

Experiences and Perceptions Around Eating Among Older Adults with Serious Mental Illness: A Qualitative Analysis

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Abstract

Background

People with serious mental illness (SMI) have a reduced lifespan, 10–20 years shorter than those without SMI. They experience an increased level of comorbidities such as metabolic syndrome (comprised of abdominal obesity, hypertension, impaired glucose tolerance, and hypertriglyceridemia), contributing to type 2 diabetes and cardiovascular disease. External circumstances such as precarious living environments and poor socioeconomic status influence access to healthy food, and psychiatric symptoms may further impede healthy eating habits. To better understand facilitators and barriers to healthy eating among community-dwelling older adults with SMI, we report the results of a qualitative analysis.

Methods

We interviewed 10 community-dwelling older adults with SMI (mean age 64.57, SD 6.815, range 53–76). A qualitative analysis using constructed grounded theory methodology was conducted to assess participants' experiences and perceptions around eating and access to food.

Results

Two main themes emerged in our analyses: 1. Salient exposures influencing the development of eating habits and 2. The influence of convenience on eating. Participants indicated that the early home environment, work experience, and time spent in mental health programs can influence eating habits. Participants also described how convenience guided the types of food they consume. This convenience-based approach to nutrition often determined whether participants ate non-nutrient-dense foods.

Conclusion

Early childhood environments, employment, and mental health programs that incorporate cooking experiences and nutrition or health groups provide opportunities for people to learn and practice changes to diet and eating habits. The convenience of healthy food can promote healthy eating habits.

Background

Serious Mental Illness (SMI), such as schizophrenia, bipolar disorder, and major depression, refers to a mental, behavioral, or emotional disorder that significantly interferes with or limits one or more major life activities. ((SAMHSA), 11/15/2024) Approximately 14.6 million adults in the United States (5.6%) are living with SMI. (*2024 Companion infographic report: Results from the 2021 to 2024 National Surveys on Drug Use and Health*, 2025) People with SMI experience significant health disparities, including a

markedly reduced life expectancy, 10–20 years shorter than that of the general population without SMI. (Walker et al., 2015) This reduction in lifespan is attributable to multiple factors, including unstable living environments and an elevated prevalence of comorbid conditions, such as metabolic syndrome, which includes a cluster of risk factors like abdominal obesity, hypertension, impaired glucose tolerance, and hypertriglyceridemia. (Tsz et al., 2025) These risk factors substantially increase the likelihood of developing type 2 diabetes and cardiovascular disease.

In addition to these medical challenges, external factors such as insecure living conditions and poor socioeconomic status further exacerbate health outcomes by limiting access to nutritious food. It is estimated that in high or upper-middle income countries, more than 40% of people living with SMI experience food insecurity compared to 17% of those without SMI, and those with SMI are 3 times more likely to encounter it, compared to those not living with SMI. (Smith et al., 2024) Moreover, psychiatric symptoms associated with SMI can complicate efforts to maintain a healthy diet, as these symptoms may impair decision-making, motivation, and the ability to maintain structure and engage in self-care practices. (Cáceda et al., 2014; Seeman, 2023)

In a meta-analysis on the effectiveness of nutritional and dietary interventions to improve metabolic syndrome risk factors for people with SMI, Rocks, et al. (Rocks et al., 2022) evaluated 25 randomized and non-randomized trials of diet-only or multi-component lifestyle interventions (typically combining dietary counseling with physical activity, behavior change techniques, and goal setting) aimed at reducing metabolic risk in people with serious mental illness. Overall effects were modest, but interventions delivered individually and/or by dietitians demonstrated small yet significant improvements in weight (and modest blood pressure effects), suggesting these formats were the most effective yet found limited evidence to support these interventions. Though they suggest that interventions may be more effective when delivered one-on-one by a dietitian. (Rocks et al., 2022) Burrows et al. report on 46 studies addressing dietary and nutrition interventions for individuals with SMI. (Burrows et al., 2022) These interventions included nutrition education, behavior change, and supplementation (e.g., omega-3) for improving outcomes like weight management and depressive symptoms. Burrows et al. emphasize the importance of integrating dietary interventions into mental health care, advocating for increased involvement of dietitians in multidisciplinary teams to address physical and mental health outcomes. The study authors found that future research should focus on diverse interventions (such as dietary education, behavior change, dietary supplementation), prevention strategies, and addressing gaps such as the needs of different age groups.

This paper fills a critical gap in understanding the experiences and perspectives on eating and nutrition among older community dwelling adults with SMI. While existing research has established that dietary practices and nutrition are modifiable factors contributing to morbidity and premature mortality in this population, it often lacks the inclusion of patients' lived experiences, priorities, and challenges. Without the patient perspective, interventions risk being misaligned with the realities faced by individuals with SMI, potentially limiting their effectiveness and sustainability. Understanding how patients perceive their nutritional needs and the barriers they face is essential for designing strategies that are not only

evidence-based but also tailored to their unique circumstances. Incorporating the patient perspective ensures interventions are patient-centered, potentially fostering greater engagement, adherence, and long-term impact. The purpose of this study is to explore the nutritional practices, barriers, and perspectives of older adults with SMI to inform the development of targeted, patient-centered nutrition interventions.

Methods

Conceptual framework and methodology

The study employed a grounded theory design (Charmaz, 2014; Glaser & Strauss, 1967). This theoretical framework of Constructivist Grounded Theory is based on symbolic interactionism, which highlights individuals' understandings and perspectives as they occur within the context of relationships. (Blumer, 1969; Charmaz, 2014; Glaser & Strauss, 1967)

Participants and Settings

To be included in the study, potential participants were assessed for eligibility, which included English speaking, > 18 years old, diagnosis of serious mental illness (e.g., schizophrenia), and passing a capacity to consent test based on comprehension of the consent form. Study approval was obtained from the University of California, San Francisco Institutional Review Board. Confidentiality and anonymity were maintained in accordance with the IRB's guidelines. Potential participants had previously signed a consent to be contacted for future studies or were referred through a transitional residence program. They were contacted either in person or over the phone by the project director to discuss their interest in joining this study and to screen for eligibility. Informed consent was obtained during a face-to-face interview and capacity to consent was confirmed at this time.

Data Collection and Analysis

Grounded theory investigations promote the iterative collection of data to create a conceptual framework that can then be used to form and test hypotheses in future work as initially described by Glaser and Strauss (Glaser & Strauss, 1967) and further informed by Charmaz (Charmaz, 2014) and Clarke (Clarke, 2005). Focus groups, and observations are the primary sources of data collection. We utilized theoretical sampling to ensure maximum variation and build conceptual density of the emerging results.

An interview guide provided the basis for the interviews. For example, interview questions were: What does a "healthy diet" mean to you?, What affects your appetite?, and Do you have a healthy lifestyle? Why or why not? Interviews were audio recorded and transcribed. As is consistent with data collection in grounded theory studies, the interview questions evolved throughout the interview process. In one interview with 2 participants, group interaction helped engagement in dialogue about their experiences, and to confirm or refute the statements. The remainder of the interviews were one-on-one.

Interviews were transcribed verbatim then double-checked against the recording for accuracy. To organize and analyze the data, interview transcriptions and fieldnotes were entered into Atlas.ti qualitative analytical software. One member of the research team (EH) independently coded the interviews. Initial open coding was conducted with transcript analysis through word-by-word and segment-by-segment coding. Axial and selective codes were used to determine themes and properties in the data and to eventually develop a framework of codes and categories. Theoretical memos captured the developing conceptualizations about the codes and categories and about relationships between categories were maintained. The research team (EH and HL) discussed conceptualizations about the categories and relationships between categories. Theoretical and methodological notes were used to document decisions made during the analytic process. Data collection ended when theoretical saturation was achieved, meaning that no new information was being obtained. (Charmaz, 2014)

Results

Ten community-dwelling older adults (mean age 64, SD 6.815, range 53-76) (Table 1) with a SMI diagnosis (Table 2.) completed the semi-structured interview in a private setting. Two main themes emerged in our analyses: 1. Salient exposures influencing the development of eating habits and 2. the influence of convenience on eating. (Table 3.)

Salient Exposures influencing eating habits:

Participants identified 3 distinct exposures that influenced the development and evolution of their eating habits: early life experience, work environments, and living in residential programs. For these results, early life experience was defined as formative experiences during childhood and adolescence, including family eating practices, socioeconomic factors, and cultural norms that shaped participants' initial relationship with food.

Work environments were conceptualized as the occupational settings and routines that influenced food availability, meal timing, dietary choices, and acquisition of cooking skills. Nine of the 10 participants had experience living in a transitional residential program (TRP). A TRP is a short-term residence where participants stay after a hospitalization for an acute psychiatric emergency and before transitioning into the community.

Early life experience: Early life experiences played a critical role in shaping cooking skills and eating habits, often serving as the foundation for lifelong behaviors and preferences. Participants shared vivid memories of learning to cook at a young age, through hands-on experiences or observation with family members such as parents or grandparents. These early lessons were often informal but deeply impactful, with cooking becoming a way to bond with loved ones and pass down cultural traditions.

My grandparents raised me. They started teaching me you know, just by watching them basically and um, participating a little bit with grandma. The basics of cooking, how not to burn the house down and you know, maybe how to fry an egg and make some toast.

The generational transmission of habits, techniques, and attitudes toward food preparation were consistently reflected. One participant explained that her approach to cooking was deeply influenced by her mother's style and presence in the kitchen. "My mother was a great cook. I cooked at my kid's house for Easter. Um, nothing extravagant, but I did cook. And my son was like, 'You just like granny. You so slow in the kitchen.'" The statement *"You just like granny. You so slow in the kitchen"* suggests that her son recognizes similarities between his grandmother and his mother—not only in the end result of their cooking but also in the process itself.

Additionally, the act of cooking for her family during Easter—a significant holiday—shows how she continues to honor and preserve family traditions, much like her mother likely did. This quote not only illustrates how family influences cooking techniques but also how these shared habits and values are passed down and recognized by younger generations, creating a sense of connection and continuity within the family.

Work environments: Some participants described how their past work environments were influential in shaping their current eating habits and food preparation skills. Three participants specifically highlighted their experiences working in culinary and restaurant settings, which provided them with valuable skills and insights into food preparation.

When I was 16, I got into restaurant work, and I was pretty much on my own at that point. Um, and I was a dishwasher, and watched what was going on and then I graduated to a line cook and I was actually cooking at a seafood restaurant, a French steakhouse. I learned that way.

Another participant shared how their culinary expertise was gained through practical experience rather than formal training. "I just started from the ground up. I didn't go to any cooking schools." He went on to describe a dish he enjoys making now, which reflects the influence of his professional background: "rigatoni with a ragu type of thing because it's real easy to do, you know just cut fresh garlic up, throw it in the pan, hit it with sauce, fresh herbs, like fresh oregano. I've got a thing for oregano."

Work environments and constraints were described as having lasting effects on individuals' eating habits, even years after leaving those roles. For example, one participant describes how her past work routine shaped her approach to food and mealtimes.

And I don't know if it's out of habit 'cause of the way I used to work. I worked at the school district, so everything was done on the run, you know. I never really sat down because I would escort kids to lunch and stuff so I don't remember really sitting there eating with them. So I don't know how I ate. I think just in passing and that's kind of how I do now.

This lack of structured mealtimes became ingrained in behavior, to the extent that they continue to eat sporadically or skip meals entirely, even though their current lifestyle may no longer necessitate such habits.

Transitional residential programs: All but one person had spent time in a TRP. Participants described how these programs influenced their dietary habits and food choices. Customarily residents in TRPs are involved in menu planning and take turns preparing meals for the house, allowing them to practice or acquire cooking skills. One participant reflected on how their time in a TRP was transformative after living on the streets for an extended period:

That was just something for me who had been on the street a long time and -uh, didn't get to- I had to eat what I had to eat, not what I wanted and, and at (the program) I got to eat what I wanted to eat.

This person expressed their satisfaction with the program. "I was in heaven there."

Another participant living in a TRP at the time of the interview, emphasized how the program positively impacted their eating habits. When asked if it influenced what they ate: "Absolutely. Here there's enough food to eat, um, healthy meals and I like cooking so, I'm the one." Another person who was living on their own at the time of the interview reflected on when in the past he had eaten the healthiest. "Oh! Definitely when I've been in a program."

The structure of organized programs can impact eating habits. Programs often emphasize routine and consistency, which can help participants establish healthier patterns of behavior, including regular mealtimes. One participant shared that before joining the program, they were accustomed to eating only one meal per day. However, in the program, they developed the habit of eating three meals daily and they continued to do so while living independently. This shift demonstrated how structured environments encouraged individuals to prioritize their nutritional needs and adopt more balanced eating practices. "Since I've been in the programs it had me eating more regularly and so now, I'm in the habit of eating 3 times a day."

TRPs provided opportunities to learn about nutrition which had lasting impacts on participants' daily lives. For example, one person was introduced to the Great Plate. Another shared how the knowledge gained in a TRP helped shape their decision-making regarding food choices. They described how they consciously incorporate healthier options like vegetables into their meals, guided by concepts learned in nutrition classes. They highlighted how the education expanded their understanding of topics like omega-3s and the benefits of certain foods, fostering a deeper awareness of how nutrition supports overall health.

A thought'll go through my head, you know, hey you know I should open a can of green beans or a can of corn or something and I'll do that. A lot of it has been (people's names) over the years and uh, and me going to (name of program) and hearing the nutrition class kind of stuff. You know, I didn't know about omega-3s and uh, just how the body works like that and just how good some vegetables can be and it at least brought it to my thought process if that makes any sense.

Convenience:

In this context, convenience refers to how easily and quickly individuals can access, prepare, and consume food. Convenience is influenced by factors such as the availability of food options, proximity to food sources, access to cooking spaces, ease of meal preparation and consumption, and affordability. Foods that require less effort, time, or resources to obtain and prepare are often considered more convenient, even if they are less nutritious.

Availability and proximity: The availability of food and ingredients are integral to convenience. Whatever is most conveniently available can dictate dietary choices and habits. “Not everybody eats 3 meals a day with this balanced stuff, but you do the best you can. You know, or at least I do the best that I can with depending on what’s available.” When asked if convenience impacted what he eats one participant offered: “Yeah, I mean if you just look at Burger King. Um also, Burger King was partly price by having food delivered to me on GrubHub um a meal to me or whatever, I would do that, so yeah.” One participant described the impact of having food delivered by Meals on Wheels, a national non-profit organization that address hunger and isolation for older adults. “Usually, I don’t eat breakfast. Lately I’ve been eating 2 breakfasts a week because I’ve got the Meals on Wheels program now....They really help stretching my food budget.”

Neighborhoods and living environments were described as influential to dietary habits, as factors such as access to fresh food, cultural norms, socioeconomic status, and proximity to grocery stores or restaurants shape what individuals eat. For example, one participant describes access to healthy options. “Having stores close by, that is probably one main thing. If you can just walk easily a half a block to a store, that just really is a big one.” Another participant noticed a change in the availability of produce in his neighborhood. “The city’s been doin’ really good with as far as getting the store owners to put in like little vegetables and potatoes and carrots and these little fruit stands, I guess.”

Many participants walked to shop or get at least some of their food. “I walk to everywhere that I go, yeah... I carry it in a bag, yeah. Reusable bag most of the time to save the environment.” A couple of people frequently used delivery services. “They were delivered to my door...They were less expensive than Safeway for the most part. They only had a small delivery fee and um, I didn’t have to go out and lug um back on the bus and stuff.”

Conversely, others noted challenges related to the dearth of availability and proximity of food and healthy ingredients in their neighborhoods. For example, walking safely to nearby stores was not a viable option, and reliance on public transportation introduced obstacles. One participant, who lives in a food desert and must travel to another neighborhood to shop, described the difficulties of this process:

It’s hard to get clear to Foods Co. from the Tenderloin, right? And get on a bus with all you can carry ‘cause you don’t wanna have to make 2 or 3 trips, so yeah, it’s kinda hard so I gotta get back into that. Into doin’ that kind of think to save myself money. I can’t keep going to these neighborhood stores. So, yeah, lately I’ve been eating a lot of stuff like pre-made sandwiches.

This same participant described exposure to ultra-processed foods that he finds difficult to avoid and resist.

Like yesterday I went and got me a new pair of shoes...over at Ross and uh- the boogers had all these candies and cotton candies and stuff and they ...you gotta go through a maze of just delicious stuff and I picked up some Sunkist and fruit gems.

Sometimes the challenge was inside one's own building or home. One person who had vending machines in her building commented, "I have been going to corn chips. It ate my money last time so that was annoying."

These barriers not only led to the consumption of more processed and less nutritious food but also contributed to food insecurity. When asked if he had enough to eat, a participant said, "No, not right now. And it's just because I don't get going to the Foods Co. I've got money in my pocket to go get the food. It's just such a chore to get there, you know?" Another participant expressed deep concern about losing access to convenient, affordable food options after the recent closure of a nearby grocery store within walking distance.

I'm kinda concerned with the fact that I don't have a neighborhood store anymore. It just dawned on me. Um, I used to just take my little rolling backpack and walk to Safeway. ... I knew that (the closure) was gonna be a mess. Even though I didn't like this store I would go there. I wouldn't go there and shop, shop, but I would go there and pick up necessities, one or two items because it was just too chaotic. But with it gone, it's scary now. And there's a Molly Stones up the street, but they're really expensive.

Availability and access to healthy foods did not guarantee that people would eat them. One participant enjoyed the convenience of Meals on Wheels. However, he would pick out what he likes to eat often avoiding the vegetables. "You know, they're really great, um, the meals I normally pick apart and get the meat out of 'em, you know, kind of the spinach out of 'em....I usually throw away the vegetables."

Meal preparation and consumption: In this context, consumption refers to the act of eating or the ability to eat food. The ease and convenience of preparing and consuming meals encompass both physical and emotional factors. Various facilitators and barriers impact how comfortably and efficiently individuals can prepare and consume food, which, in turn, affects the convenience of maintaining healthy dietary habits.

Having a space to prepare food is integral to convenience, even if it is simply a place to heat up prepared meals: "I mainly eat dinner, kind of a early dinner, and that'd be lot of uh, TV dinners." And "I mainly cook in the microwave." While most participants reported having the physical space to cook, many found the effort required to purchase ingredients and prepare meals overwhelming. When asked what makes it difficult to eat a healthy diet, one participant explained, "Havin' to prepare it. Having to buy it and prepare it is the hard part for me". For some, the option to buy prepared food served as a practical solution to these challenges. One participant who described past experiences of overwhelm when cooking, enjoyed

the option of purchasing prepared meals. “I used to cook but this is easier. They (SNAP) gave me more money so I can do it, and you know, and model it after the Great Plate”.

There is a social dimension to eating that is emphasized in transitional residency programs, where residents prepare meals together and share them as a group. One resident reflected on this experience, highlighting both the increased enjoyment of eating and the positive impact of shared meals on his appetite: He consumed more in this environment. “I eat more and food is good... and just being with people is funner to eat with people.”

Limited mobility or physical conditions can add challenge to shopping. One participant who had difficulties with his legs and issues standing for extended periods would limit shopping to the nearby liquor store. “Grocery Outlet is less expensive than the liquor store, but the liquor store is more convenient because Grocery Outlet can be hit or miss with long lines.” Physical illness influenced dietary choices and habits. For example, physical discomfort like nausea while lying down lead to reduced appetite and lighter meals, resulting in a shift to fewer daily meals. “When I lay down, things churn and I feel like I’m going to vomit so I have to get up and sit for a while. I don’t eat as much as I used to.” Additionally, illness disrupted regular eating patterns and lead to irregular, potentially unhealthy food choices, where eating “the wrong things” or splurging on expensive meals reflects the impact of illness on both nutritional and financial decisions. “When I was sick in bed and I was eating the wrong things, but I was able to save money. There would be times that I would get up long enough to go to a restaurant to eat a \$30-\$40 meal.”

Emotional state can influence one’s ability to easily maintain healthy eating habits. A participant described how his panic attacks disrupted his eating habits: “The only time that I won’t (eat) is like in the evening if I get a panic attack, right? Then I’ll go to bed and sometimes I’ll get up hours later to eat.” Another describes how his mood made it difficult to regulate his eating behavior. “When I’m in a bad mood I just sit in front of the TV eating and want to feel better. I eat more.”

The co-occurrence of substance use disorders is prevalent for individuals with SMI. Substance use can exacerbate symptoms of mental illness, disrupt daily routines, and impair self-care behaviors, including healthy eating. “I was using substances for the last year, alcohol. So, a lot of times just didn’t care about food. I was just either mind elsewhere or passed out.” A participant living in a TRP, shared how abstaining from alcohol had positively influenced his eating habits, enabling him to eat more frequently and make healthier food choices. “I’m not drinking or using so I’m eating 3 times a day and usually it’s pretty healthy. I always try to throw something healthy in there.” His experience highlights how recovery from substance use can foster improvements in dietary habits.

One person who lived alone struggled with the emotional impact of isolation, eating alone, and cooking for one. She also disliked the waste of throwing out unused ingredients. To avoid loneliness, she preferred dining out, where casual interactions with others help alleviate feelings of solitude. “I don’t like eating by myself, so I rather go out and eat than I do in the house. I kind of chit chat with anybody. I got one of them faces everybody talks to me.” She used to pick up food from a food bank but found the

offerings overwhelming for a single person, as the quantities and repetitive items led to food waste. Without consistent cooking, perishable items would spoil, making it difficult to maintain a balanced diet while living alone. “ I’m constantly throwing things out of my refrigerator, you know. If I don’t use it, it’s just too much. If I’m not cooking consistently it’s gonna go bad. It’s hard to keep everything fresh for one person.” After missing several food bank pick-ups, she was discontinued from the program. However, she expressed interest in trying a meal prep service, admiring its convenience and portion control, which could suit her needs if affordable. “I was gonna try that because my son and ‘em did it and it was was the cutest little thing. They had little packets and they give you every little ingredient you need, and you just put it together real quick.”

Affordability: While convenient, premium or limited stores may pose financial barriers for many individuals, potentially impacting ability to sustain a healthy diet. Foods associated with a healthy diet, such as fresh fruits, vegetables, lean proteins, and organic options, tend to be more expensive. Conversely, ultra- processed foods, while frequently convenient and less expensive, provide minimal if any nutritional value. “Thank God for the food programs but sometimes the economics makes it hard too ‘cause the processed food is cheap”.

When asked where he gets most of his food one participant replied, “Right now it’s Mollie Stones around the corner. They have everything! But it comes at a price.” While some places may be convenient, they are not necessarily affordably within reach, especially with inflation in recent years. “L’s (a small local restaurant) is uh- well I don’t even go in there anymore. I mean I know the guy and everything but he says, you don’t come in here anymore. ‘You’re too expensive!’ ”

Some people described not having sufficient funds to eat each month. “I was always concerned at the end of the month I wasn’t going to have money. So, I would kinda say you’ve got this much this week and a lot of times that wasn’t what I needed or wanted.” Food programs like food banks, pantries, Meals on Wheels, and SNAP were frequently used by participants and described as essential supplements to their diets. “I’d go down to the Food Bank and volunteer or grab food or both ‘cause they let you have what you want when you volunteer.” Another participant described his experience at a food pantry. “They have mostly vegetables and fruit mostly. And then they have sometimes, frozen salmon. Or uh frozen chicken legs. And like then like today they had a can of pork. So, I might have some of that over the weekend.”

Electronic Benefit Transfer (EBT) is a system used in the United States to electronically distribute government assistance benefits, such as food or cash, to eligible recipients through a debit-like card. EBT cards are a convenient and secure way to ensure that individuals and families in need have access to essential resources. Recipients can use EBT cards at authorized retailers (grocery stores, supermarkets, farmers’ markets, etc.) to purchase eligible items. Retailers must be authorized by the USDA to accept EBT payments. EBT cards used specifically for buying food are typically associated with the **SNAP (Supplemental Nutrition Assistance Program)**. While SNAP is a federal program, it is managed by state level agencies. For SNAP benefits, items must be food-related (e.g., fruits, vegetables, dairy, meat). Non-food items like alcohol, tobacco, and household supplies cannot be purchased with SNAP

funds. Participants discussed using EBT cards and SNAP to purchase groceries and some prepared foods.

If you have to stress out about the price of food, then things can get really kinda tight and you're going, what can I eat for very little money? Or you know, that's a consideration. So, you know if you're on an EBT, what you think is an extremely generous allowance, you don't stress out on what things cost or whether you're going to have enough to get through an entire month.

When asked "what makes it easier to eat healthy?" one person simply put it, "Easier? The EBT card." He later added, "when I got my EBT card it gave me more options." The monthly SNAP amount an individual is eligible for varies based on a formula considering income. In 2025 the maximum SNAP monthly benefit was \$291 for one person. Participants described receiving significantly less.

I get, I think it's 39 dollars a month now, where they cut it back from the last 2 years. I'd been getting \$250. I'll go over to the corner store and get a sandwich from there if I get hungry during the day sometimes. Uh, really I've not eaten as much as I used to. I was eating a lot more but, well, this month, last month they cut our food stamps (SNAP).

Discussion

This study examines experiences and perceptions around diet and food access among community-dwelling older adults with SMI, a population facing elevated morbidity, premature mortality, and food insecurity. These disparities arise from the intersection of mental health conditions, lifestyle factors, and structural barriers. Many older adults with SMI live in low socioeconomic contexts where financial constraints, geographic barriers, safety concerns, and limited availability of affordable, healthy foods restrict access. Age-related declines in mobility and physical health may further compound these challenges, particularly in food deserts. To our knowledge, this is the first qualitative study exploring these experiences among community dwelling older adults with SMI.

Early life experiences strongly shaped cooking skills, dietary preferences, and eating behaviors, consistent with prior research in older adults (Atkins et al., 2015; Bloom et al., 2017). Family practices, cultural norms, and formative life events influenced food-related knowledge and routines that persisted into adulthood, reinforcing dietary patterns and cultural identity.

Employment also emerged as a determinant of dietary behavior. Unemployment is a known social determinant of mental health and contributes to intergenerational disadvantage (Kirkbride et al., 2024). In this study, unstructured or unstable work environments were associated with irregular eating patterns, including skipped meals, whereas structured and supportive employment promoted routine eating and healthier habits. Some participants gained lasting food skills through culinary work. These findings underscore the broader health benefits of vocational rehabilitation, including supported employment, which provides structure, financial stability, and opportunities to develop sustainable health behaviors. Vocational rehabilitation does more than provide financial stability; it offers the daily structure and

routine necessary to foster positive health behaviors, regular eating habits, and long-term wellness. (Bond et al., 2008)

Transitional residential programs (TRPs) played a significant role in shaping dietary habits. Participants described these programs as transformative, citing structured mealtimes, communal dining, and wellness-oriented environments as key facilitators of change. Regular access to balanced meals helped normalize eating patterns, particularly for people with SMI who often have disrupted hunger cues. (Mötteli et al., 2023) Nutrition education (e.g., MyPlate, omega-3 benefits) increased awareness and led to sustained dietary improvements. These findings align with evidence that structured lifestyle interventions in residential mental health settings are feasible, acceptable, and associated with improved outcomes. (Korman et al., 2020) A scoping review of nutrition interventions in residential programs for individuals living with disadvantage such as SMI, found that nutrition interventions improve behaviors and motivation critical to a successful transition to independent living. (Vaiciurgis et al., 2022) By providing structure, support systems, and educational opportunities, TRPs empower individuals to build sustainable, health-conscious routines. Overall, TRPs appear to provide a critical foundation for establishing durable, health-promoting routines.

Social and environmental contexts further shaped dietary behaviors. Communal eating in TRPs enhanced enjoyment and improved food choices, highlighting the importance of social engagement. Substance use also played a significant role: active use disrupted routines and reduced nutritional intake, whereas recovery supported more consistent and healthier eating patterns. Chronic substance use is associated with micronutrient deficiencies, malabsorption, and metabolic dysregulation, which can exacerbate psychiatric symptoms. (Mahboub et al., 2021) Furthermore, the behavioral focus on obtaining and using substances often replaces regular food intake with "empty calories" or prolonged periods of fasting risking malnutrition, necessitating structured nutritional rehabilitation during the recovery process. (Jeynes & Gibson, 2017; Ross et al., 2012) These findings underscore the complex interplay between physical, emotional, and social factors in the convenience of meal preparation and consumption. These findings emphasize the need for integrated interventions addressing both nutrition and substance use.

People with SMI often live in urban areas with limited access to fresh foods and rely on corner stores or fast food. They are nearly three times more likely to experience food insecurity (Jester et al., 2023), a modifiable social determinant of mental health (Jeste et al., 2025), making convenience a key driver of dietary behavior. In this study, proximity and accessibility strongly shaped food choices: nearby stores, delivery services, and programs like Meals on Wheels improved access to healthy foods, while living in food deserts led to reliance on distant or costly options and poorer dietary patterns. These findings align with prior research documenting food insecurity among individuals with SMI. (Compton, 2025; Compton & Ku, 2023) However, proximity and availability alone was insufficient; financial pressures, and personal preferences often led participants to make less nutritious choices. These findings suggest that interventions must go beyond increasing access to healthy food; they must address practical barriers, cultural preferences, and individual behaviors. Emerging "Food is Medicine" approaches, including

produce prescriptions, and partnering with healthcare clinicians and social services, show promise in improving diet quality and reducing food insecurity. (Hildebrand et al., 2025; Mozaffarian et al., 2024)

Affordable access to nutritious food is critical as financial constraints can force individuals to prioritize cost over quality, leading to poorer dietary outcomes. Programs that support food access, such as food banks, pantries, and government assistance like SNAP/CalFresh, emerged as essential resources for many participants, helping to supplement their diets and alleviate financial stress. Cutting programs that supplement resources for food or purchasing food negatively impacts not only the frequency that people eat but also the quality of nutrients that they consume. Despite the benefits of supplemental food programs, reductions in benefits or limited monthly allocations were cited as significant barriers to food security and healthy eating. Participants described the adverse impacts of recent cuts to SNAP/CalFresh benefits, which reduced their ability to purchase enough nutritious food, sometimes resulting in decreased meal frequency and reliance on less healthy, inexpensive options.

While programs like EBT cards were recognized for providing critical support and enabling access to healthier food choices, participants also noted the limitations of these programs, including insufficient benefit amounts and the temptation to purchase processed or prepared foods that accept EBT but are less nutritious. These findings emphasize the need for policy interventions to increase benefit amounts, maintain funding for food assistance programs, and expand efforts to ensure affordable, nutritious food options are accessible to all. Addressing these systemic barriers could significantly enhance food security and promote healthier dietary patterns across vulnerable populations.

Limitations: This convenience sample represents a densely populated, urban area in the western United States and may lack sufficient diversity in participant perspectives. Future research should expand the geographic scope, diversify sampling strategies, and partner with community organizations.

Conclusion

Early life experiences and exposure to healthy foods and eating habits are critical in the development of preferences and the modeling of healthy eating habits throughout the lifespan. Mental health programs, such as transitional residencies, that incorporate cooking experiences and nutrition or health groups can provide opportunities and entry points to help people learn and practice changes to diet and eating habits. Vocational programs can also address SDoMH by modeling and incorporating healthy eating habits. Further research investigating barriers, facilitators and drivers of nutritional security and determinants of health in older adults with SMI will be beneficial.

Declarations

Declarations

The authors have no financial or non-financial interests that are directly or indirectly related to the work submitted for publication.

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Author Contribution

E.H. recruited and consented participants, conducted interviews, transcribed and coded interviews, determined themes and sub-themes, and wrote the main manuscript text. H.L. reviewed interviews, guided and discussed conceptualizations about the categories and relationships between categories, and contributed to the manuscript text and editing.

Data Availability

The datasets generated and/or analyzed during the current study are not publicly available due to the sensitive nature of the data in a vulnerable population and restrictions imposed by the Institutional Review Board and participant consent agreements.

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Tables

Table 1. Demographics

		Frequency
Residence	apt with roommate	2
	apt alone	5
	board and care	1
	transitional residence	2
Sex Assigned at Birth	male	7
	female	3
Identified Gender	male	7
	female	3
Ethnicity	African American / black	1
	Native American	1
	white	7
	multiethnic	1
	Total	10

Table 2. Participant Psychiatric Diagnoses (N = 10)

Diagnosis	n (%)
Schizophrenia	3 (30%)
Schizoaffective disorder	1 (10%)
Bipolar disorder	2 (20%)
Anxiety disorders	6 (60%)
Depressive disorders	4 (40%)
Post-traumatic stress disorder (PTSD)	5 (50%)

Note. Participants could endorse more than one diagnosis; therefore, percentages exceed 100%

Table 3

Themes and Subthemes Identified in Qualitative Analysis

Theme	Subthemes
Salient exposures influencing the development and evolution of eating habits	Early life experiences
	Work environments
	Residential program settings
Influence of convenience on eating	Availability and proximity of food
	Meal preparation and consumption practices
	Affordability