

BHN Newsletter

BHN: Fuel Your Brain, Feel Your Best!

Food Insecurity and Mental Health: What's the Relationship and What's an RDN to Do?

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CPE

The World Health Organization (WHO) defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.”¹ It is more than the absence of mental illness, a diagnosable health condition characterized by maladaptive patterns of thought, emotion, and/or behavior, and includes such conditions as major depression, generalized anxiety disorder, bipolar disorder, and schizophrenia.² Individuals may be mentally healthy along a spectrum just as individuals are physically healthy to various degrees. The WHO regards the attainment of mental health as subject to socio-environmental circumstances.

One circumstance that researchers have explored in relation to mental health is food insecurity. Food insecurity is the “household-level economic and social condition of limited or uncertain access to adequate food,”³ a definition that denotes financial, geographical, and/or logistical barriers to food that is both unspoiled and nutritious. Whether food insecurity impairs a person's ability to achieve and maintain optimal mental health or, conversely, sub-optimal mental health impairs a person's ability to achieve and maintain food security, is a question that remains unanswered by the existing body of research. Nonetheless, with continued investigations into the existence of this relationship, its strength, the direction of effect, and how it may differ among sub-groups, it is a question that may provide valuable information about populations with whom registered dietitians/nutritionists (RDNs) interact.

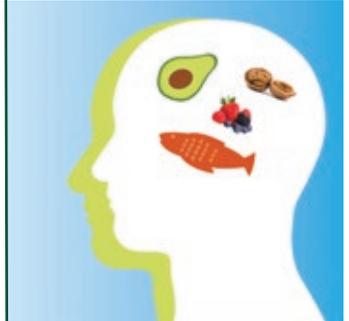
The Faces of Food Insecurity and Mental Illness

Data from 2012 revealed that approximately 5-15% of families in industrialized

countries and 14.5% of the United States population (49.0 million people) experienced food insecurity.⁴ In 2006, the United States Department of Agriculture (USDA) re-labeled the two classifications of food insecurity, “food insecurity without hunger” and “food insecurity with hunger,” to “low food security” and “very low food security,” respectively.³ Most recent figures from the United States reveal that nearly 40% (7.0 million people) of food insecure households experience very low food security,⁴ characterized by higher relative rates of disrupted and reduced food intake, weight loss, and hunger.³ Demographic factors associated with high rates of food insecurity are numerous and interrelated: high unemployment; low household income; low level of educational attainment; difficulty meeting basic expenses such as housing, utilities, and medical care; households with children; single-parent households; maternal age at child's birth; Black, non-Hispanic households; Hispanic households; and senior citizen status.⁵⁻⁸

For purposes of statistical representation, poor mental health is indicated by the presence of mental illness and/or episodes of serious psychological distress (SPD), a non-specific measure of mental health burden. In the United States, most recent estimates revealed that 1 in 17 adults and 1 in 10 children have a serious mental illness.⁹ Approximately 11% (24.3 million) of adults in 2007 experienced SPDs.¹ Though mental illness affects all races, ethnicities, education levels, ages, and socioeconomic groups, higher rates of mental illness and/or episodes of serious psychological distress (SPDs) among adults have been found in those who are 45-64 years old, females, those with low educational attainment, those in poverty, and those who are not married.¹⁰

In addition to demographic factors, characteristics related to physical health have



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From the Chair

Mary E Kuester, MA, RD



It is hard to believe that I have reached the end of my term as Chair of BHN and soon we will be transitioning to a new leadership team. We started the leadership year with the motto, "Making the World a Better Place, for Everyone" from the Kid President video entitled "A Pep Talk from Kid President" on Youtube (www.soulpancake.com). In this video we are encouraged to "create something that will make the world an awesome place."

I think that many of us became dietitians because we wanted to help people have better lives, in a sense we wanted to create a better world. This can take many shapes and forms whether working directly with clients, doing research, or advocating for nutrition services. Working in behavioral health nutrition we have the opportunity to have a positive impact on people who are often overlooked or marginalized in our society. Every day we have the opportunity to make the world a better place by helping people have a healthier relationship with food, understanding the relationship between mental health and good nutrition as well as helping people gain access to healthier food options. We are often able to make more progress when we work together with other professionals rather than on our own. I am very proud that during my year as Chair we have partnered with the Hunger and Environmental Nutrition Dietetic Practice group on a series of webinars as well as articles for this newsletter. I hope you enjoy this issue and find many ways to help your clients.

We have had a busy year providing resources that help you in your practice area as well as give you a chance to meet other BHN members. Following is a brief list of some of the activities/ resources we have promoted:

- Quarterly Newsletters that includes articles pertinent to topics in behavioral health nutrition.
- Quarterly webinars- one for each practice area.
- FNCE Spotlight session on the role of nutrition in psycho-therapy.
- Member reception at FNCE that included case study presentations from our Resource Professionals.
- FNCE Member Showcase where guests to our booth received a custom made luggage tag that asked "What's Your Baggage?"
- Promotion of BHN at Lifestyle Intervention Conference in Las Vegas, Nevada.

We have also made an effort to have more members become involved in presenting webinars by requesting proposals for our Eating Disorder Webinar this spring. Look for more of these requests in the future. In addition, we realize that being able to have practical information easily accessible is essential for you to work at your best. To that end we will be completing a major redesign of our website (www.bhndpg.org) to provide you with up-to-date information and resource.

Wishing you all the best in the coming year and remember to "create something that will make the world an awesome place!"

Nominations Committee is pleased to announce BHN Election Results!

The following officers will assume duty on June 1, 2014:

Chair-Elect - Adrien Paczosa, RD, LD, CEDRD

Secretary - Kacy D. Grossman, MS, RD

Nominating Committee Chair-Elect - Terry Anderson Girard, MS, RD, LDN

Newsletter Editors' Message

The Behavioral Health Nutrition Dietetic Practice Group is excited to bring to you this newsletter devoted to the therapeutic value of food and nutrition in behavioral health care and recognition of the risks for food and nutrition insecurity in the vulnerable populations we serve. In the behavioral health arena, nutrition professionals have long acknowledged the interrelationship of food insecurity and mental health, essentially the ability to achieve and maintain food security influenced by environmental factors, physical and mental capacity, and economic and social supports.

The recently published Fall 2013 issue of BHN Newsletter included a timely report from our HOD Delegate, Harriet Cloud, addressing food insecurity and the Academy's goal of increasing membership awareness of the prevalence and consequences of national food and nutrition insecurity, and inspiring members to support and promote policy and advocacy programs at local and state levels. In consequence, BHN has collaborated with the Hunger and Environmental Nutrition (HEN) DPG to provide a series of webinars as well as articles featured in this publication that focus on food security and sustainable nutrition for behavioral health populations.

We hope this Spring 2014 issue of BHN Newsletter serves to inspire as well as equip BHN members with the information and tools needed to achieve the mission of this DPG: Empowering BHN members to excel in the areas of Addictions, Eating Disorders, Intellectual and Developmental Disabilities and Mental Health by providing resources and support.

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been associated with both food insecurity and mental illness/SPDs. Numerous studies have uncovered relationships between food insecurity and certain diseases, conditions, and measures of physical health, including sub-optimal nutrient intakes;⁸ reduced serum nutrient levels;¹¹ increased rates of obesity, particularly among women;¹² increased risk of developing metabolic syndrome, diabetes mellitus, and gestational diabetes;¹³⁻¹⁵ and greater prevalence of poor/fair self-reported health ratings.¹⁶ Similarly, mental illness and/or SPDs have been associated with higher prevalence of obesity, diabetes, heart disease, stroke, and arthritis.² Moreover, the life expectancies of people with mental illnesses is 14-32 years shorter than the general public, a discrepancy not explained by suicide rates.¹⁷

In light of these shared risk factors, investigators have begun to search for direct links between food insecurity and mental health status in hopes of finding potential interventional target areas for improving food insecurity, mental health problems, or the physical health outcomes to which they are linked. Examples of theories driving these investigations include: (a) the psychosocial impacts of unpredictable access to food manifest as measurable alterations in mood and/or behavior; (b) poor nutrition caused by impaired access to food may potentiate mental health sequelae; (c) challenges to daily life imposed by having mental health problems may make afflicted persons more vulnerable to food insecurity; and (d) poor physical health induces or exacerbates mental health problems and/or food insecurity.

Food Insecurity and Mental Health: Literature Review

A recent large-scale cross-sectional survey of 77,053 Canadian adults examined if and how poor health (physical or mental) impacts the likelihood of being food insecure. The authors revealed a clear dose-response relationship between the number of chronic physical or mental conditions experienced by adults and the severity of household food insecurity, independent of household socio-demographic and economic

factors. Among all chronic physical and mental health conditions included in the analysis, mood and anxiety disorders held the strongest link. The authors proposed two possible mechanisms: mental health problems may increase the severity of food insecurity by requiring substantial allocations of families' disposable incomes, and/or mental health problems encumber efforts to cope financially when resources are limited. They could not rule out a bi-directional effect between health and food insecurity, however.²⁰

In a similar study among rural low-income families, a direct relationship between chronic physical and mental health conditions and overall rates of household food insecurity was determined; and depression, specifically, was associated with an increased rate of persistent (versus intermittent) food insecurity. In this study, household expenses, utilization of food assistance resources, and budgeting skills were among the control variables. These controls challenge the theory that impaired mental health leads to food insecurity by way of limited disposable income and poor financial coping skills.²¹

Studies focusing on the maternal and child populations have exposed a complex yet compelling interplay between mental health and food insecurity. Among mothers, food insecurity is associated with increased depression and/or anxiety, and among children, it is associated with increased behavioral problems.²²⁻²⁸ Maternal experiences of depression, substance abuse, psychosis spectrum disorder, and domestic violence have been shown to increase the odds of food insecurity, and food insecurity has predicted higher rates of clinically significant behavioral problems in their children in a cohort study of low-socio-economic status families.²² Another large-scale cross-sectional study of mothers and children that adjusted for substance abuse and prenatal domestic violence found similar results, specifically in terms of depression and anxiety. Nearly a third of food-insecure mothers experienced either major depressive disorder episodes or generalized anxiety disorder over the course of one year. Also, the researchers identified a direct relationship between severity of food insecurity and percentage of children with a behavior problem (aggression,

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depression/anxiety, or hyperactivity/inattention), with up to 36.7% of children with severe food insecurity.²³ The latter study adjusted for maternal depression and anxiety, suggesting that the effect of food insecurity is not limited to modeling parental emotional and/or mental instability or genetic predisposition necessarily. Likewise, an eight-year longitudinal study using validated measures of child mental health symptoms that controlled for parental depression found that children of food-insecure households were twice as likely to display hyperactivity/inattention.²⁴ Other controls included immigrant status, family structure, maternal age at birth, family income, parental education level, and prenatal tobacco exposure.

Adequate research is not available to define the precise mechanism(s) behind behavioral problems in children living within food-insecure families. As there is lack of evidence for significant differences in nutrient intakes between food-secure and food-insecure young children, nutritional etiologies are not definite. Data from limited qualitative research points to increased psychological stress experienced by children in food insecure homes, as stress may impact the developing brain in ways that foster the development of behavioral disorders.²⁹ Another potential mechanism that emerged from longitudinal data is the impact of food insecurity on parenting practices that affect attachment and mental proficiency in toddlerhood.²⁸ Overall, more research is needed in this area.

Food Assistance for Vulnerable Populations

Whether food insecurity leads to poor mental health, poor mental health leads to food insecurity, or both circumstances feed each other in a vicious cycle, policy and program-based efforts to ameliorate food insecurity have the potential to positively impact lives of people struggling with mental health problems. In the United States, there are several government-based food assistance programs, including the Supplemental Nutrition Assistance Program (SNAP), the Supplemental Nutrition Assistance Program for Women, Infants and

Children program (WIC), the WIC Farmers Market Nutrition program, Senior Farmers Market Nutrition Program, the Commodity Supplemental Food Program, and the Emergency Food Assistance Program (TEFAP).

The largest program that provides food assistance and has been shown to improve food insecurity is the Supplemental Nutrition Assistance Program (SNAP). According to the Center on Budget and Policy Priorities, over 47 million Americans rely on SNAP to procure food; and nearly 72% of recipients are families with children. The Congressional Budget Office regards SNAP benefits as one of the most cost-effective of all spending and tax options for boosting growth and jobs in a weak economy. Every \$1 in SNAP benefits is estimated to generate about \$1.70 in economic activity.³⁰

Changes in SNAP funding levels threaten the reach of the program, however. In November 2013 Congress approved an average benefit reduction of 7% or about \$10 per person per month, leaving recipients with less than \$1.40 per person per meal in fiscal year 2014.^{28,31} Furthermore, the 2014 Farm Bill added an \$8.6 billion reduction, including a limitation in states' abilities to link SNAP benefits to the Low Income Home Energy Assistance Program (LIHEAP), which is designed to help low-income families that pay heating bills on top of their other housing expenses.³²⁻³⁴

The Role of the Registered Dietitian Nutritionist

While most dietitians do not work exclusively in a mental health setting, episodes of serious mental illness and/or severe life impairments related to mental illness are becoming more common among people with physical health conditions that RDNs regularly encounter (e.g. diabetes, cancer, heart disease, and obesity, etc.). As previously reported, one in 17 American adults and one in 10 American children have a serious mental illness (e.g. major depression, bipolar disorder, schizophrenia, etc.).^{9,35}

Given that RDNs will encounter people with mental illnesses in their practice, it is imperative for them to be aware of the social, economic, and nutritional impact of these conditions, including the possibility of food insecurity. One reality of working with this population is that the RDN

may only have one chance to make an impact. Frequently these populations are transient so it is vital that the RDN is prepared at the first meeting with everything that they will need to provide the best quality care possible.

In persons with food insecurity and/or mental illness malnutrition may be a real possibility. Malnutrition is defined as the lack of necessary or proper food substances in the body or improper absorption and distribution of them.³⁶ Malnutrition is seen frequently in persons with mental illness/food insecurity. This malnutrition may take the form of obesity, marasmus, kwashiorkor, and marasmus-kwashiorkor mixed, with starvation being the most severe form of malnutrition.

In this population some level of starvation may be identified. L. John Hoffer defines starvation as total food deprivation, any prolonged sub-maintenance food intake, or the physiologic state that results when food intake is chronically inadequate.³⁷ Each person with malnutrition may not move into starvation but the potential is there. Starvation may be imposed from an outside circumstance or by willful control by the individual who is starving. Food unavailability, lack of purchasing power, social conditions or disease may result in starvation.³⁸

A comprehensive nutrition assessment is an essential tool for the RDN when working with clients who are faced with mental illness and/or food insecurity. Through the nutrition assessment the RDN may determine more exactly which areas the client is deficient in nutrient consumption. In this population it is important to evaluate not only the client's anthropometric measurements but also to evaluate the quality and quantity of the client's intake.

The comprehensive nutrition assessment should include the client's eating pattern, frequency of meals, food group omissions, nutrient density, substance use or abuse, chewing/swallowing difficulties, history of eating disorders, use of psychotropic medications, food sources, and physical activity, food drug interactions, psychiatric and medical conditions, laboratory results, anthropometric measurements, and other non-specific signs and symptoms.

Some information that will provide insight to the RDN about their clients' nutrition status may be gleaned from

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these questions:

- How often or how many meals does the client eat on a daily basis?
 - Do they eat every day?
 - Are they afraid to eat?
 - Do they think their food is poisoned?
 - How many meals or snacks do they eat daily?
 - How does their intake measure up to their estimated needs?
- Do they omit any food groups?
 - Do they include foods from all of the key food groups?
 - Is there a food group that is avoided – leading to a deficiency of key nutrients provided by that food group?
 - Are they dieting? Why and what type of diet restriction are they imposing upon themselves?
 - Fad diets?
 - Do they drink excessive amounts of water or other non-nutritive fluids such as coffee, soda, etc.?
- Where do they get their food?
 - Food assistance programs?
 - The corner convenience store? Sources of foods in these stores are generally highly processed, high fat, high sugar, high calorie, high sodium, but have low nutrient density.
 - Group home provider?
 - Panhandling?
 - Fast food restaurants?
- What kinds of food do they eat?
 - Do they have any food cravings? What kind (high fat, high sugar, salty?)
 - Do they take supplements? What kind and for what?
- Do they have a way or place to prepare food?
 - Do they have kitchen access?
 - Do they have a safe way to store, refrigerate, and/or cook food?
 - Do they do their own food preparation or are they dependent upon someone else to prepare the food for them?
- What is their history with substance use/abuse?
 - Alcohol
 - Street drugs
- How are their dentition and oral motor abilities?
 - Do they have teeth?
 - Any difficulty chewing?
 - Any difficulty swallowing?
 - Are they able to manage a fork, knife, spoon, and cup?
- Is there a current or history of eating disorder?
 - Anorexia Nervosa?
 - Bulimia Nervosa?
 - Binge Eating Disorder?
- Are they taking any psychotropic medications?
 - Have they experienced any changes related to these medications such as weight gain, increased appetite or decreased appetite, food cravings?
 - Do they have their laboratory tests done to monitor their biochemical indicators?
 - Are they having or have they had any adverse food-drug interactions? Many of these medications may cause dry mouth, nausea/vomiting, constipation/diarrhea.
- What type of physical activity do they get?
 - Sedentary?
 - Walk daily?
 - Pacing?
 - Extreme exercise?
- What are their psychiatric and medical conditions?
 - Do they believe that they have these conditions?
 - Are they aware of these conditions and how nutrition impacts the condition?
 - Are there conditions that will impact intake such as paranoia or thoughts that their food may have been tampered with or poisoned?
- Have there been any laboratory tests to determine nutritional status?
 - This information may be difficult to find or obtain or may not be available at all.
 - If they are available, do they show any deficits?
- How are their anthropometric measurements?
 - What is their BMI?
 - Are they near their IBW range?
 - What is their waist circumference?
 - Do they appear to have muscle wasting?
 - Ascites?
- Do you observe or do they report any non-specific signs or symptoms such as fatigue, irritability, apathy, trouble concentrating, and/or poor appetite?

Once these questions are answered it is then necessary to analyze the information and develop a plan of care that addresses the problems. This plan of care may include nutrition counseling. When providing counseling to this population it is important to remember that there may be challenges such as, cognitive difficulties, psychotic symptoms, motivational difficulties, and/or a lack of insight and disorganized lifestyles. Using a goal based approach to behavior change has been proven to be beneficial in overcoming these challenges.³⁹

The RDN working with persons with mental illness and food insecurity will need to work collaboratively with other professionals and agencies. Providing a referral to mental health services or to a social service agency may be necessary. It becomes incumbent upon the RDN to become aware of the services that are available to their clients. The RDN must be able to provide to the client a list of nearby services. This means services that the client can get to by walking or by taking public transportation. For the low income, food insecure, mentally ill client, accessing information or services on a computer may not be a possibility or reality.

To reduce the burden of food insecurity among those they serve, and to potentially impact the severity of both their mental and physical health problems, RDNs can work to identify opportunities to assist their clients to participate in available assistance programs as appropriate. Many food assistance programs remain underutilized. SNAP, for example, only reaches about 75% of eligible individuals so that in any given month, approximately 13 million eligible households are not receiving SNAP benefits.³⁴ In addition to SNAP, there are a number of other government food assistance programs that clients may be eligible to receive, including the Women, Infants and Children program (WIC), the WIC Farmers Market Nutrition Program, Senior Farmers Market Nutrition Program, and The Emergency Food Assistance Program (TEFAP).

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Additionally, Registered Dietitians/Nutritionists can advocate for the reduction of other socio-ecological problems associated with the development of mental illness in vulnerable populations. For example, RDNs can advocate for safe, secure, and affordable housing; licensed child development environments and support services, if warranted; and school environments that promote good nutrition and health promotion. Ensuring that patients and clients from birth through adulthood receive maximum support may perhaps slow the vicious cycle of poverty, food insecurity, and poor physical and mental health.

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This article was developed in collaboration with Hunger and Environmental Nutrition DPG



CPE credit (1 hour) is available from BHN for the full text version of the article, Food Insecurity and Mental Health: What's the Relationship and What's an RDN to Do?

Access the article at <http://www.bhndpg.org/moa/cpes.asp> for reading/taking the quiz.

"Harvest" Nutrition Intervention

This article was developed in collaboration with Hunger and Environmental Nutrition DPG.

In tune with the recent popularity of growing and preparing your own fresh produce, RD and RDNs are seizing the opportunity to teach nutrition through garden-related activities. Maryann Ludlow RD, CD, CDE promotes healthy behavior change with a seasonal program for hospital employees. Amy Volkman RDN, LD, LMNT inspires new perspectives and proud accomplishments through a gardening club for people with intellectual and developmental disabilities. And Mary Ryan MS, RDN, CEDRD, LD has brought fresh herbs and mindful eating to the table for Eating Disorder outpatient education groups. They share their inspirational stories below.

Rooftop Veggie Garden Grows New Food Attitudes

Maryann Ludlow RD, CD, CDE

I am privileged to work at a facility, Fletcher Allen Health Care, which is a leader in the healthy food in health-care movement. Much of the food that we serve, both to patients and in our public dining areas, is locally and sustainably grown and raised. Fletcher Allen also grows a small percentage of its food on site.

About this time last year, I was asked to collaborate on a very exciting project. It was an extension of the hospital's commitment to support healthy lifestyles among employees and community members. The main campus of the hospital has a beautiful rooftop garden area, with waist-high raised beds enclosed in planting boxes. These had been used to grow a small amount of food for use in the main kitchen. However, since the volume it generated was so small, it was decided that our hospital community would be better served by transforming this space into a teaching garden. The plan was to invite employees who had no experience growing a vegetable garden to a season-long workshop, to teach them to do just that! Our prospective students

had to meet two criteria: they had to really want to learn to grow veggies, and they had to want to learn how to prepare them in healthy ways. The planned hands-on learning experience was to be co-led by Lisa Hoare, our talented FAHC gardener, and myself, a dietitian with many years of veggie gardening experience.

We launched this pilot project with an invitation to a couple of departments to have any interested staff apply. We got a great response...far more folks applied than we could accommodate. We chose those who best fit our criteria (not an easy task). Then, with our band of 10 enthused, eager gardeners, we began our adventure!

We used a gardening method called "Square Foot Gardening", popularized by gardener Mel Bartholomew, in his book of the same name. This is a great method for beginner gardeners who are gardening in a small space, as it breaks down the space into manageable foot-square blocks, with recommendations for how much of which plant will fit into each block. (For instance, he recommends planting 16 carrot seeds in a square foot, but only one broccoli plant, because of the size difference in these plants). For someone who has never planted a

carrot or broccoli before, this method allows them to "wrap their heads around" each plant's space requirements. It also makes the whole planting space feel very manageable.

Every week, during a "formal" two-hour outdoor workshop, we covered both gardening and nutrition topics. Each topic was pertinent to what was going on in the garden that week. For instance, in the early weeks, Lisa led a discussion and demonstration on veggies that are best suited to start from seed outdoors vs. starting inside or purchasing seedlings from a greenhouse. I talked about the health bounty of the early crops that were being grown, such as baby greens.

Examples of other topics that we covered included soil amendments, nutritional and light requirements of different plants, nutritious no-cook meals for hot days, and putting food by. Our "semester" was the growing season, from mid-May to mid-October here in northern Vermont, with some help from season extenders, such as heavy-weight row covers, at either end.

A fun addition to the classes was our hands-on cooking demonstrations, which we did most weeks on the grill in the garden. These were designed to allow our students to help prepare

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their wonderful produce, in healthy, quick and easy ways. We discovered the amazing versatility of the grill; we did everything from making soup to canning jam on it! Some weeks we went grill-less and put together wonderful salads or wraps with garden produce.

The students were asked to commit to spending up to four hours a week maintaining their garden spaces and attending the workshops. Our group did this and more! There were a couple of people who couldn't finish the season for work and/or personal reasons, but most remained involved, and formed a tight-knit community who helped each other with day-to-day tasks such as watering and harvesting.

The season was peppered with appearances by guest speakers and “field trips”. We went on a “wild edibles” walk, led by a local RD who is also an herbalist; and visited a teaching garden run by the Vermont Community Garden Network, a leader in our state's community garden movement. One of our guest speakers was a University of Vermont student who shared her expertise in seed saving techniques. We also had a guest chef, one of our culinary-school trained hospital chefs, who created some simple but elegant summer outdoor fare.

Our students were incredibly enthusiastic and good-natured! Their passion for growing their gardens was palpable! There's nothing more wonderful than seeing someone harvest something they grew for the very first time... the magic of that first cherry tomato plucked from the vine, and eaten with true appreciation for its complex flavors... those first handsome carrots emerging from the dirt, rinsed, and passed around for all to chomp!

We had our students fill out evaluations of the program at the end of the season. One question, of great importance to us, asked if they felt this program had changed their attitudes and behaviors toward healthy food and eating. They all responded with a resounding “yes!” Many of them said that they were now eating fruits and veggies they'd never eaten before, and they felt so much healthier incorporating these foods into their daily lives. They felt that growing and preparing

the foods in a fun environment with others was much more likely to change day-to-day behaviors than just reading or being told about it.

This year, we'll be expanding this program, with workshops both at the rooftop garden and at another hospital campus several miles away. The new site will give gardeners the chance to work more traditional, ground-level raised beds, and will offer larger plots for growing spreading plants, such as winter squash. It's also a space more conducive to bringing the family and getting kids involved in growing and eating garden veggies.

We can't wait for another season of reveling in the dirt and seeing the delight of people growing their own food!

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Raised Beds Yield Fresh Local Produce, Exercise and Sensory Therapy

Amy E. Volkman RDN, LD, LMNT

A desire for fresh local foods and the need to get “back to our roots” was the driving force behind starting a small community-type garden. The Glenwood Resource Center (GRC) in Glenwood, Iowa serves people with intellectual/developmental disabilities and has a history of self-sustained farming and apple orchards on its approximate 1,200 acres of land. In the 1950's, the facility had over 85 acres of farmland and 64 acres of apple orchards. Over time the farming lifestyle and much of the apple orchards have disappeared as other vocational skills became a focus and grocery stores became more available.

Two years ago, we were inspired to start a garden as a way to utilize GRC's acres of open land and provide a holistic activity that incorporated natural physical activity, healthy eating, and sensory therapy. Two employees with gardening experience picked the location, guided the process to prepare the soil, and designed the layout for suitable plant varieties. Our environmental services department built six large raised beds of different heights



Chives and jalapeno plants in a raised bed. The Gardening Club members also look for new recipes that utilize their fresh produce.



Seedlings ready to be planted in the garden. The Gardening Club utilizes a greenhouse which allows for seedling growth during cold months.

on a concrete slab to accommodate wheelchairs and different physical abilities. The “Gardening Club” started with seven participants and has since quadrupled in participation.

Both residents and employees of GRC donate their time and energy to grow a thriving garden. No pesticides are used at the garden and any plant material after harvest gets composted for next year's fertile soil. Activities at the garden can meet all physical abilities. Some club members do more heavy lifting, digging, and harvesting while others help water the plants and tend to the raised beds. One garden bed is dedicated to growing aromatic herbs as part of sensory therapy.

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The garden has become so much more than a food source. It has altered people’s perspectives on where food truly comes from. People who tended to the garden began to understand the care, nurture, and time it takes to grow a small strawberry plant. We took pride in a tomato that was picked at perfect ripeness. We became excited to discover the different aromas and flavors of basil. We were more willing to try collard greens. We learned to deal with disappointment when a whole bed of bell pepper plants died. Some roommates seemed to forget about their disagreements and work side-by-side to till the soil. There was no “staff” and “patients” distinction – just a group of people who came together for a common cause. The garden became a place where we could be out in fresh air, have a goal, be self-motivated, and naturally active.

As a dietitian, I do my best to provide education in a simple and creative way, but that can be a challenge. While many people know what a “healthy food choice” is, the motivation for behavior change can be difficult to inspire. How do you encourage healthy eating when understanding of long-term health consequences is a difficult concept to grasp? How do you motivate someone to try new foods? The garden has helped with that. It’s exciting to hear a client eagerly tell his mom that he cooked mashed turnips for the first time and loved them. I was thrilled when a client who does not like green foods tried lemon basil and green onions. I often remind Gardening Club members that you do not need to like everything you grow, but trying something new every year is an accomplishment to be proud of.



The Garden at GRC is approximately 2500 square feet. Tomatoes, green beans, and bell peppers are grown around a concrete base that houses raised plant beds.

The Gardening Club is excited for the next growing season with new plants and herbs to try. We plan to expand both the garden and composting production; work with local 4-H clubs; showcase produce in the local county fair; and, of course, continue to find new recipes to enjoy our fresh-grown fruits and vegetables.

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Special thanks to Jeremy Davis, recreation specialist; Tyler Bartley, resident treatment worker and Jason Hughes, resident treatment worker who were imperative in starting the garden and contributing to this article.

Fresh Herbs Engage Eating Disorder Patients in Nutrition Education

Mary T. Ryan, MS, RDN, CEDRD, LD

Nutrition rehabilitation in the treatment of eating disorders is a complex process that addresses malnutrition caused by food restriction, an imbalanced intake of nutrients, or the loss of nutrients related to various methods of purging (self-induced vomiting, abuse of laxatives, diuretics, diet pills or exercise); weight restoration in underweight patients; and correction of nutrient deficiencies in all patients. Additionally, patients are encouraged to increase the variety of acceptable foods and eliminate “fear foods” that trigger disordered behaviors related to eating and exercise. Ultimately patients work to establish a positive relationship with food and to manage uncomfortable emotions without using “ED behaviors.”

Group nutrition education in eating disorder treatment often focuses on the importance of various nutrients in the body and nutritional links to processes such as digestion, metabolism, brain function and mood, and physical activity. Other important topics include fad diets, the “diet mentality,” and media literacy to help clients navigate the difficult recovery environment of a culture obsessed with weight loss and unrealistic “ideals of beauty” that can derail their best efforts to improve their relationship with food.

Through my experience as a dietitian at an intensive outpatient clinic for Eating Disorders (EDs), I discovered that, despite attempts to make nutrition education content interesting and relevant, it may not matter what we teach if patients are not engaged in the learning process.

There are many reasons patients may not be interested in the nutrition education portion of ED treatment. Malnutrition affects cognitive function and we can assume all of our patients, regardless of their weight, are malnourished to some degree upon starting ED treatment, which may limit their ability to learn. Many patients enter treatment involuntarily, referred by parents, spouses, and medical or mental health professionals, and are resistant to or ambivalent about recovery. Even when patients want to be in treatment and have improved their nutrition enough to restore brain function, many of them have firmly entrenched beliefs about nutrition, some even have formal education in health and nutrition, or they prefer to focus on what they perceive as the “real work” in ED treatment – psychotherapy, particularly if they suffer from depression, anxiety or other co-occurring mental illness.

The reality of a diverse patient population with a variety of needs led our team of RDs at The Moore Center, an outpatient Eating Disorder clinic in the Greater Seattle area, to explore creative and experiential approaches to nutrition education groups with the initial goal of engaging our patients. One example of this approach is a 2-hour interactive class focusing on fresh herbs, which we developed for our Intensive Outpatient Program (IOP). Class objectives include identifying potential health benefits and interesting cultural and historical facts related

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to herbs and spices; participating in a mindfulness activity; and preparing and sampling simple recipes that include a selection of fresh herbs.

Fresh herbs are a great multi-sensory way to experience mindful eating by highlighting color, taste, texture, and aroma. Incorporating fresh herbs may help binge or compulsive overeaters be more present during a meal or snack. Adding fresh herbs to a familiar food that may have triggered past binge eating or food restriction can change the experience of that food by adding color, aroma, taste, and awareness of potential health benefits that reduce anxiety associated with these foods. Using fresh herbs requires an additional step in food preparation, another way to engage patients in the present moment and possibly decrease mindless eating.

For eating disorder patients who struggle with food restriction, using fresh herbs with negligible caloric contribution offers a way to practice mindful eating without triggering fears related to calories, fat or carbohydrate content of food. Herbs and spices are also a source of powerful bioactive compounds that reinforce the role of food as medicine, an important aspect of nutrition rehabilitation in ED treatment.

Our outpatient class features a selection of commonly available herbs. A table for each herb is set up with pre-washed samples of the herb and a packet of information about possible health benefits, interesting historical and cultural facts, culinary uses and tips related to selection, storage or preservation techniques. There is also a simple vegetable- or fruit-based recipe using the herb, and a worksheet to be completed by the group seated at each table. After a brief introduction which includes a discussion about how herbs and spices relate to nutrition goals in ED treatment, patients are led through a mindfulness activity using the herb featured at their table. Each group then works together to complete a worksheet using "research" related to their herb and prepare a simple recipe for the whole class to sample. As they taste the recipes each group shares what they learned about their herb.

Feedback from this herb class was overwhelmingly positive. From the mindfulness activity to the research including fun facts and interesting health benefits, patients enjoyed the variety of activities and a new way of looking at nutrition. Even those who already knew a fair bit about these herbs found the class "refreshing" and a fun way to interact with other group members. Some of the patients I also worked with on an individual basis reported making at least one of the simple recipes following the class, and

a parent told staff this was the first nutrition class her daughter was excited about after several months of treatment.

While this informal feedback is not a rigorous measurable outcome in terms of using fresh herbs to transform a disordered relationship with food, it does provide immediate feedback about perhaps the most important aspect of nutrition education groups: patient engagement. It was clear throughout the class and afterwards, that group members were engaged in learning. They focused on mindful tasting, researched interesting facts about their herb, and appeared eager to share both the recipes they prepared and the information they gathered with the rest of the class.

Bridging the gap between food-related anxiety and an improved relationship with food is no small task. Nutrition education groups in eating disorder treatment can provide unique opportunities to engage our patients and clients using creative and experiential approaches that are difficult or impractical in the context of individual nutrition sessions.

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Call for BHN 2014 Award Nominations

Do you know someone who has made a difference in their practice area and you would like to recognize them for their accomplishments? Nominate them for the BHN Distinguished Member Award and the BHN Excellence in Practice Award!

Criteria for the Distinguished Member Award:

1. Member of BHN Practice Group for at least 5 years and a current member.
2. In practice for at least 10 years.
3. Active participation at the national, state, and/or district level(s).
4. Not a previous recipient of the award.
5. Demonstrated leadership in BHN practice group and/or other work related to promotion of nutrition and health in the populations served by BHN membership. Leadership may have been demonstrated through work in legislation, research, management, education, publication, etc.
6. Not currently a member of BHN executive committee.

Criteria for Excellence in Practice Award

(awards may be given in each practice area):

1. Member of BHN Practice Group for at least the past 3 years.
2. Current practicing in Eating Disorders, Substance Abuse, Intellectual and Developmental Disabilities, or Mental Health.
3. Evidence of contributions to the specified practice area (e.g., publications, presentations, treatment innovations, mentoring, nutritional health promotion, etc.)

Nominations for awards are accepted through June 1st.

Please contact Wendy Wittenbrook, MA, RD, CSP, LD, Nominating Chair at Wendy.Wittenbrook@tsrh.org for a nomination packet.

Food Insecurity Among Households with Working-Age Adults with Disabilities

Authors: Alisha Coleman-Jensen and Mark Nord

U.S. Department of Agriculture

Economic Research Report No. (ERR-144) 50 pp, January 2013

<http://www.ers.usda.gov/publications/err-economic-research-report/err144/report-summary.aspx>

Accessed December 10, 2013.

Entire report available at <http://www.ers.usda.gov/publications/err-economic-research-report/err144>

Food-insecure households are those that lack consistent access to adequate food for one or more household members. Prior research found that households with adults with work-limiting disabilities were more likely to be food insecure. This report describes food security in two groups of households with working-age (18-64) adults who have disabilities: those with disabilities who are unable to work (not in labor force-disabled) and those with disabilities that are not necessarily work-limiting (other reported disabilities). The analysis focused on type of disability and other characteristics of working-age adults with disabilities, such as employment and education, to identify factors that may put households at greater risk for food insecurity. In addition, participation in the USDA Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) and disability assistance programs was examined to determine the extent to which adults with disabilities accessed these benefits and the programs' role in preventing household food insecurity.

What Were the Study Findings?

There is a strong association between disability and food insecurity. Substantially reducing the prevalence and severity of food insecurity among households in which one or more members is affected by disabilities would reduce the overall prevalence of food insecurity. The main study findings include:

- Food insecurity was more prevalent among households with working-age adults with disabilities: 33.5 percent of households with an adult who was not in labor force-disabled were food insecure; 24.8 percent of households with adults with other reported disabilities (adults age 18-64 who had a disability but did not indicate they were out of the labor force due to disability) were food insecure; while 12 percent of households with no adults age 18-64 with disabilities were food insecure.
- Very low food security, the more severe range of food insecurity characterized by disrupted eating patterns and reduced food intake, was also more common among households with adults with disabilities than among other households: 17.3 percent of households with a member who was not in labor force-disabled had very low food security and 11.8 percent of households with a working-age adult with other reported disabilities had very low food security. Among households with no working-age adults with disabilities, 4.6 percent had very low food security.
- Households that include working-age adults with disabilities comprise a large share of food-insecure households. An estimated 31.8 percent of households with food insecurity included a working-age adult with a disability. Nearly 38 percent of households with very low food security included a working-age adult with a disability.
- Whether disabilities prevented employment was an important factor related to food insecurity among households that included adults with disabilities. Vision, mental, and physical disabilities were related to higher odds of food insecurity than were hearing, self-care, and going-outside-home disabilities.
- Participation in SNAP was relatively high among households with members who were not in labor force-disabled and households with working-age members with other reported disabilities compared with those without working-age adults with disabilities. Among low-income households that participated in SNAP

and with an adult who was not in labor force-disabled, 56.1 percent were food insecure.

How Was the Study Conducted?

We used the Current Population Survey Food Security Supplement (CPS-FSS) from 2009 and 2010 to examine the association between food insecurity and disability. The CPS is administered by the U.S. Census Bureau and is nationally representative of the civilian, non-institutionalized population. The CPS-FSS is the source for the U.S. Department of Agriculture's annual food security statistics. The analysis examined the prevalence and severity of household food insecurity by the presence of adults age 18-64 with disabilities. The study used multivariate logistic regression analysis to account for differences in income, education, family composition and other characteristics between households with and without adults with disabilities. The percentage of households participating in SNAP and disability assistance programs was also examined by disability status and food security status.

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BHN leaders listed
in this newsletter.

Student Corner:

Orthorexia Nervosa: How is this Affecting the Male Population?

By Dylan A. Bailey

Introduction to Orthorexia Nervosa

Health. Wellness. Longevity. The justification for such terms can be met with aspects such as, the “rising cost of health care”, the “obesity epidemic”, and the “green movement” (1) manifesting themselves heavily on the minds of health-conscious individuals. Orthorexia Nervosa (ON) occurs when an individual adopts unhealthy obsessions with healthy eating (2), subsequently resulting in extensive dietary restrictions, a distortion of priorities, obsessive tendencies associated with food, and severe social isolation (3,4,5). Stemming from the Greek words “orthós” (straight, right, proper) and “orexis” (appetite), ON was coined by Steven Bratman, MD, who first wrote about this condition in an October 1997 issue of *Yoga Journal*. But how is it possible for eating healthy to actually cause harm to one’s health?

An individual struggling with ON will follow a strict diet, of which major food groups are often not sufficiently consumed, resulting in a shortage of essential nutrients, modification of social and personal relationships, and change in the individual’s general psychosocial condition (6). Essentially, the desire to eat healthy foods is not itself a cause for concern, yet the obsessions for these foods, coinciding with the loss of moderation, balance, and withdrawal from life, can result in the fostering of this condition (3). What can start as diet tied to philosophy or theory, quickly adopts “pure” and “spiritual” connotations in the ON individuals mind (3,5). Additionally, feelings of superiority can arise when compared to the eating lifestyle and dietary habits of others (3). Often, specific foods, whole food groups, and food preparation methods deemed perilous to his/her health will be avoided by a person with ON, as ingesting what he/she considers to be quality food becomes of paramount importance. (3,4).

Obsessive expressions towards food are qualitative in an individual with

ON, unlike cases of anorexia nervosa (AN) or bulimia nervosa (BN), in which food quantity becomes a motivating factor to regulate weight status (3). The more qualitatively restrictive and complicated the diet, the more an individual with ON will be attracted to it (7). It has even been reported that in extreme cases, a number of ON individuals would rather starve than consume foods regarded as “impure” or “unnatural” (3). Currently, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V) does not recognize this recent eating behavior as a disease, but research has begun to highlight the stark prevalence of ON. Donini (3) reported that 28 of 404 Italian subjects (6.9%) displayed orthorexic behavior. Ramacciotti (8) also indicated a 57.6% (N=102) prominence of ON among a general Italian population sample. A “highly sensitive eating behavior disorder” or ON, was assessed in a sample of 318 resident medical doctors in Ankura, Turkey, utilizing the ORTO-15 test. Results from this test indicated that 45.5% of the study group scored below 40, defining them as orthorexic (6). Fidan (9) demonstrated that 43.6% of the 878 medical students of Ataturk University Medical School in Erzurum, Turkey, expressed ON tendencies using ORTO-11, the ORTO-15 test translated into Turkish. ON has even been reported to occur among dietitians (10), athletes (11), and performance artists including opera singers, ballet dancers, and orchestra artists (12).

A Dual Manifestation of Orthorexia Nervosa within the Male Population

Albeit limited, much of the recent research indicates a prevalence of ON among males, highlighting the idea that ON affects males equally, and potentially more frequently than females. Donini (3), Fidan (9), Garcia (11), and Aksoydan (12), have all determined that males experienced higher rates of ON occurrence when compared to females, with factors such as

age, and weight further categorizing incidence of ON within the gender. ON tendencies among males have been reported to maintain a direct relationship with increasing age (3) and weight (12). One possible explanation for this could be the need to adopt a higher sensitivity toward nutrition, fueling a desire to prevent or treat illness and improve general health (5,12). Older males have an increased susceptibility to experience chronic illness, with efforts to avoid disease prompting the assessment of diet as an area of concern, justifying the modification and adoption of particular health conscious dietary behaviors. The media can be a primary contributor to the idea that eating well is important for keeping wellness (9), as knowledge concerning the relationship between diet, health, and illness, can transition into obsession, and the development of ON. Being overweight or obese can additionally result in possible ON occurrence, as society has begun placing an increasing amount of importance on health and body image. Further, an obesogenic environment has given rise to the stigmatization of fatness, as male-centric ideals (muscularity, strength, power, athleticism) have gained heightened societal focus.

Moreover, ON is occurring within younger males maintaining lower weight status, and a previously existing risk for eating disorders (EDs) (9,11). In correlation with the strict physical and aesthetic stereotypes associated with males, in which “six pack” abdominal muscles dominate billboards, adopting the “health-fanatic” lifestyle can be seen as an acceptable action, legitimizing an individual’s maniacal obsession with healthy eating. Even though weight loss is not a motivational factor for the dietary extremes expressed within ON, eating healthfully is seen as positive, and males are beginning to adopt this knowledge. Yet males, being new to a



Dylan A. Bailey

Orthorexia Nervosa...

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world filled with aesthetic and health filled expectations, can experience anxiousness and susceptibility toward bombarding social messages concerning food, pathologically exacerbating ON occurrence (3).

ON prevalence has illustrated a relationship to the fitness industry and athletic roots, as evidenced by ON manifestation in Italian male athletes (11), performance artists (12), and recreational fitness participants (13). Athletes are often well aware that nutrition plays a crucial role for enhancing performance and recovery, reaching an ideal weight, shaping the body (male specific pursuit of muscularity) and preventing physical detriments, which can lead to food control as a necessary factor to maintain intensive exercise practice and to achieve optimal performance (11). Knowledge concerning the significant role nutrition upholds in athletics, coupled with the prevalent availability of dietary information from unqualified sources, and the self-motivation character trait seen in athletes (14), can promote swift implementations of inadequate dietary practices. This can be detrimental for athletes displaying ON tendencies, as the potential avoidance of whole foods or food groups can result in nutrient deficiencies, and low energy availability within a population for whom adequate nutrition and energy intakes are essential for advantageous sport performance. Additionally, sports nutritionists or other health professionals dealing with male athletes need to understand that reluctance to discuss eating problems may occur, as difficulties can arise due to the shame and embarrassment associated with displaying stereotypically female dilemmas (14).

Implications for Dietetic Professionals and ON Treatment

Although ON subjects are not obsessed with food quantity intake as observed in AN and BN, some aspects of ON and clinically recognized EDs can be observed as similar including a genetic predisposition to perfectionism, anxiety, rigidity, a need for control

of life transferred to eating, and character traits of detailed, careful, and tidy personas with an exaggerated need for self-care and protection (4). Zamora (15) explains that ON patients display obsessive-compulsive mechanisms with personality traits, phobic mechanisms, and hypochondriac mechanisms similar to those of restrictive anorexia. Might someone who is heavily obsessed with achieving the perfect diet, constantly thinking about food, and dedicating significant time to planning, purchasing, preparing, and consuming it, be categorized as having obsessive-compulsive disorder (OCD)?

Individuals with greater orthorexic tendencies were reported to have higher obsessive-compulsive symptoms (4). Garcia (11) confirmed that ON showed a strong relationship with Yale Brown Cornell Eating Disorder Scale (YBC-EDS) positivity, food and eating preoccupations, and eating and exercise rituals, making the association between ON and obsessive-compulsive symptoms clear. Ultimately, the specific clinical implication of ON is still under debate. ONs significance within the ED or OCD spectrum is certainly unknown, as future research can clarify its exact diagnostic placement.

Nonetheless, treatment solutions should utilize cognitive behavioral therapy (CBT) to challenge the patient's distorted belief system, by tapping into current faulty beliefs and altering them (7). Individuals with ON need to understand that food quality is not the only determinant of health. Furthermore, nutrition education should emphasize eating techniques which will inhibit a relapse of obsessive tendencies. Medications, specifically selective serotonin reuptake inhibitors (SSRIs), have also been reported to be useful during ON treatment (7), but patients obsessed with dietary purity may be hesitant to adopt a prescribed drug regimen. Conversely, unlike patients with other ED's, subjects with ON may be more responsive to treatment due to their overall concern with health and self-care (7).

Now, even though the treatment of ON requires a multifaceted team of physicians, psychotherapists, and nurses, registered dietitians (RDs) can be the first in line to intercept an individual displaying ON tendencies.

Behavioral & Psychological Aspects of the Orthorexic Patient (3,16,17)

Distortion of Priorities

- Longing to spend less time fixating on food, and more time with others
- Thinking with critical concern about what will be eaten on that day or the following day
- Belief that creating and following the perfect diet is uncompromisable
- Constant worry regarding food quality

Social Isolation

- Beyond ability to eat a meal prepared by someone else
- Positioning on a nutritional pedestal, consistent scrutiny of others and their diet
- Discussions on food are always based around having the perfect diet
- Hopes to spend less time on food and more time with friends, living and loving

Obsessive habits and repercussions of the lifestyle

- Needs to take their own food wherever they go
- Sense of control upon following a "correct" diet
- Straying from "correct" diet is met with feelings of guilt or self-loathing
- Lack of self-assessment capabilities regarding dietary behaviors, reduced capacity to criticize

A person with ON may seek an RD for more information in regards to maintaining an optimal way of eating, with input to dietary concerns aligning with the disordered behavior (7). Registered dietitians need to be aware that the male population is currently displaying a growing incidence of problematic obsessions or fixations regarding healthy eating behaviors referred to as ON. By understanding the symptomology associated with ON, RDs have

Orthorexia Nervosa...

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an opportunity to play a pivotal role in treatment via the referral of patients to other appropriate professionals or primary care facilities.

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In the BHN Pipeline!

David A. Wiss, MS, RDN, CPT

Behavioral Health Nutrition DPG is looking forward to a great year in 2014-2015! We have a lot of good things in store for our members. Look for a new website coming soon! BHN will be adding fact sheets to our website this coming year. We encourage you to participate in development of these fact sheets. Whatever your area of expertise, we need your knowledge. We encourage you to ask yourself, "what information would have been most helpful to me when I first started my practice?" or "what would really help me in current practice?" Let us encourage you to submit a fact sheet for consideration! We would also like to encourage you to come to the 2014 Food & Nutrition Conference & Expo (FNCE) in Atlanta, Georgia on October 18th – 21st. BHN activities includes our spotlight session: Dysphagia, Mealtime, and Intellectual Disabilities on 10/20/14 at 8:00AM, a member breakfast, and the opportunity to network with the fantastic BHN Dietitians.

Behavioral Health Nutrition has recently seen a need to advocate for better reimbursement specifically for nutrition services for those with Intellectual and Developmental Disabilities (IDD). Services for individuals with IDD have been reduced, which has included nutrition services. This has unfortunately led to a reduction of dietitians in this field. More importantly, it has left many individuals with increased nutrition needs without adequate nutrition services. Behavioral Health Nutrition has decided to establish a reimbursement committee to advocate for better reimbursement of nutrition services for individuals with IDD, but we need your help. The committee will need state specific information from each of the 50 states on their reimbursement parameters. We encourage you to help us with this project. If you are interested in helping, contact Sharon Lemons at Sharon_RD@att.net.

2013 BHN Membership Survey highlights!

- Primary area of practice: Eating Disorders 27%; Mental Health 27%; Intellectual and Developmental Disabilities 21%; Addictions 7%.
- 26% of BHN RDs are self-employed, followed by 18% working in State government, 16% in non-profit.
- 28% work in an outpatient office/clinic, 23% in inpatient acute, and 22% in private practice.
- The top three favorite BHN benefits are: newsletter, webinars, website resources.



Harriet H. Cloud, MS, RD

Multiple issues were addressed in the House of Delegates during 2013, all of which required follow-up from Academy committees and organizational units. More information is provided below:

1. Vision for a New Model of Differentiated Entry Level Nutrition and Dietetics Practice.

This is the summary of the Council on Future Practice work in collaboration with the Accreditation Council for Education in Nutrition and Dietetics (ACEND), CDR, Education Committee, and the Nutrition and Dietetics Educators and Preceptors (NDEP) to define and differentiate the practice roles of the associate, baccalaureate and graduate degrees – in preparing nutrition and dietetics professionals. The Visioning Report was first shared with the HOD at the 2012 Fall HOD meeting in Philadelphia. Since that time the Council on Future Practice has continued working on the final report which is described as being completed over a 10 year period. The total current report is available on the Academy website under the Council on Future Practice at www.eatright.org/futurepractice.

2. Spring 2013 HOD Virtual Meeting on Food Insecurity.

During the Spring Virtual Meeting, Food and Nutrition Insecurity was discussed for two days with the expected outcome of increasing the awareness of the membership related to hunger and

House of Delegates Report

Harriet Holt Cloud, MS, RD, FAND

food insecurity. Many suggestions were made for activities related to the nutrition and dietetic profession leading community efforts to end food and nutrition insecurity.

As a follow-up, the Academy has led efforts for the Farm Bill to be passed by the House and the Senate, although SNAP benefits were cut by \$8.5 billion. In addition, members of the Academy can receive a new periodical entitled Food Insecurity and Hunger in the U.S.: New Research which focuses on recent and important food insecurity and hunger research from academia, government agencies, think tanks and health and policy organizations. The e-newsletter is published three times a year as a collaborative effort by Food Research and Action Center and Children's HealthWatch. The first issue, Spring 2014, features research on SNAP and food insecurity and can be assessed at <http://frac.org/reports-and-resources/fracs-weekly-news-digest/>.

3. Fall 2013 HOD Meeting on Nutrition Services Delivery and Payment.

Outcomes of the fall meeting held during FNCE were that the HOD requested the Coding and Coverage Committee and the Legislative and Public Policy Committee collaborate in developing a Nutrition Services Delivery and Payment Action Plan. The plan is to be submitted to the HOD by May 1, 2014. In addition, the HOD requested assistance from ACEND, CDR, NDEP and the Committee on Professional Development that nutrition and dietetic practitioners are educated related to evolving delivery and payment models. Finally the HOD requested the

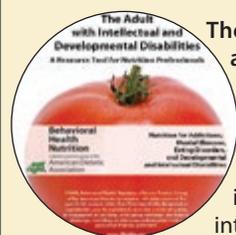
creation of a communications and marketing plan for members related to delivery and payment models for the RDN. All of the above is scheduled for sharing with HOD by May 1, 2014.

During the fall meeting of the HOD, the need for outcomes data to support increased reimbursement for nutrition services emerged as a theme. The Academy has made a significant effort to encourage and educate members on the importance of research, standardized language and evidence based practice. Research is not only for one area of practice, but outcomes data is needed for all areas of practice to show their value and clinical outcomes. This has led to the mega issue for the Spring 2014 Virtual Meeting. The question is "how do we mobilize members to commit their time, talent and resources to research"? The meeting objectives:

- Increase members' awareness of Academy research resources.
- Recognize various ways members are utilizing and contributing to research.
- Develop a plan to empower members to use, participate in and conduct research to benefit the profession and the public.
- Identify ways that members can build a professional culture that encourages and embraces research.
- Advocate for resources to conduct research.

Any comments or concerns you have related to the issues of the HOD are most welcome and can be sent to harriet.h.cloud@gmail.com.

BHN PUBLICATIONS



The Adult with Intellectual and Developmental Disabilities

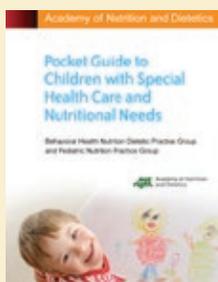
This resource tool is designed to provide an overview of nutrition in individuals with intellectual and developmental disabilities.

The resource guide is contained on one CD-ROM as a 209 page PDF file.

BHN Member Price: \$25.00

To order, visit

<http://www.bhndpg.org/publications/index.asp>



Academy of Nutrition and Dietetics Pocket Guide to Children with Special Health Care and Nutritional Needs

This pocket guide was developed through collaboration of the Behavioral Health Nutrition and Pediatric Nutrition dietetic practice groups of the Academy. This updated version contains the essentials to nutrition management in a comprehensive interdisciplinary approach to medical management of CSHCN. Up to date scientific evidence has been translated by the authors and editors into tables and practice guidelines for dietetic professionals.

To order, visit

<http://www.eatright.org/shop/product.aspx?id=6442467529>
(print only)

Or at <http://www.eatright.org/shop/product.aspx?id=6442467916>
(print + online set).

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A complete list of BHN Executive Committee members and volunteers is available at www.bhndpg.org.

BHN: Fuel Your Brain, Feel Your Best!

Mission: Empowering BHN members to excel in the areas of Addictions, Eating Disorders, Intellectual and Developmental Disabilities and Mental Health by providing resources and support.

Vision: Optimizing the physical and cognitive health of those we serve through nutrition education and behavioral health counseling.

Academy of Nutrition and Dietetics website: <http://www.eatright.org>

BHN website: <http://bhndpg.org> • BHN practice standards: <http://bhndpg.org/moa/practice/index.asp>

