Abridged Report

Food Access and Nutritional Health among Families in Emergency Homeless Accommodation

Michelle Share · Marita Hennessy

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“

This situation has broken me

It is so stressful and so dehumanising and the fact that there is no end in sight you know there is no in a few months this might happen . . . (P8)

”

Note on report

This report highlights the key findings of the research study *Food Access and Nutritional Health among Families in Emergency Homeless Accommodation*.
It is an abridgment of a more comprehensive and detailed report of the study.
The full report is available at: https://www.focusireland.ie/research/

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Acknowledgements

This research would not have been possible without the participation of the families who were willing to share their everyday experiences of dealing with food and eating while they lived in the challenging circumstances of emergency homeless accommodation. We are particularly grateful for their efforts to describe their food situation while they endured the uncertainty in their lives.

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May 2017

Introduction

The study aimed to explore food poverty among families living in emergency homeless accommodation in the Dublin region, and the impact this has on the nutrition and health outcomes of parents and their children.

'Food poverty' is a multidimensional construct with numerous definitions. Framed by a multidimensional perspective, the present study considers food poverty in terms of: access; availability; affordability; and awareness (knowledge and skills about food) (Healthy Food For All, 2016). As homelessness contributes to social exclusion and marginalisation (Shinn, 2010; Wright, 2005) we take into consideration the importance of the social and cultural acceptability of food in terms of its access and availability (Dowler, Turner, & Dobson, 2001; Riches, 1997).

The study objectives were to:

1. Understand the prevalence of food poverty among families experiencing homelessness who reside in emergency accommodation.
2. Understand families' access to food, storage, and cooking facilities in the context of emergency homeless accommodation.
3. Explore the impact of homelessness and emergency accommodation on daily food habits, nutrition, health and well-being among parents and children.
4. Consider family strategies in negotiating emergency homeless living situations.
5. Make recommendations for policy-makers as well as front-line service providers to improve food security among families experiencing homelessness.

Methodology and methods

Research objective 1 was implemented through a review of literature (Chapter 3). Research objectives 2, 3, and 4 were informed by the literature review and examined through a mixed methods research strategy that incorporated:

- An interviewer-administered survey, and photovoice in which 10 parents in emergency homeless accommodation documented their food lives through photography.
- Parents' photographs were used as prompts during in-depth photo-elicitation interviews about their everyday food practices.[1]
- Interviews with six service providers involved in the provision of health and social services for homeless people.

Recommendations for policy makers (Research Objective 5) were informed by the review of literature, the service provider interviews, findings from the parent interviews, and discussions between Focus Ireland's Research Advisory Group and the researchers. Data collection took place between December 2016 and April 2017.

1 Data is anonymised. Parent data is reported as P1, P2, P3 etc

Key findings and conclusions

Family characteristics, pathway to emergency accommodation and current living circumstances

Table S1 · Participant demographic characteristics (n=10)

Sex	
Female	6
Male	4
Age of parent	
Range	22–45
Mean	34.4
Nationality	
Irish	6
Other nationality	4
Highest Level of education completed	
Primary	2
Secondary/Junior Certificate Equivalent	2
Secondary/Leaving Certificate Equivalent	6
Household type	
Couple with children	4
Lone parent with child(ren)	6
Main source of income	
Lone parent benefit	5
Job seekers/unemployment benefit	4
Other benefit	1
Age of children	
Range	4 months – 22 yrs
Under 12 months	1
1–2 years	4
3–5	3
6–8	2
9–11	2
12–14	3
15–17	1
18 and above	2

Pathway to emergency accommodation

There was some variation among participants in their pathway to emergency accommodation. Three reported that they had previously lived in private rental accommodation shared with others, but this became unviable when accompanied by their children.

One couple with an infant had been renting a room in a shared house. They reported that the leaseholder broke the conditions of the tenancy agreement and they were subsequently evicted. They were unable to find anywhere to live.

Another participant, who had lived in the same private rental accommodation for three years, became homeless when she had no success in finding alternative accommodation after her landlord sold the premises. Another family had been living in private rental accommodation for several years using rent supplement and their own funds. After their rent increased by €270 per month she tried to find another place but could not find anywhere that aligned with the rent allowance.

Two families reported that they had been living in shared multi-generational households but this had become unsustainable as a result of on-going family disharmony. In contrast, one lone parent had been satisfied sharing in an extended family household but had to leave because of neighbourhood intimidation. The mother was concerned about her child's safety and growing up in a negative environment.

One participant became homeless after they had attained refugee status. They had been living in Direct Provision accommodation but were required to leave some months after attaining refugee status and could not find anywhere to rent.

Duration of homelessness

Time spent designated as homeless ranged from one to 36 months with a modal category of one to three months.

Current living circumstances

Participants' current living circumstances varied in terms of the main purpose of the accommodation and the facilities provided. A number of accommodation settings were distinctly geared to the budget travel market but some seemed to have reoriented to serving homeless people only. Other types of accommodation could be described as B&Bs for homeless families and tourists; commercial hotels serving tourists mainly, with homeless families in a minority.

Other families were in hostel accommodation, sharing bathrooms with other residents of the hostel, who were also homeless.

Cooking and dining facilities also varied as shown in Table S.2 below:

Table S2 · Accommodation categories and facilities provided

Type	No of families	Bedroom	Bathroom	Kitchen/ Cooking facilities	Food provision	Utensils provided	Fridge provided in room	Storage provided
Hostel for homeless (A)	2	Family shared bedroom	Shared	Shared kitchen with cooker and shared fridge	None	No plates; pots; pans	No fridge in room	No private storage space in kitchen
Hostel for homeless (B)	2	Family shared bedroom	Private	Shared kitchen with cooker and shared fridge	None	Yes	Fridge in room	No private storage space in kitchen
Commercial hotel geared to tourist market	2	Family shared bedroom	Private	No cooking facilities	Breakfast	N/A	No	NA
Budget B&B for homeless and tourists	3	Family shared bedroom	Private	No cooking facilities	Breakfast	N/A	No	N/A
Budget hotel for homeless only	1	Family shared bedroom	Private	Shared microwave and fridge	Breakfast and dinner	N/A	No	N/A

Note: N/A = not applicable

Families' access to food, storage and cooking facilities in the context of emergency homeless accommodation

Food provision

Some families' emergency accommodation provided breakfast and/or dinner. Although participants with accommodation provider breakfast felt this was beneficial, it was not always accessible to them. Parents' accounts aligned with those of the service providers. Access to breakfast could be problematic for families: its timing, location in a communal dining area, combined with the pressure to ready and transport children to school, meant that they often did not avail of the breakfast provided. Instead, they purchased en route or children received breakfast at school (if it was available and they arrived in time to receive it). Morning periods in any family domestic setting with young children are typically characterised by multiple parallel activities and complex scheduling arrangements. For families in emergency homeless accommodation this situation is more problematic. It impacts them not only in terms of not having what is deemed by many health professionals to be the most important meal of the day, and crucial for children so that they can engage with education, but also in terms of how families experience socially diminished circumstances, children without a place to sit to eat their breakfast, and who have become 'normalised' to dining in homeless communal settings, or with tourists, rather than as a family around their own table.

As with breakfast provision, families may not always access the accommodation provider dinner. Dinner was usually available in the late afternoon, between 4:30pm and 5:30pm. This constrained families, particularly when they had to travel from an outer suburb where their child(ren) attended school. Furthermore, the timing also meant that families had to spend longer in the evenings than desired in their one-room space. Families with dinner provision also tired of the communal dining arrangements and would return to their room where they ate on the bed.

P4 had access to her accommodation provider's dinner service. Dinner, available between 4:30 and 5:30pm, consisted of a daily repertoire of four items, and a 'special'. Where possible, P4 and her family availed of the breakfast provided, but after living in the same hotel for 15 months they had grown tired of the food and also questioned its quality. The fixed time of the dinner could also be inconvenient if a family wanted to do something else, such as visit relatives or friends, attend an appointment, or lessen the time spent in the emergency accommodation bedroom. Through her photo (Figure 1), P4 explained that although there was a hotel dining area she and her family tended to take the meal to the room and ate it on the bed as they disliked the environment, and because the timing did not always suit their toddler's schedule or mood.

Such regimented meal times and restricted food choices in homeless accommodation services have also been found to negatively influence children's dietary intake (Richards & Smith, 2006a).

Although service providers and charities emphasise the importance of access to food provision in emergency accommodation, the findings of the present study and other research highlights that food provision is not straightforward. Structured meal provision and early dinners in homeless shelter accommodation can also lead to children's late night snacking (Dammann & Smith, 2010). The findings highlight that structured meal provision in emergency accommodation is problematic as families have no control over their own, and their children's, food choice and are not able to eat in socially acceptable circumstances as a family. It is questionable the extent to which B&B, hostel and hotel accommodation are best placed to do this for families.

Figure 1 · Dining on the bed with hotel-supplied dinner

Food storage

For all families, regardless of accommodation type, food storage was a constant everyday pressure that impacted on their food choice and dignity.

B&B and hotel accommodation, particularly in budget-type premises that are used for homeless families, are not intended for long-term dwelling. All but one family shared one room, and in some cases children shared a bed or single parents shared with their child/baby. Storage for personal possessions was extremely limited and parents faced particular challenges with baby equipment, toys and washing. Through her photo (Figure 2), P9 described the constraints of living in a room that was jammed with her possessions 'Everywhere there is nowhere to put the feet' and that she had nowhere to stimulate her four-month-old baby – 'can't put the baby on the floor – where are you going to put her?'

Figure 2 · Storage constraints

In addition to these constraints, parents also tried to store food in their rooms and experienced great difficulties in doing so. Families with meal services stressed that there was a need to be able to provide food for their children outside of the two hours of service. While some had a small fridge in their room, others did not, and some used the windowsill to keep perishable items cool. P2, through his photo (Figure 3), described how he used the window-sill for perishable items that were used to make sandwiches for his children.

Figure 3 · Window-sill refrigeration

Service providers also highlighted that although there were many opportunities for families to avail of food hampers etc, lack of storage meant that they could not use them.

Lack of food storage and refrigeration also impacted on what parents could buy. They could not buy larger quantities of food that would have offered better value. This resulted in frequent shopping trips. Although families did not report insufficient money for food, they found that their circumstances forced them to spend more on food, particularly ready-made meals, snack foods and takeaways than they would have before becoming homeless. Most reported also spending more on transport.

Even for those with access to kitchen facilities, not having adequate storage space meant that they limited their choice of ingredients to items that they could store and that generated minimal food waste.

None of the families with access to a kitchen had a personal, lockable cupboard, and some were required to share a fridge/freezer with other families. Although P6 felt that it was beneficial to have access to a fridge and a freezer, access was problematic. She described the difficulties of her situation through her photo (Figure 4) of a jammed up freezer of food that was out of date/left behind by previous residents of the emergency accommodation.

Figure 4 · Jammed-up shared freezer with out-of-date food from previous residents

These circumstances caused many other difficulties, such as experiencing food theft, having insufficient space in the shared fridge, and of having to use makeshift storage and transportation equipment for their food.

P5 carried his ingredients to the kitchen in a plastic bag and stored them in a cardboard box in his room. Through his photos (Figures 5 & 6) he described his circumstances.

> ***I take this picture because the way I live is basically not very good. I have no place to put my stuff I have to put it in a bag (P5).***

Figure 5 · Conveying ingredients to a shared kitchen

Figure 6 · In-room storage of non-perishable items

Such facts have been well documented nationally and internationally in research that has examined the food situation of homeless people.

The situation of the families in the present study, in relation to the challenges of food access, storage and preparation, aligns with those reported by Bowen et al. (2016) and Lewinson (2010) of people who live in precarious accommodation, such as hotel or apartment buildings where individuals can rent small dormitory-style rooms on a daily, weekly, or monthly basis-with typically shared bathrooms and no kitchen/cooking facilities.

Cooking facilities

Families had differing experiences with access to cooking facilities that ranged from no access to any cooking facilities; shared microwave and fridge; shared kitchen with cookers, fridge, and dining area. Families without access to cooking facilities felt that their situation could be improved if they had kitchen facilities, however, the accounts of the families with such access highlighted numerous constraints.

These included: restricted access to kitchen; lack of equipment; queuing to cook and dine; and CCTV surveillance. Through her photos P7 described her cooking and eating situation as one of a controlled environment where eating together as a family in a relaxed way was further reduced by being viewed on CCTV (Figure 7).

> ***No matter where you are standing in the kitchen there is a camera pointing at you and all them cameras are upstairs in the office for them to look at – It feels like I am always being watched no matter where I go in the whole building, sometimes it's for safety but not a good feeling (P7).***

The challenges faced by homeless families living in sheltered accommodation and in B&Bs was well documented in the UK during the 1990s (Stitt, Coufopoulos, & Grant, 1995; Stitt, Griffiths, & Grant, 1994) and in Ireland during the early 2000s (Halpenny, Keogh, & Gilligan, 2002; Hickey & Downey, 2003; Smith, McGee, & Shannon, 2001). Similarly, the present study identifies that access to food, storage, equipment and a place to eat is much more than a functional requirement. In all of their descriptions about trying to cook and dine at their emergency accommodation, participants revealed the erosion of their dignity as a human being. This is evident in how their access to food preparation and cooking facilities was controlled and regulated.

We also see how families with access to cooking facilities experience family dining. For some it is not possible at all, whereas for others they may do so under surveillance seated in a row. Commensality, eating together in a positive social environment, is recognised to be protective of health. It offers opportunities for relationship building, for reflection on the day, or upcoming events, and to eat and enjoy food in an unhurried way and for language and cultural socialisation (Ochs & Shohet, 2006). This possibility was not afforded families with access to kitchen facilities in emergency accommodation. Eating together as a family is important as it allows parents to model and to establish structures for positive eating practices with their children (Patrick & Nicklas, 2005).

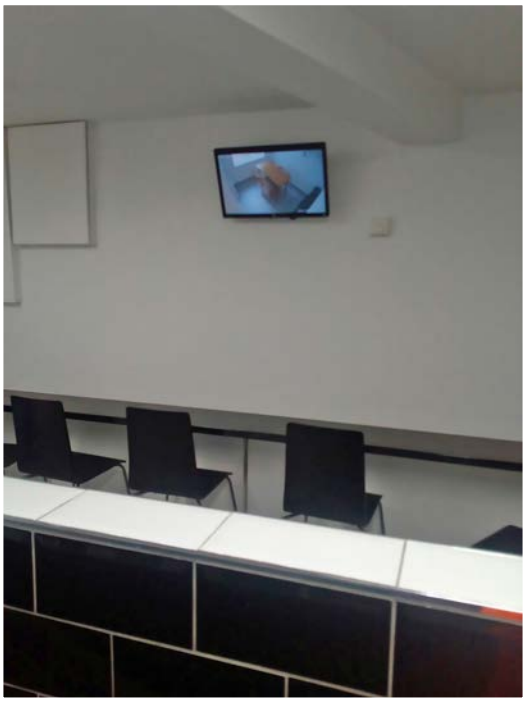

Figure 7 · Under surveillance

Impact of homelessness and emergency accommodation on daily food habits, nutrition, health and well-being among parents and children

Daily food habits: Prevalence of takeaway meals, convenience foods and snacks

Regardless of accommodation type, emergency accommodation impacts negatively on families' daily food habits and dietary quality, not only in terms of what is consumed but also in how they prepared and ate their food. Although families with access to cooking facilities reported cooking simple meals, they were constrained in the range and type of ingredients they cooked because of inadequate storage, refrigeration and access to the kitchen itself, and many resorted to convenience foods. The foods consumed on an everyday basis were high fat items: whole fat milk and chips. Reported daily fruit and vegetable consumption was low. Participants reflected that their daily food patterns had changed since moving to emergency accommodation as they now relied on more takeaways.

As well as food access, affordability and availability, food poverty is also commonly conceptualised in terms of knowledge and skills about nutrition and cooking. In their discussions about their efforts to provide food for themselves and their children, none of the participants demonstrated a lack of knowledge or awareness about food and nutrition. Moreover, they were constrained in their food choices by the contextual conditions of their living circumstances.

Even participants with meal services still needed to provide food for themselves and their children for other times of the day. There were limits to what they could do in their room and so, in addition to takeaway meal deals of chicken and chips, or pizza, they supplemented their diets with foods such as breakfast cereal, toast, noodles, instant pasta, biscuits and crisps. How families prepared foods such as noodles and instant pasta varied depending on their access to cooking facilities. Those without any microwave or kitchen access were reduced to improvised cooking techniques, such as boiling food in a kettle.

Having procured a takeaway meal, or made an improvised convenience meal in one's room, participants described the difficulties of eating in the room. For some there was no table or chair, or only one chair. All families used the bed as a table and one used the floor, with an improvised tablecloth of aluminium foil.

Eating meals in the room and on the bed, particularly with young children and babies, placed great pressure on parents as they tried to keep the area clean. Through his photo P2 described how he and his family did not eat on the bed and instead ate on the floor having made an improvised tablecloth with tin foil (Figure 8).

They tried to make environmental adaptations: some tried to 'normalise' the situation with their own plates and cutlery, particularly for children, yet this generated further challenges with washing up in a bathroom sink without a draining board.

While some families ate directly from takeaway containers others used their own plates. This presented further challenges with hygiene as they tried to wash up after the meal. Through her picture of the bathroom sink (Figure 9), P4 described how she would wash dishes in the sink and place them in the bath before drying them.

Another parent, P8 faced similar difficulties and remarked:

> ***It's completely unhygienic – you would never think of putting your clean dishes on top of the toilet.***

Families that chose to cook in the room were also concerned about breaking rules. Dealing with food waste was also problematic and, as one key informant described, led to undignified practices in hiding the food waste. Such practices become the norm for many families in emergency accommodation, and it reduces them to produce and consume food not in the manner that is the acceptable norm in society (Friel & Conlon, 2004).

Figure 8 · Dining on the floor

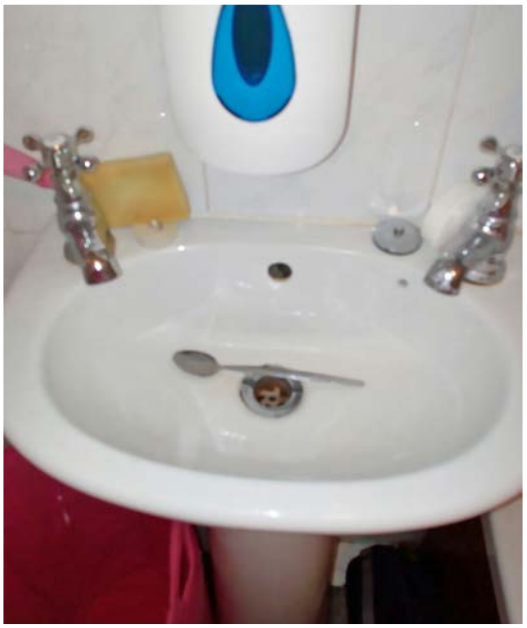

Figure 9 · Bathroom sink for washing dishes

Physical health

Diet-related physical health issues reported by participants included constipation and weight gain. Such issues have also been found in other research with homeless families where diets are dominated by high fat and low vegetable consumption (Davis et al., 2008). In terms of weight gain, for one participant years of dwelling in one hotel room without cooking facilities resulted in a spiral effect as she felt trapped in a small room and had a lack of opportunities to exercise, which led to grazing. Lack of storage for perishable items, and concerns about food waste, also led to overeating. Participants' accounts demonstrated a lack of control over their food situation and of poor quality food choices that impacted their physical health.

P4, through her photo (Figure 10), spoke of the digestive problems that she and her family experienced: all members of the family suffered from constipation, exacerbated by a lack of physical activity. Furthermore, 'sitting on top of each other, all being all trapped in one room with nowhere to go' made the situation worse.

This was particularly acute for those with lengthy periods in emergency accommodation and as one key informant observed 'you can see the physical changes manifested on them'. (KI1)

Living with uncertainty about housing impacts on mental health (Corman, Curtis, Noonan, & Reichman, 2016). Not all participants had diet-related physical health concerns, but all reported stress and anxiety from living in cramped one-room accommodation, without any private space, or physical space for food storage and cooking. The only space for most was the bathroom. Their lives were lived on the bed. Their situation is reflected in other research on families in temporary accommodation that reveals the stressor of the lack of privacy and its impact on intimacy (Lewinson, 2010).

Figure 10 · Takeaway on bed

Child wellbeing

Parents' descriptions of their room space and of the challenges of storing and preparing food clearly articulated that child safety was a concern for them, particularly in relation to babies and toddlers. Being in a confined space that mainly comprised beds meant that parents had to use inappropriate spaces for kettles and for food storage, which made children vulnerable to accidents. Both P7 and P4 spoke of their concerns of children pulling things on top of themselves, particularly kettles, and of their vigilance to ensure that a kettle was emptied after it was used. P6, through her photo, described a perilous situation for her two-year-old child in a room that was jammed with extension cords and where she had nowhere but the floor to prepare her child's food (Figure 11).

Some parents had to carry a baby or handhold a toddler up and down flights of stairs to access the shared kitchen while simultaneously carrying ingredients. Parents in these circumstances also had concerns about their child's safety.

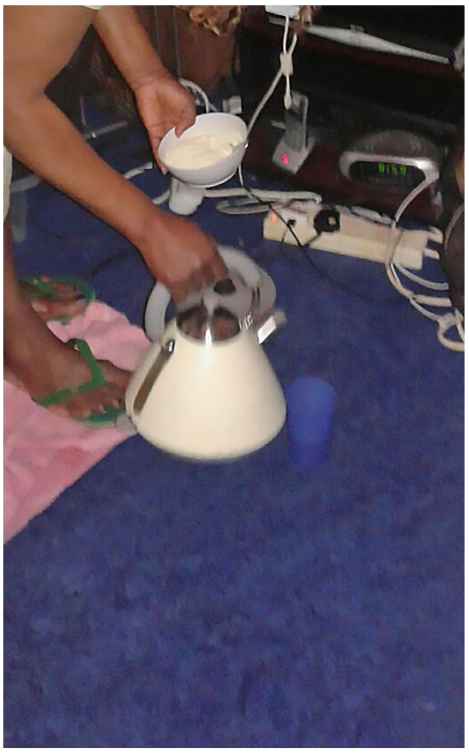

Figure 11 · Child safety

Child food practices

Parents of babies and toddlers emphasised the particular challenges in providing their children with positive food experiences. Parents' descriptions of their circumstances revealed compromised weaning practices and children's poor socialisation around food. Parents' reports also supported those of the Key Informants. They related that the emergency accommodation environment made it difficult for mothers of artificial formula bottle-fed or breast-fed babies. The former faced constraints related to the hygienic preparation and storage of baby milk and lack of kitchen access. For the latter, there was a lack of privacy and space and access to a 24-hour kitchen with cooking facilities.

Two mothers described regression in terms of their children's diets, with toddlers being fed jars of baby food intended for four-to six-month-old babies, and two-year-olds being returned to artificial milk.

Through her photo (Figure 12), P6 talked about how her living conditions were so challenging, with no access to a fridge and no access to a kitchen overnight that she resorted to returning her two-year old child to infant formula. She explained that she tried to keep fresh milk warm in a flask but this did not work well.

P4, who had concerns about her toddler not eating the food supplied in the hotel 'other than a sausage', used jars of commercially prepared baby food. She reflected on her photograph (Figure 13) in terms of knowing that it was not appropriate for a two-year-old to be eating readymade food intended for 4-6 month old babies, but felt she had limited choice.

These findings emphasise the inadequacy of emergency hotel and B&B accommodation for parents of babies and toddlers and of its negative impact on children's diet and food socialisation. Furthermore, these findings need to be considered in the context of the extensive research that highlights children of homeless families living in sheltered accommodation report dietary deficiencies such as iron deficiency in children under the age of two (Partington, 1998) overweight (Smith & Richards, 2008) and obesity (Schwarz, Garrett, Hampsey, & Thompson, 2007).

Figure 12 · Reverting to artificial baby food

Figure 13 · Baby food for toddlers

Family strategies in negotiating emergency homeless living situations

Families designated to emergency homeless accommodation such as B&Bs, hotels or hostels find ways of trying to provide food for themselves and their children. Parents spoke of eating with families/and or friends; using improvised cooking techniques and prohibited equipment and of using charity services. Their strategies reflect those reported in other research on homeless families. Many families relied upon other family members to provide them with meals but this could become burdensome and lead to feelings of guilt for all parties. Availing of dinner with their families also helped participants to provide a normal environment and better nutrition for their children and allowed them to maintain some dignity as they could eat in a family setting.

All parents highlighted that their children's food was a priority for them and that they went to considerable efforts in challenging circumstances to provide for them. This was clearly demonstrated by parents who tried to provide fruit for their children for vitamins.

Few families used charitable meal services on a regular basis, but almost all had some experience of doing so. For most, dining in a communal setting with other homeless families and homeless individuals was deemed to be inappropriate for children. It also reinforced negative feelings about living in emergency homeless accommodation:

> ***It says that you are now on the bottom rung of society there is no lower you can get. [P8]***

Recommendations

This report comes at a time of significant re-orientation in the policy guiding the provision of family emergency homeless accommodation. In line with the commitments in *Rebuilding Ireland* (Government of Ireland, 2016), the Dublin Regional Homeless Executive [DRHE] is moving away from the extensive use of commercial hotels and towards a system of 'Family Hubs'. According to the DRHE, Family Hubs will feature permanent on-site support services (in some cases 24/7) and access to cooking and laundry facilities. They will provide internal and external play areas, homework rooms, and space for medical consultations.

The establishment of the Family Hubs to some extent addresses the concerns that motivated this research programme. The lessons from this research report can provide important insights regarding the management and implementation of Family Hubs during their start-up phase.

The recommendations that follow are based on what has emerged from the findings of this research study, the international literature, and dialogue between the researchers and Focus Ireland's Research Advisory Group.

Recognition of the severe challenges of homelessness for families in emergency accommodation

Prolonged stays in emergency accommodation can undermine family autonomy and resilience and contribute to 'institutionalisation' and can make successful exiting from homelessness to independent living more difficult. This report highlights that the approach to food service provision in emergency homeless accommodation can serve to either undermine or support families' autonomy, resilience and dignity. Families are highly capable and have a right to autonomy and control of their food choices and routines.

Recommendation 1: Across all emergency settings that accommodate homeless families, any rules and regulations in relation to the use of kitchens and eating facilities (for example, restrictive kitchen opening hours) should recognise the different routines of families and provide more flexible services.

Communal eating and shared kitchen arrangements can create practical problems for families and may reinforce institutionalisation arising from extended stays in emergency accommodation.

Recommendation 2: In planning the Family Hubs it is important to maximise the extent to which families have unrestricted access to their own kitchen, including adequate storage, preparation, and cooking facilities.

The absence of kitchen facilities not only impacts on the health of families, but can also inhibit family activities such as sharing a family meal, carrying out homework, and socialising. A kitchen table is integral to family life.

Recommendation 3: As a minimum standard in all emergency settings a kitchen table in a private and appropriately sized space should be provided.

The challenges families face in the preparation of nutritious meals are primarily due to practical barriers and restricted facilities, rather than any lack of awareness of healthy eating. For this reason, the use of nutrition education programmes – as seen in other jurisdictions – will have little relevance for the large majority of homeless families.

Recommendation 4: Nutrition education programmes should not be considered as an appropriate intervention for homeless families resident in emergency accommodation.

Standards in emergency accommodation

While both the Department of Housing and the DRHE have emphasised the range of improved facilities that will be available in Family Hubs, no standard framework has been published to set out minimum standards that will apply to the operation of these Hubs.

Recommendation 5: A set of standards in relation to any premises defined as family emergency accommodation should be drawn up under the auspices of the Cabinet Sub-Committee on Housing and Homelessness, established under Rebuilding Ireland.

Recommendation 6: The standards for Family Hubs should include guidelines for the operation of the regulations that apply to families living in emergency accommodation. Such regulations should: reflect the particular challenges faced by different family types (e.g. single parent families, those with limited English), include clear complaints and appeals processes, and should remove fears of being asked to leave.

Recommendation 7: The future development of any temporary or emergency accommodation for families needs to incorporate family autonomy and the rights of the family in its design and delivery.

Recommendation 8: It is likely that families will continue to be accommodated in emergency accommodation other than Family Hubs for some time, and in exceptional circumstances thereafter. A separate set of minimum standards should be drawn up in relation to such facilities, including provision of access to cooking and eating facilities and the maximum length of time that families can be accommodated in such places. Standards in relation to food provision and access to cooking, storing and dining facilities should be underpinned by principles of dignity and respect for children and families.

Recommendation 9: Given that Family Hubs are at an early developmental phase it is important to develop and implement a Monitoring and Evaluation plan that can be used to understand how these services respond to the needs of families. Such a plan should be designed in collaboration with those who reside in Family Hubs and families should also be involved in the evaluation itself.

Emergency accommodation as a temporary measure

No matter what improvements are made in the physical quality and access to services in emergency accommodation, living in emergency accommodation by its very nature has a detrimental impact on the health and well being of family members. Over time, poor nutrition can lead to a decline in general health and mental health of families. The most effective improvement in the provision of emergency accommodation is to ensure that it is for the shortest time possible, through the provision of secure and affordable homes.

Recommendation 10: Policy on emergency homeless provision for families requires the implementation of an individualised housing plan for each family developed in consultation with them. It should also set a maximum period during which a family would have to remain in emergency accommodation before they receive an appropriate offer of secure and affordable housing. However, such a timeline should not result in families being coerced into accepting unsuitable housing offers.

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