported (McMillan, Kampers, Raynor & Dewing 2010).

Service responses

The above discussions highlight that the issues of people consuming nutrition and hydration provided to them has far more to with the holistic experience than the actual provision of the food. An important step is determining whether the issues are physiological or psychological/social in nature and considering ways to address the social aspects of meal times. The following sections discuss approaches to service delivery that have been shown to provide a holistic approach to meeting the needs of vulnerable people.

SRV & Person-Centeredness

Social Role Valorisation (SRV) proposes that people who don't conform to dominant societal values are liable to be devalued or socially rejected and ostracised, and systemically disadvantaged. This will result in hurtful experiences including being rejected, negatively stereotyped, losing control of their lives and decisions, accorded lower social status and treated badly, even harmed. Groups to whom this is liable to happen include the disabled, elderly, indigenous, migrants, the poor, people who have been in jail and the mentally ill. In order to prevent or ameliorate this process of devaluation, we might attend to the person's real needs by providing supports that assist them to be valued in society. Where a person is most liable to be presumed to be incompetent (especially the elderly and the disabled) our concern should be to improve the person's skills and abilities. This will involve making sure they are as competent as possible in important everyday tasks, to avoid negative attention and to improve their capacity to manage and be as autonomous as possibly. We should also make sure they have strong social connections and relationships. This protects people from the likelihood of rejection and social ostracism. We should also ensure they present with a positive image to avoid negative stereotypes and further rejection (Osburn, 2006).

When people see a service attending to the needs of someone, they assume the service workers must know best and that the person must need expert advice and care. In this way, human service models and processes tend to drive out natural relationships and ordinary neighbourly assistance and helping (Uditsky, 1993). One of the functions of assistance to people needs to be to protect them from the stereotypes associated with being seen as a 'charity case', being seen as a burden, being seen as helpless and deficient. The human service client role, or 'clienthood' can be life defining and invade a vulnerable person's capacity to make their own decisions, have the lifestyle that suits them, or make choices that are particular to their needs and history, in favour of decisions and arrangements that suit the service agency and fit in with the service and staff needs (Thomas, Keller & Milne, 2000).

Person-Centredness is a service process that is designed to keep us focussed on the individual person and their real needs, in keeping with the intentions of SRV, to create the conditions for a good life for people. A person-centred approach dictates that service providers attend to the needs of people individually instead of attending to a labelled group, using a 'one-size fits all' model, or by fitting people into the service's constrained program. It requires the service to think deeply about the individual person and consult widely with them, their supporters and their loved ones. They should be ready to try innovative approaches and apply flexible service and staffing arrangements to meet the person's needs without taking over their life.

When using a person-centred approach, a service should consider supporting and shoring-up existing supports and natural relationships, in preference to replacing them with paid staff, so that people are embedded in a natural network of relationships, rather than these connections giving way to paid relationships. Person-Centredness dictates that a service plan must stay focussed on who the person is and what their preferences are. The service would also want to ensure that any paid staff that are needed, are being flexible in their tasks and how they go about them. Focus needs to be on what is most needed by the person rather than staff tasks being dictated by service practices and discipline areas. The skill of the facilitator in understanding the person and their needs and directing and leading a person-centred meeting/plan accordingly is crucial (Ryan & Carey, 2009; Snayde, & Moriarty, 2009).

Local Community Building Initiatives

A number of models of support that can be provided to people in their own homes where family and friends are not available, that might have features in accord with SRV and person-centredness have been developed. They include the 'Street by Street', 'In Your Street', 'Side-by-Side' and 'Befriending' programs.

These ways of addressing the needs of socially isolated people arose out of the decline of community and neighbourliness in modern western cities. Some of these programs are more involved in instrumental support to people with significant problems functioning in the community whilst others are designed to be easily applied by people in their local area, in much the same way as one might once have expected neighbours to 'look out' for each other. These involve canvassing the very local neighbourhood for people who are willing to provide some small assistance to those in their midst who are socially isolated.

The Street By Street program focuses on providing practical help with tasks, but for the purpose of relieving social isolation. Once an isolated person is identified, people are contacted in the same street or nearby, with a request to assist with small tasks. This national Australian initiative is designed to reinvigorate our neighbourliness and attention to vulnerable neighbours in our streets and suburbs to provide a more supportive community and avoid or delay people needing to go into supported accommodation settings. Support might be as simple as taking out the garbage bin for the person, collecting their mail, or saying hello over the back fence regularly to make sure they are ok (Hughes, ND).

The In Your Street program operates the same way and seeks to assist in the establishment of relationships between people who live locally and are able to share some of their time and assistance. This may include regular visits from a neighbour to ensure that a person is eating well, or to help with small daily tasks. The relationship is the key issue here. However, this program is not deemed to be suitable for people with a more significant disability or dementia. In that case, they would seek to involve family or paid staff (Val Freeman: personal communication).

'Befriending' is a complex of programs used in the United Kingdom much like the social support model used in NSW (Mentoring and Befriending Foundation, 2010). Befriending has been used as an intervention to support people with complex health and social needs. The term is used to describe the development of a relationship in which an individual who is not family, a close friend, or a paid

worker, volunteers to spend time with, encourage and support a person during a time of crisis or transition. It serves the aims of the individual but also the State in that it is used to improve well-being as an early intervention, to aid rehabilitation and build resilience after trauma or ill health. It is hope that this intervention will reduce future dependence and prove more economical for the health care system.

The programs seek to address social and emotional isolation and lack of access to community resources that result for people who have poor physical or psychological health, disability or age-related problems. Many of the people supported in this way have multiple disadvantages including poverty, family breakdown, unemployment and lack of training opportunities. The aim of such programs is to reduce social isolation and exclusion, and increase health and well-being. People are assisted to participate in community activities and recreation, do everyday tasks, pursue interests and skills, and increase their social networks.

People supported through such programs may have intellectual and physical disabilities, psychiatric illness, Autism, be women who have experienced domestic violence, elderly, have dementia, be chronically or terminally ill. Respite for carers might also be provided.

Many participants describe a two-way process in which the volunteer is also helped by the relationship, having been themselves in such difficulties before or by getting some of their needs met in the relationship. An example is given of an elderly woman teaching her volunteer a foreign language, prior to the volunteer going on a trip overseas.

The primary functions of a Befriending Program are described as enabling access to services, enabling an increase in choice and control, providing early intervention and prevention of more serious dislocation and disengagement, and generally increasing social capital in the local community.

Assisting people with an early intervention focus includes helping them get access to the right services, but also providing support and encouragement so that people can improve their self-esteem and well-being. An example is given of a woman who had experienced domestic violence being assisted to get back to work and feel safe and confident in her work place. The support is designed to be practical and functional and it focuses on assisting people to be independent and autonomous. It is envisioned as a time-limited service and as part of a package of services that are designed to increase functioning and independent living.

The Mentoring and Befriending Foundation (2010) describes three levels of need:

1. Promoting well-being: Primary Prevention. This is aimed at maintaining independence and social connections for people at risk of losing skills and social connection.
2. Early Intervention: Secondary Prevention. This is about halting further deterioration in people who have health and psychiatric problems.
3. Maximising Independence: Tertiary Prevention. This level aims to reduce the impact of disability or deterioration and maximise the person's functioning in the community.

Implications for practice

A review of the literature and practice models demonstrates that to meet the needs of vulnerable people who do not consume nutrition and hydration that is provided to them through the current Meals-on-Wheels model, significant changes will need to be made that acknowledge and incorporate the holistic approach to meeting individual needs.

Separation of food provision and meal time assistance

The Meals-on-Wheels model assumes that the person is able to heat up and eat a meal, but possibly not able to shop, cook or prepare the meal (for whatever reason). Such an assumption ignores the variety of reasons why a person may be needing assistance with mealtimes, and having trouble maintaining adequate nutrition. In order to provide a service that truly addresses the needs of individual people, provision of food and cooking needs to be addressed separately to actual eating, feeding and mealtime behaviour.

If the person's problems are around getting the food and cooking it, assistance to purchase, transport and/or cook food is what is needed. Many types of nutritious meals are available ordinarily in the community through the delivery of fresh food or purchase of prepared meals in supermarkets or take-way shops. A variety of approaches might be tried depending on the particular needs of the individual. The person may be assisted with shopping and cooking at home; the person may be provided with funds to go to a local café; the person may be assisted to purchase delivered meals.

Given that the reasons for poor nutrition in older and disabled people are generally not the lack of provision of food, service providers might consider alternative ways of providing assistance with meals. Where eating, feeding and mealtime behaviours are the problem, provision of support with the mealtime is needed.

Person Centred Approach

The person centred approach requires a comprehensive and individual examination of the person's circumstances to determine what the person's real needs are, with people who know the person well. From this, a comprehensive picture of how those needs might best be addressed can be developed, by people who know the person and others who understand the local community and available services. Research suggests that people with dementia are less likely (than other elderly and disabled people) to get access to various community supports including Meals-on-Wheels. They are more likely to be getting general practitioner and other medical support, although not specialist medical interventions. Many could benefit from gerontological support, physiotherapy and occupational therapy as well as functional support at home but these services are little used due to friends and family not considering or knowing about other options until the person is so incapacitated that nursing care is all that is considered. In fact, the use of specialist medical and allied health services decreases the need for hospitalisation and nursing intervention (Weber, Pirraglia & Kunik, 2011). A considered and thoughtful person centred plan would enable a coordinating service provider to examine all the person's needs at one time, and determine a range of supports and services that could best address the needs. Such a coordinating agency could then refer if necessary to other specialist providers whilst retaining a coordinating role, to ensure that proposed supports were addressing the problems identified.

Eating and Swallowing Problems

To provide regular meals to people who have difficulties cooking and feeding themselves, and are in danger of lacking adequate nutrition, is obviously an important social good. However, simply delivering a frozen meal and expecting this to be sufficient intervention, ignores the many and complex reasons why a person may be having trouble feeding themselves in the first place. People who are eligible for Meals-on-Wheels should first be assessed for eating and

swallowing problems. Aged-care and disability support staff, and of course family members, may have inadequate training to notice eating and swallowing problems.

Best practice in this regard involves: proper training of staff to assess eating and swallowing problems; assessment of the whole mealtime situation, including assessing the family mealtime arrangements, history and style of the particular person. This should include tasting the food proposed, to ensure that it is indeed palatable and consistent with the style of food the person prefers or did prefer in the past (Charras & Femontier, 2010). Videos of appropriate support and assistance may be used to teach family members how to assist with eating (Aselage & Amella, 2010; Keller et al., 2010).

Friends and Family

The most reliable kind of support to the person who is experiencing eating problems is a loved-one, a family member and a familiar face. Best practice dictates that family and close friends are the best people to assist with cooking, eating and meal behaviour. Canvassing of local supports but with a view to using, by preference, a known friend or family member to assist with eating would represent a valuable change in how Meals-on-Wheels is delivered. A service provider might assess the individual, and then find the best available person and show them how support might be given. This could include encouraging family get-togethers and other social settings consistent with the person's past ways of socialising around mealtimes. (Lin, Watson & Wu, 2010; Keller et al, 2010; Charras & Fremontier, 2010)

Local Neighbourhood Support

For people with short-term problems (such as recent release from hospital or physical injury) the street-by-street model of involvement of local neighbours could be a good and simple solution to eating and cooking problems. This does not necessarily mean Meals-on-Wheels would be the best way to ensure good

nutrition. Neighbourhood support could involve assistance with shopping or cooking or organising other delivered meal services (e.g. *Lite and Easy* delivered meals are of comparable cost; frozen meals from the supermarket are also of comparable cost). Such support would be easily faded once the person was well again, allowing independence and autonomy and reducing dependence on service systems (Mentoring and Befriending Foundation, 2010).

Ongoing Local Neighbourhood Support

For people with dementia or more significant difficulties in cooking and eating, social support in a flexible independence-focused way like the Befriending Programs could be a useful model. If the person is having difficulties with heating food up in the oven or microwave and actually eating, considerable effort will be required as the support needs to be daily to ensure at least one nutritious meal is consumed each day. Again, best practice dictates that this is best done by a family member or at least a familiar face. The recruiting of volunteers could focus on local known people. Otherwise, services might expect that it may take some time for the person to be accepting of mealtime support. Best practice indicates that such support would be more effective if the volunteer ate with the person and/or the meal happened in a familiar social setting with others eating too (Charras & Fremontier, 2010; Keller et al., 2010). Such meal provision could be a hot meal delivered when a companion was guaranteed to be there, or a frozen meal to be prepared then or later when help was available.

Eating Out Locally

Another way to ensure nutritious meals are available to a person, particularly if their problem was shopping and cooking of food, is to recruit the assistance of local businesses that provide hot meals. This might be a local café, pub or restaurant. The person may be provided with funds, or the business may be funded to supply a meal each day to a vulnerable person. The provision of a regular meal in such an environment has the advantage of allowing social

engagement and the selection of a variety of preferred meals. This may be a preferred method for someone who would otherwise be socially isolated at home and who might not be competent with using cooking equipment at home e.g. older man, disabled person (Thomas, Keller & Milne, 2000).

Conclusions

It is clear that, once we acknowledge that eating, feeding and mealtimes are very different problems to shopping for, cooking and preparation of food, that the solutions to these problems must be two different solutions. It may be the case that some people will be experiencing problems in both areas, but this is part of what needs to be established in a person-centred plan and mealtime assessment.

Solutions need to be considered with priority given to natural relationships (family, friends) and community relationships (neighbours, volunteers). Paid relationships need to be considered last, unless particular circumstances dictate that paid help would be best (specialist skills needed).

Solutions need to consider the culturally valued analogue in that local community. That is, how do socially valued members of the community normatively have meals provided? This might include eating out at local venues, assistance with shopping and cooking, neighbourly visits, or buying pre-prepared food.

In this schema Meals-on-Wheels becomes one of a number of solutions considered for people at risk of poor nutrition. Several other solutions, as described above, might be included in a raft of ideas that have added benefits such as increasing social capital, improving neighbourliness and securing relationships. Initial funding money might be well spent trialling person-centred planning to discover the needs of particularly vulnerable people or people who have been difficult to serve via the old model. This would provide an opportunity to trial some innovative solutions as suggested above.

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