Hungry for Change: **Social exclusion, food poverty and homelessness in Dublin**

HUNGRY FOR CHANGE:

SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

everyone has a right to a place they can call home

FOCUS IRELAND

Hungry for Change: Social exclusion, food poverty and homelessness in Dublin

A Pilot Research Study

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Foreword

When we undertook this study, it would be fair to say that little did we realise just how difficult the issues of food, diet and nutrition are for people out-of-home. We had plenty of anecdotal evidence that homeless people had severe difficulties ensuring they have a regular, healthy diet that satisfies, is nutritious and helps maintain good health. Indeed, Focus Ireland has ensured access to dedicated food services since we opened our Coffee Shop in Temple Bar in 1985. However, the findings of this pilot research study present all homeless service providers, particularly food service providers with a new set of challenges to be met and overcome.

Our study clearly shows that homeless adults are vulnerable to poor diet and nutrition. Homeless adults have a poor diet when compared with the general Irish population and 8 per cent were reported to be underweight as compared with just 1 per cent of the general population.

Our study also found a strong link between accommodation type and food poverty. Access to and the quality of kitchen facilities proved to be a key concern for study participants. Use of communal kitchen facilities was dependent on a number of factors not least of which were hygiene, food theft, storage capability, availability of sufficient utensils, and the rules governing hours of access.

The cost of goods and services remains a key consideration for homeless households. Our respondent's regularly reported that they experienced difficulties in reconciling their tight budgets with the principles of healthy eating. The majority of our respondents were in receipt of statutory payments but the increases of Budget 2004 promise little relief in meeting these difficulties.

These findings demonstrate a need for further investigation and Focus Ireland is committed to working in partnership with other agencies to ensure more information and data on food poverty and homelessness is obtained. We do not wish this to be a once off investigation but instead hope it will offer a basis for future work in other locations where homelessness is a growing concern as well as presenting a range of lessons for future research.

On the same basis, we have taken the opportunity of this pilot study to propose a range of policy development actions for consideration. Policy is critical to the quality of outcomes for people out-of-home and our experience of conducting this research is that we now have an opportunity to bring the attention of the homeless service provider sector to the issue of policy development to tackle, reduce and eliminate food poverty among homeless persons. We also aim to ensure policy development occurs at both national and local levels to tackle the issue of food poverty and look forward to the opportunity of engaging with policy decision-makers both within and outside the homeless sector.

This study tells us that the ability to obtain an adequate supply of food is contingent upon having an adequate income and living in an area well supplied with shops as well as having access to them. We know that this is a set of circumstances that can be denied by being out-of-home. If as a result of this study we begin to move towards transforming access to food from what is effectively a privilege to a right then we will begin to establish a different type of claim on the future for homeless persons.

Health is a necessary condition for life and access to a standard and variety of diet that will create and sustain good health is within the expectation of basic needs and rights held by homeless persons. Therefore tackling food poverty among people out-of-home means more than obtaining a freedom from hunger but implies a right to food. To tackle food poverty we must make access to a healthy diet a positive human right to food and not simply a negative freedom from hunger. In parallel, to effectively tackle homelessness we need to ensure access to housing is a positive social and justiciable right and not simply a negative freedom from rooflessness.

Declan Jones
CEO, Focus Ireland

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Executive Summary

Introduction

This is a pilot study. It seeks to break new ground in social research and deliver a better understanding of the impact of poverty and social exclusion on the food, diet and nutrition of people who are homeless in the city of Dublin.

This study was undertaken during 2002 and 2003 in response to a 2001 Combat Poverty Agency invitation for research proposals to "examine the policy response to food poverty in Ireland". The CPA has offered a definition of food poverty as "the inability to enjoy an adequate and nutritious diet due to the affordability of and access to food".

Why Focus Ireland carried out this study

Focus Ireland has been responding to the needs of homeless adults and children since 1985, through the provision of a range of services from long-term and transitional housing to day centres and emergency accommodation.

The provision of food to our customers, clients and residents across these services forms an important element of Focus Ireland's overall service provision. A number of our housing projects have communal restaurants in addition to the individual kitchens contained within each apartment or house. Our Coffee Shop, based in Dublin's Temple Bar serves daily meals to our customers. In 2001, more than 2,300 customers used this service and in the same year the Coffee Shop served in excess of 42,000 meals.

It has been our experience that given the often chaotic and transient nature of the lives of homeless households and individuals, the ability to consume a healthy diet on a daily basis can be severely constrained by issues of affordability and access, as well as issues of choice, food preparation, storage and cooking facilities.

However, there is no published Irish research on this issue and Focus Ireland felt well placed to develop a research proposal, which aimed to generate unique findings and insights into food poverty among this distinct group.

The objectives of the research study were:

1. To establish the extent to which individuals out-of-home are vulnerable to poor diets and inadequate nutrition.

2. To explore the difficulties that homeless households face in sourcing, funding, storing and preparing nourishing food for themselves and/or their families.

3. To explore issues of service use and service access by individuals experiencing homelessness and to explore the coping mechanisms employed by homeless adults when food services are restricted, closed or inaccessible to them.

4. To set out policy options for homeless service providers to tackle food poverty in a co-ordinated way, as well as input into national strategies to tackle food poverty among socially excluded groups in Ireland.

Research methodologies

The study sought to collect information over a number of research domains including socio-demographic characteristics; food consumption and dietary patterns; food purchase, expenditure and preparation; general health; and general comments and observations about the lived experience of food poverty.

This information was collected in three ways. Firstly, a quantitative survey tool, including a food frequency questionnaire was designed to collect information on all of the above factors. Secondly, a qualitative interview schedule was developed to explore in more detail the issues of food purchase, expenditure and preparation, and the lived experience of food poverty. And thirdly, a short self-completion survey that gathered information on service provision was posted to 18 homeless food service providers in Dublin city.

The Sample

Sampling guidelines indicating the types and numbers of a variety of homeless households were drawn up and used to identify potential respondents for the survey.

Three main variables were chosen for the breakdown of the target sample of 75: gender, age, and family type. A pre-requisite for inclusion in the study was that the respondent had to have been homeless for the 30 days prior to the survey.

A variety of homeless service centres were accessed to make contact with potential respondents including a number of day and food centres, a night shelter and a hostel. Respondents were paid with a €15 gift voucher for Dunnes Stores for their participation. Seventy-four interviews were achieved of which 72 had useable data.

Summary of the Main Findings

Socio-demographics, homelessness and health

Sixty-three (63) per cent of respondents were male and 37 per cent were female. Participants ranged in age from 19 to 88 years, the mean age was 36. Sixty-seven (67) per cent of all respondents were single; the majority of whom were male. Sixty (60) per cent of female respondents were caring for children, more than half were lone parents.

Forty (40) per cent of male respondents had been homeless for longer than 3 years at the time of the interview and 44 per cent of female respondents had been homeless for between 1 and 3 years at the time of participating in the study.

Forty-nine (49) per cent of respondents were staying in hostels, 21 per cent were staying in B&Bs, 18 per cent were using the Crosscare night shelter and 13 per cent were sleeping rough.

The majority of respondents rated their general health as good, their satisfaction with their health as dissatisfied and their quality of life as poor.

Eighty-seven (87) per cent of male and 84 per cent of female respondents reported that they smoked.

Fifty-one per cent of our respondents ‘had ever’ or ‘were currently’ using illegal drugs (49 per cent of men and 56 per cent of women in our sample). Lifetime illegal drug use was more common among younger respondents than older.

The mean Body Mass Index[1] among the full survey group was 23.31, which falls within the normal range. Eight per cent of respondents were underweight, 83 per cent of all those who were reported to be underweight were female.

Food consumption, nutrition and quality of diet

Three types of nutrition data were generated from the FFQ: compliance with the food pyramid; quantities of food consumed; and nutrient intakes.

i) The food pyramid

The level of compliance across all shelves of the food pyramid was poor and none of our respondents complied with the recommended number of servings of foods high in fats and sugars. Significantly, accommodation type was found to influence compliance with the food pyramid. Our survey findings confirmed that the night shelter users and rough sleepers were least likely to comply with the food pyramid recommendations.

ii) Quantities of food consumed

The night shelter users reported the lowest consumption levels across nearly all the food groups including cereals, potatoes, rice and pasta, breads, fruits and vegetables, and sweets and confectionery.

Age proved to be a significant variable in the consumption of a variety of foods and beverages. Younger people were more likely to consume confectionery, cakes and biscuits and fizzy drinks than their older counterparts whereas older men, in particular were more likely to drink alcohol. It was found that drug users consumed significantly more quantities of confectionery products than non-drug users.

iii) Nutrient intakes

Respondents reported low intakes of starch, fibre, vitamin A equivalence, vitamin D, vitamin E, folate and iron, which indicated low consumption levels of pasta and rice products, wholegrain cereals, fruit and vegetables especially green leafy vegetables, fish especially oily fish, cereal products, and dairy products.

Age proved to be a significant variable in the consumption of a range of macro and micronutrients. Older men and women had lower intake levels of fat, fibre, vitamin E and calcium than younger men and women.

Accommodation type also proved important. Respondents staying in the night shelter consistently reported lower intakes of a range of micronutrients. Significant differences were observed between accommodation type and consumption of alcohol, fibre and vitamin B12 ($p<0.05$).

Substance misuse was also found to be a significant factor in the consumption of foods high in sugar and in the consumption of a range of macro and micronutrients including fat, protein, sugar, carbohydrates, starch, phosphorous and calcium.

The lived experience of food poverty among people who are homeless

What became apparent from our quantitative and qualitative analysis of survey and interview data, was that the extent and experience of food poverty among homeless people was not only conditioned by issues of income inadequacy and other socio-economic and cultural determinants, but particularly, by access to accommodation, as well as the quality of that accommodation (in terms of its utility functions and service provision).

[1] Body Mass Index is a measure of body fat based on height and weight that applies to both men and women. Experts generally consider a BMI of less than 18.5 to be underweight, a BMI of between 18.5 and 25 is considered healthy, between 25 and 30 indicates overweight and more than 30 indicates obesity.

Our questionnaire survey research found that a strong relationship existed between the extent and experience of food poverty and the type of accommodation a homeless respondent had both access to and use of. This was the case for respondents accessing a spectrum of accommodation types.

Forty (40) per cent of respondents had access to kitchen facilities. Respondents staying in B&Bs were more likely to have access to kitchen facilities than other respondents; 67 per cent of respondents staying in B&Bs had access to kitchen facilities. Respondents expressed concerns on a number of issues about communal kitchen facilities including food theft, poor hygiene, over-crowding and lack of privacy, and regulations governing hours of access.

Issues of cost, personal mobility, food storage options in the participant's accommodation, and access to food preparation facilities influenced food shopping practices and patterns among interviewees.

Homeless Food Service Providers: Issues of access, use and quality

The majority of homeless food service providers appeared to offer a good range of foods to their service users/ customers at affordable prices. Almost all food providers served vegetables and just over two-thirds served fruit. The provision of red meats, poultry and fish appeared to be good. In contrast, there was limited availability of low-fat diary products while nearly all the service providers provided sweets, confectionery and savoury snacks.

Dedicated food centres were commonly used by respondents for their meals, for example, 42 per cent reported eating their main hot meal in a subsidised café/food centre. In general, interviewees were positive about the fact that food service provision to meet their needs did exist in Dublin. And hostel residents generally considered the range and variety of foods available to them to be sufficient on the whole.

During the course of the in-depth interviews a range of factors were found to influence the use of homeless services including availability, suitability, variety and choice, and quality of service. Other key issues that emerged regarding service use were access, cost and personal mobility.

Common factors that influenced the non-use of dedicated services included lack of control over personal choice and diet, concerns about personal security, the regulations relating to access, and the user group that characterised the service.

However, dedicated homeless food services were not the only outlets used by respondents. Respondents reported using a combination of food sources including commercial cafés and restaurants and family and friends. The use of commercial cafés and restaurants was largely dependent on cost and knowledge of where low cost cafés and restaurants could be found.

However, cost and knowledge were not the only factors that influenced the use of commercial cafés and restaurants, some respondents preferred to use these more expensive options in an effort to "normalise" their lives.

A significant issue for people was the alienation and isolation that they felt when out-of-home. Some interviewees felt that by only using dedicated food services and through constant association with people who were homeless, a sense of isolation from the wider society could emerge.

Discussion

Homeless adults are vulnerable to poor diets and inadequate nutrition and this is clearly demonstrated by the nutrition findings from the FFQ.

The level of compliance with food pyramid recommendations among our sample of homeless households was lower across all the food groups when compared with 1999 Slán Survey data for social class 5 and 6 in the general population.

The proportion of homeless adults that consumed white bread, fried potatoes, red meat, processed meat, confectionery, savoury snacks, beer and fizzy drinks was higher than that reported among the general population. The mean daily amounts consumed of brown bread, brown rice and pasta and high fibre foods was considerably lower than that found among the general population.

In the consumption of macronutrients, median protein intake was higher than the recommended quantity of 10 per cent, but lower than that reported for the general population (17 per cent).

Intakes of protein, carbohydrate and fibre were all lower among homeless adults than intake levels found in social class 5 and 6 of the general population. However, daily median fat intakes were higher than that reported for social class 5 and 6.

Homeless adults had lower intakes of starch, fibre, vitamin A equivalence, vitamin D, vitamin E, folate and iron, which indicated low consumption levels of pasta and rice products, wholegrain cereals, fruit and vegetables especially green leafy vegetables, fish especially oily fish, cereal products, and diary products.

Homeless adults face significant difficulties in sourcing, funding, storing and preparing nourishing food. The study found a strong link between accommodation type and food poverty. Access to, and the quality of kitchen facilities proved to be a key concern for study participants. Use of communal kitchen facilities was dependent on a number of factors not least of which were hygiene, food theft, storage capability, availability of sufficient utensils, and the rules governing hours of access.

Food shopping was also determined by a number of factors including mobility, location, and the ability to store and prepare food in accommodation. However, cost remained a key consideration. Respondents regularly reported that they experienced difficulties in reconciling their tight budgets with the principles of healthy eating. The majority of our respondents were in receipt of statutory payments but the welfare increases of Budget 2004 have done little to relieve these difficulties.

Respondents used a combination of food outlets including dedicated homeless food services, commercial cafés and oftentimes relied upon friends and family for their meals. The use of both dedicated services and commercial cafés was dependent on cost and knowledge.

Homeless adults were disadvantaged in their use of commercial cafés and restaurants not just by cost but also by the perception of staff working in these establishments. Respondents reported that staff in commercial cafés often didn't want to serve them or allow them to use their service on the basis of the respondent's appearance or the fact they might "linger" over a cup of tea or an inexpensive snack or meal.

Recommendations for Policy Actions to Tackle Food Poverty and Homelessness

Six policy frameworks have been identified within which our recommendations for tackling food poverty and homelessness can be placed. These frameworks are:

1. *Homelessness – An Integrated Strategy*: national government strategy for addressing the accommodation and welfare needs of people out-of-home.

2. *Shaping the Future*: the Dublin homeless action plan contains a range of commitments with regard to the provision of services and accommodation to adults and families out-of-home.

3. *National policy on social inclusion and anti-poverty*: At the heart of this national policy framework is the National Anti-Poverty Strategy (NAPS) *"Building an Inclusive Society"*. NAPS contains very important targets on reducing overall levels of consistent and relative income poverty, reducing health inequalities and child poverty as well as setting income adequacy targets and targets to ensure improved access to quality public services.

4. *Social welfare policy and provision:* elements of social welfare policy and provision that impact on food poverty include the free school meals scheme, breakfast clubs targeted to children in high-risk schools in disadvantaged areas and elements of the Supplementary Welfare Allowance System.

5. *National policy on health and health promotion:* key policy and strategy areas include the national health strategy *Quality and Fairness – A Health System For You* (2001) and the *National Health Promotion Strategy* (2000).

6. *Planning and development policy:* the *Retail Planning Guidelines for Planning Authorities* seeks to establish local, efficient, equitable and sustainable retail provision, which is readily accessible, particularly to marginalised groups.

Given the spectrum of frameworks for policy development and actual provision that impacts on food poverty and homelessness, the challenge of developing a dedicated policy framework to tackle this issue is a difficult one of innovation, co-ordination and integration. Notwithstanding this, the following specific recommendations are made so that the debate and discussion on further policy development in this area can begin.

National policy Homelessness – An Integrated Strategy

i) As part of an independent review of *Homelessness – An Integrated Strategy,* Focus Ireland recommends policy formulation to address issues of food poverty, health, and diet and nutrition among homeless persons.

ii) This review should consult with voluntary sector homeless service providers when setting the terms of reference and monitoring progress and outcomes, and it should be published for consideration by homeless service providers and by the Cabinet Committee on Social Inclusion, the Cross-Departmental Team on Homelessness, the National Office for Social Inclusion, and the Oireachtas Committee on Environment and Local Government as well as social partners.

iii) Policy development should be undertaken to detail, agree, resource, deliver, monitor and report on a dedicated community nutrition programme for homeless persons to tackle the issue of food poverty and improve the health related impacts of poor diet and nutrition. Such a programme requires the co-ordination of policy at national and local levels.

iv) The role of the established Cross-Departmental Team on Homelessness in facilitating the development of policy in this area needs examination and resource commitments as required. Local homeless actions plans offer a vehicle for the identification of development and implementation strategies on food poverty and offer a basis to identify and resource the local delivery mechanisms for a dedicated community nutrition programme targeted on homeless persons.

Recommendations for Homeless Service Provision

The findings of this study provide an impetus towards strengthening and improving homeless services based on attainment of quality standards and the delivery of food programmes and menus designed to tackle food poverty and nutrition deficits among homeless persons.

Specifically, in terms of food provision to customers of homeless food service providers, the findings of

this study support the consideration of the following actions. These actions are proposed for consideration within the homeless sector generally, but specifically in the Dublin region:

i) Consider increasing the range of low-fat and low-sugar foods available through food centres. In particular, this study's findings support the need to increase the provision of sun flower oil or olive oil spreads for cooking and use on bread and sandwiches and the use of fortified milk for cooking, drinking and adding to drinks and cereals etc.

ii) Consider how foods and refined cereals with low-fibre can be replaced with those of high fibre. For example, the use of brown rice and pasta instead of white rice and pasta and the provision of breakfast cereals such as porridge and bran or wheat based products rather than sugar coated cereals.

iii) Consider how to increase the range and frequency of fish and fish products on food centre menus.

iv) Consider offering the choice of decaffeinated tea and coffee as a standard not an exception of food service provision

v) Consider reducing the provision of confectionery and savoury snacks in favour of more healthy options such as fresh fruit and yoghurts and include organic fruit and vegetables on menus.

vi) Consider ensuring a diversity in menu development for food centres that avoids reliance on high-fat, low-fibre foods, provides in season fruits and vegetables and presents menu choices as part of an identifiable cuisine (e.g. Irish, French, Italian etc)

vii) Consider promoting a healthy eating week in homeless food centres as part of a national health promotion policy and in anticipation of the establishment of a dedicated community nutrition programme for homeless persons. An emphasis could be placed on the provision of food that supports healthy and balanced diets as well as the delivery of nutritional advice and supports to parents and a healthy food promotion programme for homeless children using childcare facilities.

On this basis, Focus Ireland commits to working to ensure that access to health advice and care from Community Dieticians and Nutritionists is provided. In particular, certain groups who are homeless are at a higher risk of malnutrition with lower immunity and a higher risk of infection from diseases. These groups need to be prioritised in the delivery of health services, including services that focus on diet and nutrition. The next planning period for the development of services in the Dublin area presents an opportunity for considering how this might be achieved.

In addition, we have identified training on the particular dietary difficulties facing homeless persons, in particular chronic street drinkers and drug users, rough sleepers and young single parents as an important area of ongoing work. Focus Ireland will engage with the homeless sector in Dublin to ensure this training is targeted at the multi-disciplinary Outreach teams and Community Dieticians.

Recommendations for national policy to tackle food poverty

Poverty and income inadequacy

i) The Government should meet the commitment set out in NAPS to achieve a rate of €150 per week (in 2002 terms) for the lowest rates of social welfare to be met by 2007 and the appropriate equivalence level of basic child income support (i.e. Child Benefit and Child Dependent Allowances combined) to be set at 33-35% of the minimum adult social welfare payment rate.

ii) Focus Ireland recommends that an investigation into what foods should be included in an average basket of goods for a healthy and balanced diet be conducted. A policy objective of this study should be to examine the role of price controls for staple foods such that minimum social welfare payments are sufficient to cover the costs of this basket of goods.

iii) Consideration should be given to legislative reform allowing price orders to be set for staple foodstuffs that meet a nutritional value as part of healthy and balanced diet. The Prices Act, 1958 as amended by the Prices (Amendment) Act, 1972 allows the Director of the Office of Consumer Affairs to set Price Orders. Currently there are four Price Orders that cover pubs, restaurants, hairdressers and petrol and diesel units. These orders refer mainly to issues of labelling and packaging as well as pricing and the display of pricing.

Access to Public Services

Ensure access to quality services for all socially excluded groups, including homeless persons:

i) Detailed standards in relation to access to public services for socially excluded groups are to be set out as part of government commitments under the NAPS. To bring this forward, formal expressions of entitlements across the full range of public services for all persons socially excluded and in poverty need to be established as a matter of priority.

ii) Outstanding quality standards and guidelines regarding the standard of service delivery that can be expected should be established as soon as possible.

Health and health promotion

School Meals Scheme

i) Deepen the impact of the reform of the Free School Meals Programme by investigating and developing innovative food promotion and food delivery projects at primary and secondary levels.

ii) More resources are required to deepen the impact of the Free School Meals Programme and the implementation of innovative projects to improve the diet, nutrition and overall health of children at primary and secondary levels is essential.

Diet Supplement Scheme

It is recommended that government reconsider its decision to discontinue the diet supplement scheme over the next 4 years. This scheme, which exists, as part of the Supplementary Welfare Allowance Scheme is available to a person or his/her adult or child dependant(s) provided he/she satisfied certain conditions. This entitlement was determined by the Health Boards, and in making the determination consideration was given to the type of diet of prescribed, the household income and whether the person in respect of whom diet supplement was payable was an adult or child.

Institutional arrangements

Currently, Ireland does not have an integrated statutory body or agency with a remit to tackle and eliminate food poverty in Ireland. Instead, responsibility is split across a number of bodies that are not integrated nor indeed strategically linked to tackle food poverty issues. These include:

- The National Standards Authority of Ireland (NSAI),
- The Food Safety Authority of Ireland (FSAI),
- An Bord Glás (Horticultural Promotion) and
- An Bord Bia (Irish Food Promotion Board).

The establishment of a Food Standards Authority (FSA) in the UK and Northern Ireland since 2000 has led to improvement in food quality and cost. It shares joint responsibility with the UK Department of Health for food nutrition. The FSA has also established research and data on the extent of food poverty. It is leading a national diet and nutrition survey of people on low incomes - the first survey of its type in the UK since 1936. Therefore, based on learning from the UK and Northern Ireland, we recommend that government should:

i) Consider establishing a National Irish Food Standards Authority with a clearly stated objective to tackle and eliminate food poverty in Ireland

ii) Government plans to publish a Bill in 2004 to amalgamate An Bord Glás and An Bord Bia could be deepened by the specific integration of state agencies into a Food Standards Authority and could be based on cross-border learning from Northern Ireland where such a body has been recently established since 2000.

Conclusion

While there is no agreed definition of food poverty within an Irish policy context nor any dedicated food poverty policy or strategy, this study clearly shows that there exists policy frameworks within which we can start to tackle the issue of food poverty, homelessness and social exclusion.

Existing national government strategies on homelessness and social inclusion can be broadened to include issues of food poverty, and diet and nutrition; policies such as *NAPS, Homelessness – An Integrated Strategy,* school meals schemes, the *Health Promotion Strategy* and the *Health Strategy* might all be used to begin to tackle the issue of food poverty among homeless adults and families.

Local decision makers and homeless service providers also have a role to play in putting food poverty and issues of diet and nutrition on the agenda. Local homeless actions plan should include issues of food poverty and diet and nutrition and local service providers should consider broadening the range and type of foods made available to families and adults out-of-home to meet their dietary and nutritional needs and to take account of issues of choice, special dietary needs and cultural and ethical preferences.

Finally, tackling food poverty means more than freedom from hunger; it implies a right to food. To tackle food poverty we must make access to a healthy diet a positive human right to food and not simply a negative freedom from hunger.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 1

Introduction and Background to the Study

Introduction

This is a pilot study. It seeks to break new ground in social research and deliver a better understanding of the impact of poverty and social exclusion on the food, diet and nutrition of people who are homeless in the city of Dublin.

This study was undertaken during 2002 and 2003 and occurs within the context of recent socio-economic changes in Ireland that herald the end of the so-called *Celtic Tiger* era of economic growth and wealth creation[2].

Today, public concern with the post-boom increase in the cost of living pivots on the axis of housing costs, traffic congestion and high prices for goods and services. For example, while interest rates in Ireland are at an historic low in 2003, inflation has been moving in the opposite direction[3].

Low interest rates remain a dominant influence on rates of investment in housing that continue to push prices upwards, while high inflation has been the result of recent budgetary changes in fiscal policy and lack of competition in the non-traded sectors of the Irish economy. Both impacted significantly on the Irish cost of living in 2003[4].

These issues are increasingly reflected in recent government attention. Policy attempts to control high rates of inflation, address falling cost competitiveness and maintain investment to overcome outstanding infrastructural deficits in social provision are now in demand from government's social partners and the general public.

One area of the economy receiving considerable public attention and comment in 2003 is food retailing, and public house and restaurant goods and services. The changeover to the euro as national currency in 2002 saw Irish price levels converge to the average EU level and continue an upward trend to put Irish prices at 12 per cent above EU averages in 2003.

Issues of price and choice, value for money and quality, service provision, access and proximity are today established as issues of critical concern from both perspectives of the individual as citizen but more so that of the individual as consumer.

Public disquiet at perceived price hikes and profiteering in the non-tradable sheltered sectors of the economy (i.e. pubs, restaurants) has prompted media investigations of the alleged 'rip-off' culture.

Price comparisons between EU states and Ireland and across different parts of the country are a regular feature of public debate in 2003 and are beginning to impact more significantly than before on consumer choices and demand for government action.

This pilot study is therefore timely. It brings new data, insights and findings to the general consumer debate on the above issues. More importantly, however, it is also well overdue because it begins to

2 The economic slowdown apparent since 2000 has affected the rate of employment growth with average employment increasing by 1.4 per cent (23,600 persons) in 2002 compared with average growth rates of 2.9 per cent in 2001 and 6.9 per cent in 1999

3 CSO figures show that the rate of inflation was 5.1% in February, up from 4.8% in January. Excluding mortgage interest rates, the underlying CPI was 5.3%. The CPI excluding tobacco was 4.7%. As measured by the EU Harmonised Index of Consumer Prices (HICP), Ireland's year on year inflation rate was 5.1% in February 2003, up from 4.7% in January. The early estimate suggests that euro area inflation in January 2003 was 2.1 %, down from 2.3% in December 2002. The Consumer Price Index is the official measure of inflation in Ireland. It is an important social indicator as its value impinges on the measurement of economic growth and economic wellbeing. However, there are a number of problems associated with the standard measure. The index is designed to measure changes in the cost of purchasing a basket of goods of a 'representative' household or 'typical' Irish household. It would be surprising if such an index were appropriate for everybody. Recent research has found that for the urban poor in Ireland in the late 1990s and up to 2001 a price index based on a basket of goods purchased by the urban poor has risen substantially faster than the CPI for a 'typical' household. For more details see Garvey, E. and Murphy, E. (forthcoming) The Cost of Living Changes for Low Income Households, Dept. of Economics, NUIG, Combat Poverty Agency Poverty Research Initiative.

4 Since 2000, eurozone monetary policy attempts to soften the rate of economic deceleration and to improve the climate for investment has meant interest rates moving downwards to a current rate of 2.5 per cent

address a large gap in general understanding of what poverty, social exclusion and homelessness mean in terms of the above issues as well as in terms of health and other quality of life impacts.

The Origination of this Pilot Study

In Autumn 2001, the Combat Poverty Agency (CPA) invited research proposals to "examine the policy response to food poverty in Ireland" as part of its programme of commissioned research. The Combat Poverty Agency sought to add value to this commissioned work and invited Focus Ireland to develop a distinct research proposal that could be supported by way of a once-off grant.

Our response was to develop a research proposal that would generate unique findings and insights into food poverty among a distinct group experiencing social exclusion in Ireland, namely people who are homeless. These findings and insights would then be relied upon to inform and support policy responses to food poverty in Ireland.

Focus Ireland has been responding to the needs of homeless adults and children since 1985, through the provision of a range of services from long-term and transitional housing to day centres and emergency accommodation.

The provision of food to our customers, clients and residents across these services forms an important element of Focus Ireland's overall service provision.

A number of our housing projects have communal restaurants in addition to the individual kitchens contained within each apartment or house.

Our Coffee Shop, based in Dublin's Temple Bar serves daily meals to Focus Ireland customers – people experiencing homelessness or at risk of homelessness. In 2001, more than 2,300 customers used this service. In the same year the Coffee Shop served in excess of 42,000 meals to its customers, more than 17,000 of which were hot meals. While hot meals made up the bulk of food purchases, customers also purchased salads, sandwiches, desserts, scones, tea and coffee.

Notably, Focus Ireland is the only homeless service provider in Dublin licensed to serve food under the environmental health regulations. In short, Focus Ireland continues to have a strong commitment to the provision of affordable and nutritious food for people experiencing homelessness.

The Objectives of this Study

The objectives of this pilot study stem from the working definition of food poverty under investigation by the Combat Poverty Agency and our own concerns to address the deficit in understanding that is apparent on the nature, extent and experience of food poverty among people who are out-of-home.

Objective 1: To establish the extent to which individuals out-of-home are vulnerable to poor diets and inadequate nutrition through the use of standardised or recognised nutritional data collection methodologies with a discrete sample of homeless people.

Objective 2: To explore the difficulties that homeless households face in sourcing, funding, storing and preparing nourishing food for themselves and/or their families through structured and in-depth interviews with a discrete sample of homeless households.

Objective 3: To explore issues of service use and service access by individuals experiencing homelessness and to explore the coping mechanisms employed by homeless adults when food services are restricted, closed or inaccessible to them.

Objective 4: To set out policy options for homeless service providers to tackle food poverty in a co-ordinated way, as well as input into national strategies to tackle food poverty among socially excluded groups in Ireland.

The Structure of this Report

The range of issues highlighted above have been considered, to some degree, in the conduct of this study and the structure of this report attempts to reflect the multi-layered and complex reality of food poverty among people experiencing homelessness in Dublin.

Chapter 1 outlines the background to and objectives of the study;

Chapter 2 reviews the extent of homelessness in Dublin and introduces the concept of food poverty;

Chapter 3 reviews food consumption patterns and dietary patterns in Ireland and reviews the international literature on dietary habits among people who are homeless;

Chapter 4 discusses the methodologies used to meet the objectives of the study;

Chapter 5 presents primary findings on socio-economic status, history of homelessness and health status of study participants;

Chapter 6 presents the findings on food consumption, nutrition and quality of diet among study participants;

Chapter 7 presents findings on the lived experience of food poverty;

Chapter 8 presents the findings on issues of access, use and quality of homeless services in Dublin; and

Chapter 9 discusses our policy recommendations to tackle, prevent and eliminate food poverty, social exclusion and homelessness.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 2

Homelessness and Food Poverty

Introduction

This chapter discusses the extent of homelessness in Ireland; the types of households that are homeless and the types of accommodation that are used to accommodate people who are out-of-home. The chapter also introduces the concept of food poverty and discusses the way in which it can be linked to homelessness.

Homelessness in Ireland

The Housing Act, 1988, provided for the first time a definition of homelessness. Under section 2 of the Act a person is to be regarded as homeless by the relevant local authority if:

a) there is no accommodation available, which in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or

b) he is living in a hospital, county home, night shelter or other such institution and is so living because he has no accommodation of the kind referred to in paragraph (a) and he is, in the opinion of the Authority, unable to provide accommodation from his own resources.

The Act specified local authorities as the statutory agencies with responsibility for homeless persons and it extended the powers and responsibilities of local authorities to assess and respond to the needs of people who are homeless.

Official data on the extent of homelessness is collated every three years as part of a formal Assessment of Housing Need by local authorities. Analysis of the recent national assessments shows that there has been a 6 per cent increase between 1999 and 2002 in the number of people who are homeless. The total number of people homeless in Ireland is 5,581 (Department of Environment, Heritage & Local Government, 2003).

The national assessment data yields little additional information on the characteristics of those who are registered as homeless. The national data does show the number of individuals and children who are homeless, and it also provides information on the number of single and multiple person households. Seventy-six (76) per cent of all households are single. A total of 1,405 children are out-of-home with their parents.

The extent of homelessness in Dublin

In response to the lack of detail on the characteristics of people who are homeless available through the national assessment, the Dublin authorities with the co-ordination of the Homeless Agency have adopted a different, and some would argue a more reliable assessment methodology than elsewhere in the country (Williams & Gorby, 2002 and Williams & O'Connor, 1999). This methodology has been used in 1999 and again in 2002 and has been developed to allow comparisons to be made over time in terms of changes, impact of policy and areas for further investigation.

The most recent assessment shows that the number of people homeless in Dublin has increased slightly over the period 1999 to 2002 from 2,900 individuals (2,690 households) to 2,920 individuals (2,560 households).

Table 2.1 Distribution of homeless households in Dublin according to type 1999 and 2002

Household type	1999		2002	
	N	%	N	%
Single person	2,050	76	1,780	70
Dual parent	120	4	220	9
Single parent	420	16	420	16
Couple only	100	4	140	5

Source: Counted In 2002: The report of the assessment of homelessness in Dublin. Williams, J & Gorby, S. ESRI & Homeless Agency.

While the majority of people who are homeless continue to be single adults, there has been a decrease in their number, from 2,050 to 1,780. However, the number of homeless families in Dublin has increased significantly from 540 to 640 families, with the majority of these being lone parent families. The number of dependent children within these households has risen from 990 in 1999 to 1,140. Alarmingly, over 56 per cent of these children are under 5 years of age. The number of couples out-of-home has also increased from 100 to 140.

The incidence of rough sleeping is higher with 312 people reported sleeping rough over the survey period in 2002 and 140 found sleeping rough on the one night street count. The use of B&B accommodation rose from 5 per cent in 1999 to 14 per cent in 2002 while the use of hostel accommodation rose from 51 per cent to 54 per cent over the same period. Significantly, the percentage of households with children residing in B&B emergency accommodation has risen from 56 per cent to 89 per cent over the same period. The estimated spend on B&B accommodation for homeless households in Dublin for 2002 was €19.5 million.

For single person households the average duration of homelessness is 28 months, with a higher rate recorded for men than women. The average duration of homelessness for households with children is 14.3 months. Single parent households spend relatively less time homeless (12.6 months) than dual parent households (17.6 months).

While remaining relatively stable, the anticipated decline in the extent of homelessness in Dublin (due to greater investment, changes in service provision and improved inter-agency working between and within local government, health boards and NGO service providers) was mitigated by the reduction in housing options and access due to overall supply-side shortages of housing.

This led to an intensification of demand for private and rental housing and consequent increased costs of access (house price inflation) and residence (rental inflation). This scenario was worsened by the failure of social housing output to meet target outputs over the period and to address the backlog of unmet social housing need in the Dublin region.

Food Poverty

> "Apart from its biological functions, food has many social, cultural and psychological functions. Food is an important vehicle for social relationships, communication and control. It not only conveys friendship, integration and acceptance, but social status, differences in social standing, and exclusion as well" (Feichtinger, 1996)

Food poverty has become an increasingly recognised aspect of living on a low-income and of being socially excluded. Anxiety about affording food, a poor or monotonous diet, high food prices and even hunger are a reality for many families on low incomes.

At present, and despite the policy definition of poverty set out in the National Anti-Poverty Strategy (NAPS), Ireland has no clearly stated policy definition of what food poverty refers to. The Combat Poverty Agency has offered a definition of food poverty as "the inability to enjoy an adequate and nutritious diet due to the affordability of and access to food". This approach is complemented by the definition offered by Friel and Conlon in their study "Policy Response to Food Poverty in Ireland" (forthcoming):

> "Food poverty refers to the inability to have an adequate and nutritious diet and the related impacts on health and social participation" (ibid:11)

The strength of the above definitions is their capture of an understanding of poverty as a process of exclusion from participation in society and refers clearly to 'inability' as the basis for poverty. The weakness in these definitions may lie in their failure to explicitly state income inadequacy and other determinants of 'inability' that influence the extent and nature of food poverty. The definition offered by the Welsh Assembly Government in their recently adopted nutrition strategy Food and Well Being (February, 2003) overcomes this potential weakness by stating:

> "Food poverty has been defined as the inability to afford, or have reasonable access to, food which provides a healthy diet. Whilst the link between nutritional status and low income is well established, food poverty extends beyond economic aspects to include issues such as access, ethnicity and education" (ibid:7)

Food Poverty and Homelessness

For homeless persons the everyday event of eating in their place of residence at mealtimes is not something that can be taken for granted. Neither are other activities such as food shopping and selection of cuisine type.

People who are homeless are denied the cultural and social aspects of food consumption. Their experience of entertaining friends and family over a home cooked meal is limited to singular occasions around Christmas or perhaps a birthday when wider family supports may be available to them. For example, only a few hostels or Bed & Breakfasts provide any self-catering facilities and rough sleepers have no access to any catering facilities, other than those available in some day centres around the city. Therefore, accommodation status is an important factor in this investigation of food poverty and homelessness.

Given the often chaotic and transient nature of the lives of homeless households and individuals, the ability to consume a healthy diet on a daily basis can be severely constrained by issues of affordability and access, as well as issues of choice, food preparation, storage and cooking facilities for the daily consumption of food.

Linking Food Poverty, Homelessness and Health Inequalities

One of the most acknowledged factors affecting health and health inequalities is the relationship between socio-economic conditions of income groups and poor health.

Additionally, access to health care services – from primary care and preventative services to access to hospital beds and long-term care – is another key determinant for the health status of socially excluded groups such as homeless people.

Homelessness represents an increased risk to health. Poor housing conditions may increase the risk of infectious disease. Homelessness is associated with many stressors, such as the lack of social support and/or the threat of violence and over-crowding, that in turn may increase the risk of mental health problems. Pre-existing and new physical disorders may be maintained or exacerbated by the conditions of homelessness.

In addition, physical disorders can be exacerbated by behaviours associated with homelessness such as drug and alcohol misuse. Furthermore, poor diet and inadequate sanitation and hygiene combined with poor access to health services and exposure to unfavourable weather conditions increase the risk of acute and chronic health problems such as respiratory disease and malnutrition (Pleace & Quilgars, 1996).

Research has consistently found that homeless and non-homeless populations do not differ in the health problems they suffer from, rather they differ in terms of risks to health, the prevalence of illness and access to or use of health services when ill.

In Ireland the general health problems associated with homelessness include respiratory disease and disorders, foot problems, infestation, epilepsy, peripheral vascular disease, severe mental illness and alcohol and drug misuse (Holohan, 1997). Also common are skin problems, seizures, poor dental health and hygiene.

Notably, research has identified a number of barriers to health care uptake by homeless people (Focus Ireland, 2003). Within the context of an absence of or restricted provision of dedicated health services the most regularly cited barrier to healthcare is finance, with homeless persons unable to afford consultation, therapeutic and medication costs. Irish research suggests that less than 60 per cent of homeless people have medical cards to cover these costs (Cox & Lawless, 1999).

Other barriers identified include transportation and distance barriers, lack of knowledge and awareness of where to go to access services, waiting times, personal barriers relating to mental ill health, mobility barriers exacerbated by the transient lifestyles associated with homelessness, communication and awareness barriers related to issues of language, literacy and education.

Barriers identified are specific to the experience of homelessness and include the impacts of stereotyping on homeless persons that increases their alienation and sense of anomie and can add to feelings of fear and intimidation.

The barrier caused by having to struggle to satisfy primary needs such as food, shelter and safety that take precedence over less immediate health concerns is also very real as are issues relating to being banned or excluded from services due to anti-social behaviour.

Linking Food Poverty, Homelessness and Consumer Issues

Food poverty not only encompasses issues of income inadequacy but is directly related to the issues of price, access, choice and availability of food. In other words, many recently established consumer issues relating to food – labelling, awareness, lifestyle and cultural preferences and so forth – are relevant to the nature and experience of food poverty among homeless people.

Issues around modern food retailing such as proximity and access to different categories of retailer also loom large in homeless people's experience of food poverty.

Secondary analysis of Irish data sources indicates the degree of variation by income level that occurs in weekly household expenditure on selected food items as a relative proportion of total food expenditure.

For example, households on weekly incomes of less than €214 spend just 2 per cent of their income on fresh fruit compared with 6 per cent for families with a weekly income above €1,018 and 4 per cent for families with a weekly income between €214 and €1017. For fresh vegetables, the higher income households spend just over 8 per cent weekly, middle-income households spend approximately 6 per cent but low-income households spend only 3 per cent of weekly income on fresh vegetables.

In contrast, for staples such as white bread, both high and middle-income households spend 3 per cent of their weekly food expenditure while low-income households only spend 2 per cent. In sum, low-income households spend proportionately more of their weekly income on fresh vegetables than on fresh fruit or staples such as bread, but comparatively are likely to spend less than half the amount of middle or high-income groups on food (CSO, 2001). Other data suggests that poorer people spend relatively more on food in terms of their overall income, but not necessarily on healthy options.

Additionally, secondary data analysis demonstrates how socio-economic inequalities clearly drive inequality in dietary habits. Data indicates that a range of socially disadvantaged groups show worse food intake, compliance with dietary recommendations and nutrient intake than is the societal norm and that many disadvantaged groups have issues of access to an adequate variety of good quality affordable foodstuffs.

In reality, lower income groups also have issues knowing what is healthy food and rely heavily on supermarkets for the purchase of food. This results in limited access to a stock of healthy and inexpensive foods.

Conclusion

The number of people experiencing homelessness in Ireland has increased by 6 per cent between 1999 and 2002. Research from Dublin indicates an increase of less than 1 per cent in the capital's total homeless population. It is interesting to note that in Dublin the number of single adults who are homeless has decreased while the number of families with children has increased. Accompanying the increased number of dual and lone-parent families is an increase in the use of B&Bs to accommodate them, up from 56 per cent in 1999 to 89 per cent in 2002.

The definitions offered for food poverty, in particular the definition adopted by the Welsh Assembly that "food poverty extends beyond economic aspects to include issues such as access, ethnicity and education" embrace the concepts of affordability and accessibility and suggest the parameters of an Irish policy definition for food poverty that locates the issue within the context of other socio-economic and cultural determinants.

Insufficient food and a poor diet are now recognised as major contributors to the ill health of people living in poverty and a significant contributor to health inequalities between rich and poor. Previous research has also shown that people on low incomes are effective managers of both food and money, but inadequate incomes, higher food prices and lack of choice can contribute to food insecurity, hunger and poor diets (Dowler et al, 2001).

Consequently, a range of research questions on this subject can be quickly identified in relation to homeless people. Primary among these are the following: does the diet of people out-of-home meet the recommended dietary standards as laid down by Irish government officials and health professionals? What do the dietary habits and food consumption patterns of homeless people indicate when considered against the general Irish population? What particular problems, if any, do homeless adults face in accessing, purchasing, storing and/or preparing food?

The following chapters attempt to address these key questions.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 3

Diet and Nutrition: Investigating differences between the general population and homeless people

Introduction

This chapter presents details of Irish government recommendations on what constitutes a healthy and balanced diet. This is established in terms of recommended consumption targets across a range of food groups using the food pyramid and recommended dietary allowances (RDAs) for a range of macro and micronutrients.

Secondly, in order to contextualise the food consumption patterns emerging from this study, the chapter reviews available Irish literature on diet and food consumption patterns among the general Irish population.

Although there is limited research conducted on the subject of diet and nutrition among people out-of-home and issues of affordability, access and barriers to consuming a balanced and healthy diet among this social group remain significantly under-researched, this chapter briefly reviews available international literature regarding dietary intake and food consumption patterns among homeless people.

The Food Pyramid

There are four traditional basic food groups: meat, diary products, grains; and fruit and vegetables. These were arranged in the early 1990s into the Irish food pyramid and the pyramid also included a fifth group of foods high in fats and sugar. The food pyramid is a visual representation of recommended food consumption targets from each of these main food groups.

At the base of the pyramid are foods from the grain group including cereals, breads, rice and pasta. These foods are rich in the B vitamins, iron, carbohydrates, fibre and some protein. It is recommended that an adult individual consume 6 or more servings per day from this shelf.

Fruits and vegetables are represented on the second shelf of the pyramid. Most vitamins and minerals are sourced through fruits and vegetables, fruits and vegetables also provide fibre. The recommended number of servings per day from the fruit and vegetable shelf is 4 or more.

Dairy products are on the third shelf of the food pyramid and include milk, cheese, eggs and yoghurts. These foods are rich in calcium, iron, B vitamins and phosphorous. The recommended number of servings from the dairy shelf is 3 per day.

The fourth shelf of the pyramid contains meat, fish and poultry. These foods are a rich source of protein, iron and the B vitamins. It is recommended that 2 servings from this food group be consumed daily.

The fifth and top shelf of the pyramid includes those foods rich in fats and sugars, for example, cream, soft drinks, sweets, salad dressings. It is recommended that these foods be eaten sparingly and with not more than 3 servings per day.

Figure 3.1 The Irish Food Pyramid

Recommended Irish Dietary Standards and Dietary Allowances (RDAs)

Irish government guidelines on recommended food consumption and nutrient intake targets across the range of food groups are published and available. They include details on the recommended daily allowances for a range of macro and micronutrients (Food Safety Authority of Ireland, 1999).

Macronutrients are carbohydrates, proteins and fats and are required in multi-gram quantities each day. These nutrients make up the essential structural building blocks of our bodies and provide our primary energy sources.

Micronutrients are vitamins, minerals, trace elements and other small molecules such as anti-oxidants. These nutrients are required in microgram to milligram quantities each day and serve as co-factors for essential metabolic activities or co-building blocks for structural organs. The Irish RDAs for men and women are detailed in Appendix 4.

Food Consumption Patterns and Dietary Habits in Ireland

There have been a number of recent studies exploring patterns of food consumption and dietary habits among the Irish population, most notably the Slán survey (1999) and North/South Ireland Food Consumption Study (2001) (NSIFCS).

The methodology and timelines employed by NSIFCS differed to that used for the Slán survey. The Slán Survey used a self-completing semi-quantitative Food Frequency Questionnaire whereas the NSIFCS

measured food intake using a 7-day estimated food record. NSIFCS respondents kept a diary of everything they ate and drank over a one-week period, recording the time, location, cooking method and quantity of each item consumed. Self-administered questionnaires were used to collect socio-demographic and economic information. Researchers also carried out body measurements, including height, weight, waist and hip circumference and body composition.

Although they used very different methodologies, these two studies have indicated some population norms against which the food consumption and dietary habits of people out-of-home might be considered.

Both studies highlighted a number of issues of concern to the general population, including:

- Increased percentage of population reported to be overweight or obese;
- High level of failure to comply with the recommendation of 3 or less servings per day of foods from the top shelf of the food pyramid e.g. foods high in fats and sugars;
- High levels of alcohol consumption;
- Intakes of some micronutrients below Irish RDAs.

Both of these studies found variations between age, gender and social class in terms of compliance with the food pyramid recommendations, consumption of foods high in fats and sugars, the intake of some macro and micronutrients e.g. fibre, vitamin D and vitamin E below RDAs and high levels of alcohol consumption. These are considered in more detail below.

The Slán survey, 1999

The Slán survey was a national health and lifestyle postal survey, the purpose of which was to produce baseline information for the "on-going surveillance of health and lifestyle related behaviours in the Irish adult population" (Friel et al, 1999:14).

Included in the survey were research domains covering dietary habits and food consumption. The study used a semi-quantitative food frequency questionnaire (FFQ) to record the following data:

- The habitual frequency of consumption;
- The levels of consumption of foods from the main food groups; and
- The levels of nutrient intake.

The Slán survey found that although trends in the consumption of cereals, breads, potatoes, fruits and vegetables were in line with recommendations, the level of compliance with recommended servings per day of foods from the top shelf of the food pyramid was very low. It found that almost 84 per cent of the population were failing to achieve the recommended target of 3 or less servings per day from the top shelf of the food pyramid.

The North/South Ireland Food Consumption Survey, 2001

The North/South Ireland Food Consumption Survey (NSIFCS) investigated "habitual food and beverage consumption, lifestyle, health indicators and attitudes to food and health in a representative sample of the 18-64 year old adult population in the Republic of Ireland and Northern Ireland during 1998-1999" (NSIFCS, 2001:7).

Key findings from the NSIFCS were that:

- Thirty nine per cent of the population were overweight and 18 per cent were obese (according to the World Health Organisation categorisation), with a higher incidence of obesity among men (21 per cent) than women (16 per cent);
- The intake of fibre was below the RDA for the total population;
- The contribution of fat to total energy was below the recommended levels, but it was found that young people, particularly young men consumed higher amounts of fat than any other group;
- The contribution of carbohydrates to total energy was also below the recommended level;
- The intake of protein was more than adequate; and
- The intake levels of vitamin D and vitamin E were below their RDAs.

Age and gender

The Slán survey found there was significant variation in compliance with food pyramid recommendations by age and gender. Younger men and women (aged 18-25 years) were significantly more likely to consume more than three servings per day from the top shelf of the food pyramid. Consumption of foods such as rice and pasta were also age-related with younger men and women consuming greater quantities of both. Consumption of brown rice and wholemeal pasta was higher among men and women aged 55 and over. Age related differences were also observed in the NSIFCS with regard to food choice and alcohol consumption. Older men and women (51-64 years) consumed greater quantities of wholemeal and brown breads, porridge, green vegetables and tea, while younger people (aged 18-35) ate more rice, pasta, chips and savoury snacks.

The mean consumption of alcohol was higher among men than women, men reported a mean daily consumption of beer and wine of 258.32g and 39.26g per day respectively compared with 129.42g/day and 38.38g/day among women (Friel et al, 1999).

The NSIFCS found that men drank more alcohol than women and it also observed that men and women in the 18 to 35 year age category were more likely to drink alcohol (74 per cent and 70 per cent respectively) than men and women aged between 51 and 64 years (66 per cent and 40 per cent respectively).

Differences were also found by the NSIFCS between genders and age groups in terms of meeting the RDAs for a range of macro and micronutrients.

Overall, respondents did not meet the RDA for fibre, but protein intakes were more than adequate, and exceeded the RDA. The mean daily intakes of fat in men and women (37 per cent contribution to total energy) exceeded current recommendations (a maximum contribution to energy of 35 per cent) but the mean daily intakes of carbohydrate (46 per cent) were lower than recommended (55 per cent contribution to total energy). Intakes of most vitamins were found to be adequate, but there was a significant prevalence of inadequate intakes of calcium and iron in women of reproductive age (NSIFCS, 2001).

Social class

The size of the samples employed by both the Slán survey and the NSIFCS allowed researchers to investigate differences on the basis of age groups, gender, rural and urban dwellers and social classes.

The Slán survey found:

> "There are still unacceptable socio-economic variations in the population in that the less affluent report a less healthy diet overall" (Friel et al, 1999: 13).

Findings from the Slán survey indicated that adults from social class 5 and 6[5] consumed less fruit and vegetables and dairy products than adults from higher social classes. For example, 57.3 per cent of adults in social class 5 and 6 complied with the food pyramid recommended targets for fruits and vegetables compared with 73.2 per cent from social class 1 and 2.

Twenty-one per cent of adults in social class 5 and 6 complied with the food pyramid recommendation on dairy product servings compared with 25 per cent from social class 1 and 2. The survey also reported higher levels of obesity and overweight in social class 5 and 6 (10.8 per cent and 34.2 per cent respectively) compared with social classes 1 and 2 (8.1 per cent and 29.5 per cent respectively).

Dietary Habits and Food Consumption Patterns among the Homeless

This section reviews available literature on the dietary habits and food consumption patterns of people who are homeless. It also identifies any barriers that interfere with the ability of homeless people to access a healthy and balanced diet.

It is necessary to re-iterate that there is no previously published Irish research detailing the food consumption and dietary habits of homeless people in Ireland.

There have been a number of studies exploring these issues among non-homeless low-income families. These studies have ranged from research projects dedicated to exploring the issues surrounding diet, nutrition and access to same for low income families (see Lee & Gibney, 1989), to surveys such as Slán and the NSIFCS that by virtue of their sampling strategies and sample sizes have been able to analyse their data by socio-economic group.

It is particularly difficult to compare the results from international studies on the dietary habits and food consumption patterns of homeless men and women as the type of "homeless people" included varies.

For example, some studies have surveyed rough sleepers only, some have surveyed single adults only, while others have surveyed those staying in hostel accommodation, or those who are accessing food centres only.

In addition, it is important to bear in mind the extent of variation in legislative or statutory definition of homelessness. This differs from country to country and so will affect the "type" of homeless household included in these studies.

Finally, there can be significant variation in the methodologies and research instruments employed to collect nutritional data. These points are returned to in the more detailed consideration of methodological issues elsewhere.

Irrespective of the methodology used, a review of the international literature clearly indicated that adults experiencing homelessness had an inadequate diet and were at risk of nutrition-related disorders. These studies indicated that homeless adults and those at risk of homelessness or living in inadequate housing had lower intakes of a range of micro and macronutrients.

Homeless men and women staying in a variety of accommodation types had been found to have had low intakes of energy, calcium, zinc and vitamin B6 (Wolgemuth et al, 1992) and inadequate levels of vitamin C, thiamine and folate intakes (Laven, 1985).

[5] Social class 5 as defined by the CSO includes semi-skilled workers and farmers with holdings of less than 30 acres and social class 6 includes unskilled manual workers. Social class 1 includes higher professionals, higher managerial, proprietors employing others, and farmers with 200 acres or more; social class 2 includes lower professional, lower managerial, proprietors without employees and farmers farming between 100 and 199 acres (CSO, 1991).

Other micronutrient deficiencies included calcium, magnesium, zinc, iron, folic acid and vitamins B6 and B12 (Luder et al, 1989). More recently in the UK, the Coufopoulos & Stitt (1995) study that used 3-day dietary diaries with a sample of 30 homeless respondents found lower intakes of energy, protein, carbohydrates, vitamin C, iron and calcium with higher intakes of fats, saturated fat and sodium when compared with low-income households housed in Britain.

Research conducted specifically among hostel users in Ireland, Australia, the UK and France has found similarly low intakes of macro and micronutrients.

A small-scale hostel based study conducted in Galway found that the predominantly male respondents reported intake levels of vitamin A equivalence, vitamin D, vitamin E and riboflavin below Irish RDAs. Compliance rates with Irish food pyramid recommendations for daily servings from the grains, fruit and vegetables and fats and sugars shelves were particularly poor (Walsh, unpublished, 2002).

Darnton-Hill & Ash's study[6] (1988) also found evidence of micronutrient deficiencies among hostel dwellers. Thiamine, magnesium and folate were all below Australian RDAs and participants in the study had marginal vitamin C intakes. Energy intakes were also below recommended dietary intakes.

Male and female hostel dwellers in a study in Paris reported lower than recommended energy intakes for fats and carbohydrates and higher than recommended energy intakes for protein (Malmauret et al, 2002). The study employed a 24-hour recall methodology and found that for all micronutrients, with the exception of iron intake among men, more than 50 per cent of the population studied had intakes below the French recommendations for the adult population. Of the 87 homeless adults that accessed four accommodation centres, 84 per cent drank alcohol and the incidence of smoking was also very high, 76 per cent of respondents regularly smoked.

The international literature also suggested differences on the basis of gender; single homeless men reported intakes of energy, carbohydrates, folate, zinc and magnesium all below dietary reference values (DRV) (Evans & Dowler, 1999). They concluded that homeless men and women:

> "…consumed less vitamin A, vitamin C, vitamin E, riboflavin, thiamine, niacin, pyridoxine, folic acid, zinc and iodine than the average men and women in social class IV or V of the British adult population. In addition, 'homeless' women consumed less vitamin B12, iron, calcium, phosphorous, iodine and copper and magnesium" (ibid:193).

Homeless women have also been found to have low energy intakes, and especially low intakes of folic acid, iron, calcium, iodine and magnesium (Evans & Dowler, 1999) and below RDA intakes of vitamin E and B1 (Malmauret et al, 2002).

In general, and regardless of the accommodation status and/or the gender of the homeless person, available international research has found the following characteristics among this population:

- Lower levels of a variety of micronutrients including vitamin A, the B vitamins, vitamin C and vitamin E;
- Low intake levels of calcium and fibre; and
- High levels of protein that suggest low consumption levels of a range of fruits and vegetables, cereals and brown or wholemeal products.

[6] Cited in Evans & Dowler, 1999

Conclusion

There are very clear guidelines developed by health professionals that show the necessary components for a healthy and balanced diet.

Recent Irish research has shown that differences in food consumption and nutrient intake have been observed in the general Irish population between the genders, between different age groups and between social classes. For example, the mean consumption of alcohol was higher among men than women; younger people ate more rice, pasta, chips and savoury snacks while older people ate more brown rice and wholemeal pasta; and that less affluent adults reported a less healthy diet.
While there is no published Irish research available about the food consumption patterns and quality of diet among homeless people, the international literature clearly shows that adults experiencing homelessness, at risk of homelessness or living in inadequate housing had an inadequate diet and were at risk of nutrition-related disorders. Research conducted in a variety of locations has found that homeless adults had low intakes of a range of macro and micronutrients.

These studies have investigated the issues of dietary habits and food consumption patterns from the perspective of clinical nutrition. Few studies have included an examination of the qualitative aspects of diet/food inadequacy such as the barriers that homeless people face in accessing an adequate diet, the food choices they might make under different circumstances, or the competing priorities that they might face with regard to income and expenditure choices etc.

The following chapter presents details of the methodological considerations and challenges that faced the researchers and the way in which these difficulties were addressed.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 4

Researching Homelessness and Food Poverty: Problems solved and lessons learnt

Introduction

This chapter examines the research methodology that was adopted in this study. It details the research instruments that were considered and the research instruments that were finally employed. It also discusses the sampling guidelines used and the limitations of the data generated.

Selecting the Quantitative Research Tool - issues of methodology and approach

Nutrition studies generally tend to use a number of different questionnaire and recording systems to capture nutritional data. Among the most common tools for collecting nutritional data are food diaries, 24-hour recall questionnaires and food frequency questionnaires. Each of these three different data collection tools were investigated for their appropriateness for research with homeless adults in Dublin.

The food diary method

Food diaries require participants to maintain a diary of all food and beverage consumption for a particular period, for example 3, 7 or 30 days. Participants record the types and quantities of each food and beverage consumed over the specified period. This provides detailed information on the types and quantities of food consumed; it gives information on the respondent's current diet and allows for the calculation of nutrient intake.

However, food diaries have a number of drawbacks. Firstly, they require a significant commitment on the part of the participant to record accurately and regularly all foods and beverages consumed over a particular period of time. Secondly, the longer the recording period, the more likely it is that participants may experience recording fatigue. Records kept for longer than 4 days increase the likelihood of inaccurate reporting as a participant's motivation deceases and recording fatigue sets in (Biro, 1999). This means that diary keepers need to be contacted regularly to encourage their continuation and their ongoing accuracy.

Lastly, the real level of food and beverage consumption recorded using the food diary method may be under-reported. Respondents may not correctly report the real or accurate amounts of foods and beverages consumed if they are in any way familiar with the principles of healthy nutrition.

The food diary methodology has rarely been used in nutritional studies with people experiencing homelessness. Food diaries are self-completing tools. They require participants to record and measure each item of food that they consume, and this immediately raises a number of difficulties for homeless people. Put simply, literacy and numeracy difficulties and problems with comprehension are experienced by homeless people and represent a significant barrier to attempting to self-complete a food diary. Secondly, over and above issues of literacy and comprehension is the fact that the respondent's accommodation situation is not conducive to the weighing of all of their foods. Homeless participants for a study of this type do not in many cases, have a place to stay, let alone have access to weighing scales etc. And thirdly, the homeless population is highly transient with many moves between accommodation types and intermittent service use. This makes the verification of data as well as the provision of ongoing monitoring and/or support to the participant to accurately complete the food dairy quite problematic.

The 24-hour recall method

The 24-hour recall methodology uses a survey tool that requires the participant to record all foods consumed in the previous 24 hours including their quantity. Given the immediacy of the questionnaire administration, the fact that respondents report exactly what has been eaten and the estimation of portion sizes using relevant measures, this methodology can yield valuable nutritional and food quantity data.

Additional questions can also be added to the 24-hour recall questionnaire, thereby allowing socio-demographic and other information to be collected. A number of international studies assessing the nutritional status of people out-of-home have employed the 24-hour recall methodology, for example, US studies by Wolgemuth et al (1992), Laven et al (1985) and Luder (1989), Darnton-Hill & Ash (1988) in Australia and Malmauret et al (2002) in France.

However, it is recommended that when using the 24-hour recall method two or more 24-hour recall periods are included. Repeating the 24-hour recall questionnaire ensures that the nutritional data collected is truly representative of the kinds of foods regularly consumed by participants and avoids attributing undue significance to unusual food intake or occasional changes in food consumption. Because of this, the 24-hour recall method can be a time-consuming and potentially expensive research method, requiring 2 or more questionnaires to be administered.

The semi-quantitative food frequency questionnaire (FFQ) method

Semi-quantitative food frequency questionnaires (FFQ)[7] are interviewer-administered or self-completion tools used for estimating frequency and quantities of food consumption over a retrospective period of 7 or 30 days or even over a year.

The FFQ requires participants to record how often they have eaten a particular food over a period of time, for example daily, weekly or monthly etc. Three levels of food data can be estimated from the FFQ; indications of dietary patterns, food quantities, and nutrient intake levels.

The FFQ can be a "one-off" survey tool that does not necessarily require any follow-up with participants at a later date. In addition, extra questions can be added to the FFQ because the food consumption element of the questionnaire is neither as detailed nor time-consuming an instrument as a food diary that requires updating and measurement of foodstuffs on a daily basis.

There are some disadvantages to using the FFQ. The first relates to the depth and breadth of the food listings. If the food lists are incomplete or not comprehensive enough, the consumption and intake will be underestimated, and conversely if the list is too long the burden on the participant is greater and their accuracy in recollecting food consumption and their willingness to engage in an interview may be affected.

Secondly, the FFQ yields estimated nutritional data as the amounts of food and drink consumed over the study period are not precisely weighed or measured.

Lastly, study participants are requested to consider their consumption of foods over a longer period of time than either the 24-hour recall or food diary methodology time spans and may present some difficulties in the accuracy of the participant's recall.

The FFQ has been used in a number of studies investigating dietary habits and food consumption among homeless people. UK studies by Rushton & Wheeler (1993) and Evans & Dowler (1999) used a FFQ as well as a 24-hour recall questionnaire to assess the dietary quality among single homeless adults. Peck's (2000) UK study investigating drug use and nutrition also used a FFQ to assess diet and nutrition among this group, some of whom were hostel dwellers.

[7] Referred to in the remainder of this report as FFQ

Developing the Survey Research Tools

After considering the strengths and weaknesses of the above methodological approaches the study team considered that an applied methodology that relied on both quantitative and qualitative approaches would be more suitable to meet the objectives of this study.

A structured survey questionnaire was used to collect quantitative data on food and nutrient intake, personal circumstances, food preparation and storage facilities, food shopping habits and general health.

A key challenge to the successful conduct of the survey research was determining the best survey instrument to use for our study group. The following issues were to the fore in choosing the quantitative survey instrument:

- Veracity of nutrient and dietary information
- Yield of information on eating/dietary patterns
- Length and detail of any survey instrument
- Location and environment for the interview process
- Identification of potential participants
- Issues of literacy and comprehension
- Resource commitment (financial and personnel)

The Food Frequency Questionnaire (FFQ) method was considered the most useful on the basis of the following benefits:

- The FFQ requires participants to consider food intake over a longer period of time than the 24-hour recall instrument. The literature suggests this may be a potential drawback, but conversely by considering food consumption over a longer period of time it avoids including short term changes in diet as a result of financial difficulties, drug or alcohol use, closure of food centres/homeless services at weekends or for bank holidays etc. that may occur when using a shorter timeframe on which to base food consumption and nutritional estimates.
- By using a longer recall period (in this instance a 30-day period) there was no need to follow-up with another FFQ. Previous research experience confirmed the difficulties of trying to conduct follow-up interviews with homeless persons. For example, a longitudinal study carried out by Focus Ireland in 1999 indicated the very real difficulties of locating and encouraging participation in 2nd and 3rd phase interviews (Houghton & Hickey, 2000 unpublished).
- Thirdly, the FFQ is usually interviewer administered. This helps overcome difficulties in comprehension and literacy that may be experienced among respondents. The use of an interviewer administered survey tool also minimises the amount of training of respondents in the use of the survey instrument.

For the purposes of this study, two research assistants were trained in how to administer the questionnaire but no training was required for respondents. A research assistant was used to administer the questionnaire during the pilot phase and her observations and notes helped inform the development of the final version of the FFQ.

Using an interviewer-administered instrument meant that discrepancies in reporting of the types of foods and their quantities were identified immediately and consequently corrected or verified by the interviewer. The use of interviewers in this study was also important in recruiting participants for the second qualitative phase of the study.

Finally, the structure of the FFQ and the use of standard quantities rather than the time-consuming method of actually measuring all foods consumed allowed the research team to administer a very detailed questionnaire in a variety of locations.

Designing the Survey Questionnaire

The questionnaire used for this study was divided into 6 sections and included filter questions, the 130-item food frequency questionnaire, questions relating to socio-demographic information, and food preparation and food shopping habits. A section on general health was also included.

i) The importance of filter questions and the role of a unique identifier

The initials of all respondents were recorded together with the month and year of their birth. This provided a unique identifier for each respondent allowing the research team to identify and remove any duplicate questionnaires from the data set.

Filter questions were relied upon to identify the survey sample. For example, people involuntarily sharing with friends and/or family because they had nowhere else to reside are included in the legislative definition of homelessness (Sec. 2 (a) (b) Housing Act, 1988). However, they were excluded from this study on the basis that they were more likely to have access to private kitchens, private food storage facilities and so forth thereby allowing them to potentially make more personal choices with regard to food consumption that are not available to people residing in hostels, B&Bs and/or sleeping rough.

Secondly, on the basis that the FFQ investigated food consumption over the 30 days prior to the survey, all potential survey respondents were asked how long they had been residing in their current accommodation. Any respondent who had stayed with friends/family during the 30 days prior to the survey or who had spent any of the 30 days prior to the survey in prison were excluded. Respondents staying with friends and/or family were excluded for the reasons noted above while respondents who had spent time in prison (either on remand or serving a sentence) were also excluded on the basis that they would have received 3 full meals a day. The length of time respondents had been homeless was also recorded and any respondents homeless for less than 30 days were excluded from the study.

ii) The food frequency questionnaire (FFQ)

A 130-item FFQ was used to assess respondent's food consumption and nutrient intake. The FFQ was an adapted version of the one used in the Slán health survey (1999).

The FFQ contained lists of specific foods grouped accordingly. The food categories included in the FFQ were meat, fish and poultry; dairy products and fats; bread and savoury biscuits; cereals; potatoes, rice and pasta; soups, sauces and spreads; drinks; vegetables; fruits; and sweets and snacks.

Each respondent was asked to consider how often he or she had eaten a particular food, and the suggested portion size in the 30 days prior to the survey. The degree of frequency for the consumption of the different foods were: more than once per day, once per day, 5-6 times per week, 2-4 times per week, once a week, 1-3 times per month and never or less than once per month.

iii) Socio-demographic data

Information on gender, age, family status and accommodation type was recorded alongside the FFQ data. Respondents were asked to report if they had children and how many adults and how many children were staying in the respondent's current accommodation.

In the pilot phase of the study, respondents were asked how many children they had. However this question proved upsetting to some respondents whose children were not in their care. Respondents with this family situation often found it difficult to discuss their children in these circumstances, as

often their children had been placed in state care. The question was re-phased in the context of the respondent's expenditure on food relating to the current size of their household. Information on the respondent's source of income was also recorded in this section.

iv) Food purchase, expenditure and preparation

The study aimed to gather information on the cooking and food storage facilities available to people in out-of-home accommodation types. We were also interested in the frequency of their meal consumption over the 7 days prior to the survey. In addition, respondents were asked about their food shopping habits and how much they spent on food during a typical 7-day period.

v) General health

Respondents were asked to rate their general health, their satisfaction with their health and their quality of life. In addition, they were asked to report any illnesses they had or prescribed medications they might be taking on the basis that their diet may be effected e.g. heart disease, diabetes etc. Respondents were also asked about their consumption of alcohol, their smoking habits and their current or previous history of illicit drug use.

vi) Comments and insights

In the final section of the survey questionnaire, respondents were asked to contribute general comments or insights. They were also asked if they would be willing to participate in the second, qualitative phase of the study. Where respondents agreed to participate their full name was recorded so that contact could be made at a later date. Where the respondent declined to participate, he/she was thanked and no further details were recorded.

The Survey Sample

One of the immediate difficulties facing researchers working with a homeless population is the absence of sampling frames. The homeless population is not a homogeneous one and many different types of households experience homelessness. It was therefore important for the research team to ensure that all types of homeless households were included in the survey. This was accomplished with the development of sampling guidelines.

Sampling guidelines indicating the types and numbers of a variety of homeless households were drawn up and used to identify potential respondents for the survey. These stratified sampling guidelines were developed to assist service providers and the research assistants in identifying potential participants.

An initial total sample population of 75 was determined to be adequate for this pilot study, given the total size of the homeless population in Dublin (2,920 people), the difficulties associated with contacting and encouraging participation, and resource constraints. The study also had value over and above the actual data yielded in that the appropriateness of the FFQ methodology was also tested. The sampling guidelines for this study were based upon the gender, age and family type of the total homeless population in Dublin.

Preliminary data from *Counted In 2002* - the Dublin assessment of homelessness conducted in March 2002 (Williams & Gorby, 2002) provided the basis for these sampling guidelines. Counted In 2002 illustrated some surprising new trends in the make-up of homeless households when compared with the same survey findings for 1999.

For example, although the number of individuals and children homeless in Dublin in 2002 had increased by 20 and 150 respectively since 1999, the number of households had actually decreased. There was a decrease in the number of single men and women homeless in Dublin in 2002 but an increase in the number of dual-parent and couple only households homeless when compared with 1999.

The sampling guidelines drawn up for this study attempted to reflect these changes in the profile of the homeless population.

Three main variables were chosen for the breakdown of the sample: gender, age, and family type. Based on this data it was determined that 47 out of the proposed 75 respondents should be male (63 per cent) and the remaining 28 participants should be female (37 per cent). Within these gender groups the desired sample was further broken down by age and household type.

While it is acknowledged that a number of other variables influence food consumption patterns (e.g. accommodation type, drug or alcohol misuse, pregnancy and other dietary special needs) the limited nature of the pilot study and the proposed sample size meant that the sampling guidelines needed to be relatively flexible.

It was anticipated that data on a variety of accommodation types would be captured on a de facto basis of sample selection. So too would data on drug and alcohol misuse. In other words, the characteristics of the required sample would determine that data on a range of accommodation types would be recorded by the survey questionnaire. Different household types tend to be accommodated in different ways. For example single men and women tend to be accommodated in hostels or sleep rough more often than men and women with children.

The guidelines were provided to the research assistants employed to collect the primary data. The research assistants randomly selected respondents who fitted the above criteria.

Accessing the Survey Sample

Four homeless service providers in Dublin city were approached and asked to identify clients / customers that might meet the sampling requirements of the research project. The four service providers approached were:

- The Focus Ireland Open Access Coffee Shop in Temple Bar, Dublin city centre
- The Crosscare Food Centre, Dublin city centre
- The Crosscare Night Shelter in Longford Lane, Dublin city centre
- The Society of St Vincent de Paul's Night Hostel in Back Lane, Dublin city centre

In the early planning phase of this study it was anticipated that the St Vincent de Paul hostel and the Crosscare food centre and the Crosscare night shelter (both in Dublin's city centre) would be used by the research team to access potential respondents.

However, it quickly became clear that the Back Lane hostel would not be an appropriate option for the research team. The residents of the hostel were older men who stayed in the hostel with full board. These characteristics did not necessarily exclude this service from the study but the fact that many of the hostel residents had been living in the hostel for many years and that many had paid work did. The hostel had become their home, however, inappropriate.

These men's hostel experiences and lives were very different from the experiences of both single men and women and families experiencing homelessness and residing in emergency hostels, B&Bs or night shelters.

In light of the profile of the resident's of Back Lane it was decided to omit this hostel from the list of service providers to be accessed. It was replaced by accessing the food centre operated by Crosscare and Focus Ireland's Coffee Shop.

During the course of the fieldwork, it became clear that some household types were difficult to identify through the above-mentioned services, in particular:

- Lone parents
- Dual parent families
- Single men and women aged between 18 and 25 years

Both lone and dual parent families were difficult to identify as some of the families approached expressed their reluctance to use or be associated with "mainstream" homeless services. They did not want their children in contact with such services or exposed to adults with substance misuse problems or mental health issues.

In order to contact these families (both lone and dual parent) Focus Ireland's Crisis Team were approached for assistance in identifying potential respondents. The Focus Ireland Crisis Team operates an advice and advocacy service for homeless adults, a 'key-working' system is in operation and individuals and families are assigned a key-worker to support and assist them through their experience of homelessness.

Lone and dual parent families were identified by the Crisis Team through their key working service and Crisis Team staff provided the families with brief details about the study and asked their permission to pass on their details to the research team. Potential families were then asked if they would meet with the research team for a fuller explanation of the study with a view to ultimately participating.

The Crisis Team also operate an outreach service in Haven House (a city centre based hostel for single women and women and children), where a member of the Crisis Team visits the hostel weekly to work with the women staying there and to provide information and support. Lone parent families were also contacted via this outreach service. Crisis Team staff informed the hostel staff and the women staying there of the research project and a research assistant was invited to visit the hostel to secure interviews with any women willing to participate.

Dual parent families were also difficult to access. The research team did not have access to individual emergency B&Bs and as there are no family-appropriate hostels in the city, we had to depend on homeless services to identify this population.

The Crisis Team again proved an invaluable resource in introducing the research assistants to potential respondents but dual parent families were also accessed through Focus Ireland's childcare centre based in John's Lane West, Dublin 8.

The Childcare Centre provides nursery care to children out-of-home with their parents, aged between 0 and 5 years. Focus Ireland staff in the childcare centre informed parents using the service about the study and one survey interview was arranged as a result.

Another group that proved difficult to access through the Focus Ireland Coffee Shop and the Crosscare facilities were young men and women aged between 18 and 25 years. In a number of cases "mainstream" services are not available to this group. However, in recent years, more specialised services have been developed to respond more easily and comprehensively to their needs (for example, issues around leaving care, substance misuse problems, offending behaviour etc.).

The Crosscare food centre did not yield the kind of numbers in this age group and so alternative sources had to be considered. This proved to be Focus Ireland's Extension Day Service. The Extension is a 7-day day centre for 18-25 year olds who are out-of-home. The purpose of the study and the research methods used were explained to staff of the Extension and they were asked to publicise the study among their clients. A number of interviews were arranged with young men and women aged 18-25 years as a result.

Table 4.1 Source of Interview Participants

Source of Interview	Number of Participants
Focus Ireland Coffee Shop/Crisis Desk	50
Focus Ireland "Extension"	5
Focus Ireland Childcare Centre	1
Crosscare Night Shelter	13
Crosscare Food Centre	5
Total	74

The final sample size analysed for inclusion in the study was 72. One questionnaire was removed as being a duplicate and one questionnaire was removed from the data set as the food consumption and nutrition data generated was considered unreliable.

Incentivising Participation

Survey respondents were paid €15 in the form of a Dunnes Stores gift voucher. Payment of the gift voucher was conditional on their participation in the first phase of the study. There were a number of reasons for the payment of participants, these included:

- To encourage respondent participation
- The complexity of the information to be collected
- The length of time taken to carry out the survey interview

A number of studies have found that incentives can have a positive effect on questionnaire completeness with no response bias, few response errors when some measure of validity is available and "more complete responses to open questions as reflected in a greater number of words written or more distinct items mentioned" (Willimack et al, 1995:80).

Research into the impact of payment to survey participants suggests that if an incentive is offered conditionally upon response, sample members might be more likely to "cooperate with a survey if the value to them of the incentive outweighs the cost (burden, intrusion, time) of cooperation" (Lynn, 1999:327)

Payments have also often been advocated when complicated or detailed information is required. For example, Kemsley (1969) found that a response rate of 71 per cent was obtained for the UK Family Expenditure Survey when payments were made to respondents as compared with response rates of 35 and 55 per cent for the similar 1951 and 1968 National Food Surveys where no payments were offered. There is also evidence from the commercial market research sector that payment of a nominal fee or free gift is a successful incentive to participants when complex information is required (Thompson, 1996).

The Qualitative Research - Identifying Themes for Examination

The qualitative approaches to food poverty employed for use with this sample of people out-of-home aimed to deal *in depth* with issues around food consumption. Through drawing a sub-sample from those who participated in the survey research (a process of recapture), we sought to expand on the survey questionnaire information on food issues.

The themes for the Focus Group Discussions (FGDs) emerged from our analysis of the survey questionnaires and 4 key thematic areas were selected.

i) Access to cooking, preparation and storage facilities

Access was identified as a vital factor affecting respondent's experience of food poverty. It had been noted through survey fieldwork that access to food preparation facilities had considerable effect on the day-to-day lives of survey participants. The ability to store food in a fridge or cupboard or be able to go to the kitchen and make a cup of tea, a bowl of soup or a sandwich with one's own ingredients formed part of the investigation against this theme.

Homeless persons with limited or restricted access to such facilities (e.g. communal kitchens) may be unable to respond adequately to feelings of hunger. For those with children the problem can be amplified. Often the kitchen experience may be competitive. Cutlery and utensils have to be shared or shelves may be taken by other residents. Cookers may be limited and inadequate. The hostel kitchen

might be occupied by individuals, groups or 'cliques' whose cooking and hygiene habits and standards may radically differ. The kitchen may be dirty and malodorous. The ability to maintain a healthy diet is likely to prove severely restricted. Also food theft is not uncommon.

ii) Access, choice and constraints in food purchase and consumption

Due to the often chaotic nature of homelessness choice in food purchase is often restricted to retail outlets located near to homeless night shelters and hostels. Homeless persons may be forced to rely on convenience stores rather than supermarkets with the restriction in choice and higher prices that this implies. These convenience stores rarely offer good value for money. The choice of foods may also be determined by the ability to store them. In consequence, poor diet is reinforced by use of pre-prepared food, processed food or popular snacks. The choice of food is often structured by the available cooking facilities and the risk of theft of the purchases.

Ethnic food preferences such as those specified by religious belief may prove difficult or impossible to exercise. Finally, the experience of shopping itself may feel oppressive. Given the local knowledge concerning where the shopper lives, or in some cases, unhealthy appearance, the shopper can find herself under constant surveillance

iii) Access to information about healthy diet, food preparation and storage

Knowledge concerning diet and food preparation can be limited, especially for the younger homeless person. This problem is familiar to those who have been in care as a child or young adult. They have never received the training in food selection and preparation that might be acquired in a family setting. There is likely to be a lack of knowledge about dangers, for example storing cooked and raw meat on the same shelf. In the crowded collective kitchen, hygiene may be forfeited for speed. A failure to adequately reheat food can cause major health problems. Nutrition may be also be sacrificed to comfort. Filler foods that give the feeling of fullness and satisfaction, however temporary, may be preferable to a nutritious balanced meal, which somehow fails to give immediate gratification to the eater.

iv) Expectations, cultures, values and choice concerning eating

For many homeless persons, eating in safe, secure and comfortable surroundings can be an unlikely prospect. Communally provided meal centres are likely to have sub-cultural values about which the 'novice' is unaware. The exact timing of the meal, the choices available, the manner in which they are made available and the possibilities for maximising intake can be 'secret knowledge' which must be learned. The technique of taking two buns and hiding them in a jacket for example may require the novice to make a relationship and undergo a brief apprenticeship. The need to guard food and belongings whilst eating renders the eater hyper-vigilant. The eating establishment may also be constantly watching for thieves and for those who may use the premises as a location to obtain illegal substances (drugs) from others. In consequence, collective eating is unlikely be a relaxed experience.

Applying the Qualitative Method

Using the thematic areas identified through the survey fieldwork, the study team constructed an informal interview guide that was sufficiently flexible to deal with a variety of cases.

A series of FGDs were planned so that homeless participants could explore in an interactive and supportive environment the various themes identified by the study team, as well as any other matter considered germane and relevant.

The groups would focus on the selected themes and contribute experiences in a manner that

concretised aspects of available survey data. The FGDs were therefore designed to offer a judicious mix of participants so that through mutual exploration, experiences would be exchanged and collective aspects revealed.

Research regarding homelessness presents difficulties for standard methodologies such as focus group research. It was accepted that given the multi-causal complexities of homelessness, attendance by any one of our selected participants could quite easily be interrupted as they may have moved on or away, the chaotic nature of their lifestyles might militate against timely attendance and the prospect of personal disclosure in a group setting might prove a disincentive.

On the other hand, having engaged the contributors in the original survey sample and gained their agreement to continue to the next phase it was envisaged that these difficulties could be minimised.

Although the first arranged FGD was successful it became clear that the remainder of the sample was either unwilling or unable to attend the groups. In particular, women with childcare duties appeared unable to respond.

Significantly, the issue of disclosure in group settings came to the fore as a barrier to successful conduct of the FGDs. Discussions with the field researcher revealed that for those living in hostels in particular the lack of privacy was a major issue. Within the context of the lives of hostel users, privacy and respect are limited and in consequence hostel populations are socially fragmented.

The FGD format therefore appeared unwelcoming since the prospect of entering discussions with other hostel users might offer only a repetition of the lack of privacy associated with hostel life. It was evident from responses to the survey questionnaire that the absence of control was somewhat threatening to homeless people as was the prospect of sharing private information.

Those who had found other accommodation risked a repetition of the strained interactions of the hostel. Furthermore, it was also found that female respondents might not wish to discuss dietary questions due to reticence concerning body image. Finally, it was likely that information that could reveal previous criminal behaviour was unlikely to emerge during the FGDs.

The first FGD had vociferously pointed out that the problem was lack of accommodation and not any specific problems around food and diet. Indeed, guiding the group to consider food and diet appeared to have an irritating effect and despite obvious concerns about their lifestyles, respondents largely considered food poverty an unavoidable outcome of homelessness. Even minimal prompting concerning the food question led to some hostility.

As a result of these initial experiences the research team agreed that a single case study approach (Williams, 2001) would allow for the representation of food issues, which are embedded in personal narratives and which demonstrate the ingenuity of respondents in dealing with the many constraints around food purchase, meals and diet.

It was therefore decided that a series of one-to-one interviews would be arranged, so that researchers could comply with the respondents' schedules and offer a more confidential approach. This alternative was expedited only after considerable effort by the research team.

However reluctant to attend interviews, when respondents did so they proved frank and open about the most sensitive matters concerning their experiences.

Given the difficulties involved, the research team were initially concerned that any self-selection of

respondents could lead to bias. Nevertheless, given the wide spread of individuals represented by achieved interviews, this ultimately proved to be non-problematic.

Interviews utilised an informal interview guide using the thematic areas selected and were recorded, transcribed and analysed. The interviewing technique utilised was a combination of direct questioning and discussion and a non-directive method. In the latter, information is reflected back in a manner designed to allow the interviewee autonomy in controlling the flow of information.

Participants in the Qualitative Process

The qualitative aspect of our research enquiry eventually generated one FGD and seven semi-structured interviews representing the views of a total of 12 persons all of whom had completed the initial survey questionnaire. A brief profile of each of the participants included in the qualitative interviews is provided below.

The Focus Group Discussion

- Comprised four single middle-aged adult males who were either sleeping rough (1) or hostel users (3). Discussion in the FGD was extensive and covered areas of food purchase, storage, preparation and consumption. Experience of hostels and hostel management, and the use of services proved major issues of discussion. FGD participants expanded discussion to include other aspects of their experience of homelessness.

Interview 1

- This single male heroin addict who was awaiting placement and access to a methadone maintenance programme had used hostels and was sleeping rough at the time of interview. The impact of heroin use on his diet and nutrition was to the fore in this interview.

Interview 2

- This single female parent had three children and was a hostel user. The discussion focussed primarily on the difficulties of maintaining everyday routines of household management and provision of food to children. Access to food, choice, cost and loss of the daily experience of cooking and family meal times were among the issues discussed.

Interview 3

- A single male in his twenties, this interviewee had been a heroin user and was now a full time student at college. The interview recorded his experience of drug use, subsequent mental ill health and food consumption, diet and nutrition during that period. Further details illustrated his current food consumption and issues of choice, preference and shopping patterns. The discussion included views on his ideal-type diet.

Interview 4

- This married female's experience of homelessness began with an eviction from private rented accommodation. She was a convert to Islam and married to a Muslim. Her experience of cooking in different environments (hostels, etc.) imposed a number of constraints and difficulties on her cooking and eating habits as a Muslim. This woman maintained a stoic position throughout her period of homelessness, refusing to adopt the homeless label. Diet was not such an issue for her but the discussion included issues of choice and the use of commercial fast-food outlets.

Interview 5

- This interviewee was a young single parent with one child (female). She was originally from a middle class background and her partner was a heroin user. Domestic violence ended the relationship and she has now been re-housed after a period of homelessness. The discussion followed the details of her life story and included insights on food preparation and choice when living in B&B accommodation.

Interview 6

- Two single parents attended this interview together. One was in her early 20s and the other in her late 30s. One parent had nine children and recounted numerous incidences of homelessness beginning with her heroin use and the subsequent surrender of a social housing tenancy. At the time of the interview she was on a methadone maintenance programme. The other person had three children and had been homeless since adolescence again with a history of drug misuse. The two interviewees had become friends and for several years had been supporting each other through difficulties. Discussion was extensive and varied and included details on use of homeless services, drug use and it's impact on diet and nutrition. Discussion also included issues related to body image, weight and diet.

Interview 7

- This interviewee was a single male, late 30s with professional qualifications and was originally from a middle class household. He had suffered mental ill-health (depression) and this combined with a relationship breakdown had triggered his period of homelessness. The discussion included details of access to food, choice and preparation and consumption of food. Cost of food and daily consumption were also considered.

Homeless Service Food Providers Questionnaire (FPQ)

An additional quantitative research tool was developed. The purpose of the food providers questionnaire was to assess the types of foods served to service users and the frequency of their provision.

Homeless food service providers were asked to indicate if they served a variety of foods from the major food groups including meat, fish and poultry; dairy; vegetables and fruit; cereals; drinks; and sweets and snacks; and the frequency of those servings. They were also asked to indicate the type of customer that they catered for and how often the service was available.

The FPQ was posted to 18 food service providers in Dublin city including hostels and dedicated food centres. All the information collected was confidential and anonymity was assured. Food centres and food providers were identified using the Homeless Agency Directory of Services, 2002. The directory provides a listing for all homeless and related services available to people out-of-home in the Dublin area.

The first round of postal questionnaires were dispatched in August 2002 and a response rate of 50 per cent was achieved. Food providers' who did not respond to the first postal questionnaire were sent a second one and following this round, a further 6 questionnaires were returned. By the end of the survey period (October 2002), a response rate of 83 per cent (15 out of 18 food providers returned questionnaires) was achieved. Seven of the 15 services were dedicated food centres/day centres and 8 were accommodation providers who also provided meals to their residents.

Conclusion

From the foregoing it is clear that the research team employed a range of research techniques throughout the fieldwork. This required both flexibility and innovation and was only possible due to the significant amount of preparation and pre-planning that was undertaken during both the pilot phase and the full fieldwork phase.

The research team found that a full research toolkit was required to successfully investigate the subject of this research. In order to yield both quantitative nutrition data and in-depth qualitative findings regarding the lived experience of food poverty the research team relied on a multi-faceted combined methodology and on the successful identification and use of points of access to the study group.

In conducting the fieldwork two key issues emerged:

i) The problem of reliably identifying and ensuring access to persons who were experiencing homelessness but were not necessarily in contact with homeless service providers. This was particularly problematic for young people aged 18-25 and women with children.

ii) Finding and subsequently organising follow-up qualitative interviews with a sub-set of the original sample.

These difficulties led to a longer period of field work than originally anticipated and a longer lead-in time to the qualitative phase, as attempts were made to re-contact survey participants.

The following chapter presents findings on the socio-demographic characteristics, information on homelessness and the health status of our survey participants.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 5

Research Findings 1: Data on socio-demographics, homelessness and health status

Introduction

This chapter sets out the main findings from the structured questionnaire and qualitative interviews. It covers the socio-demographic characteristics of the sample and their pathways into homelessness. This provides a context in which to analyse participant's responses to issues of diet and nutrition.

Socio-demographic Profile of Survey Respondents

Full details of the socio-demographic profile of all 72 respondents are summarised in Table 5.1. A total 47 men and 25 women participated in the survey. In terms of the sample composition this represented the full quota sought for male respondents and 90 per cent of the quota sought for female respondents. Ages of survey respondents ranged from 19 to 88 years. The mean age was 36 years.

Table 5.1 Socio-Demographic Profile of Survey Respondents

Age Group (years)	Frequency	Percent
18-25	20	28
26-45	36	50
46-65	15	21
66+	1	1
Total	72	100
Household Type		
Single/never married	48	67
Couple no children	6	8
Couple with children	10	14
Lone parent	8	11
Total	72	100
Source of Income		
Receipt of unemployment benefit/assistance	48	67
Receipt of disability allowance	11	15
Receipt of lone parents allowance	7	10
Receipt of state pension	1	1
In Training/education	1	1
Employed FT	1	1
Employed PT	1	1
Other	2	3
Total	72	100

In terms of marital status 39 men and 9 women were single or never married, 4 men and 2 women were in relationships but did not have children, 4 men and 6 women were part of a dual-parent household, and 8 women were lone parents.

Regarding child dependents, 31 men and 17 women had children, however only 3 men and 15 women had their child(ren) currently residing with them. Nine respondents had 1 child, four respondents had 2 children, two respondents had 3 children, two more had 4 children and one respondent had 5 children. The mean number of children was 2, with a range of between 1 and 5 children.

The majority of respondents (48) were in receipt of unemployment benefit and/or assistance. Seven women were in receipt of lone parents allowance and eleven respondents were in receipt of disability allowance. One respondent's source of income was a state pension, another was in training and education and the source of income of a further 2 respondents was recorded as "other". Only two respondents were employed, one full-time the other part-time.

Accommodation Status and History of Homelessness

All survey respondents had been homeless for the 30 days prior to the survey being conducted. Fifteen respondents (5 men and 10 women) were staying in B&Bs, 35 respondents were staying in hostels (23 men and 12 women). All 13 respondents staying in the night shelter[8] were male; and 6 men and 3 women were sleeping rough.

The minimum cumulative amount of time out-of-home was recorded as 1 month with the maximum being 300 months (25 years). The median length of time out-of-home was 36 months (3 years). The median length of time out-of-home for male respondents was higher at 36 months than that calculated for female respondents at 24 months. These details are summarised in Table 5.2 below.

Table 5.2 Length of Time Homeless

Length of Time	Male (n=47)	Female (n=25)
Less than 1 year	15	6
Between 1 and 3 years	13	11
Longer than 3 years	19	8
Total	47	25

The length of time respondents had been homeless was classified into 3 categories; short (less than 1 year), medium (between 1 and 3 years) and long (more than 3 years). These categories are not intended to reflect the qualitative experience of homelessness, but are used to facilitate analysis of the data and interpretation of the findings and are consistent with other research on this issue[9].

A total of 21 respondents (29 per cent) had been homeless for the short period of time (less than 1 year), 24 respondents (33 per cent) had been homeless for the medium period and 27 respondents (38 per cent) had homeless for the long period of time.

Fifteen men (32 per cent) and six women (24 per cent) were homeless for less than one year, 13 (28 per cent) and 11 (44 per cent) men and women respectively were homeless for between 1 and 3 years and 19 men (40 per cent) and 8 women (32 per cent) had been homeless for longer than 3 years. The range of accommodation types accessed by respondents is summarised in Table 5.3 below.

[8] The use of the term night shelter throughout this report refers specifically to the Crosscare night shelter situated in Dublin's south inner city

[9] See, for example, Williams, J. & Gorby, S. (2002) Counted In 2002.

Table 5.3 Current Accommodation by Household Type

Current Accommodation	Marital Status	Gender		Total
		Male	Female	
Bed & Breakfast	Single	3	0	3
	Couple, no children	0	1	1
	Couple, with children	2	5	7
	Lone Parent	0	4	4
	Total	5	10	15
Hostel	Single	17	6	23
	Couple, no children	4	1	5
	Couple, with children	2	1	3
	Lone Parent	0	4	4
	Total	23	12	35
Night Shelter	Single	13	0	13
	Couple, no children	0	0	0
	Couple, with children	0	0	0
	Lone Parent	0	0	0
	Total	13	0	13
Rough Sleeper	Single	6	3	9
	Couple, no children	0	0	0
	Couple, with children	0	0	0
	Lone Parent	0	0	0
	Total	6	3	9

The most common accommodation type was hostel accommodation. This reflected the greater number of men included in the survey. A total of 35 respondents were staying in hostels, the majority were male (66 per cent) and single (66 per cent). Four female lone parents were reported to be staying in hostels. The majority of lone and dual-parent households were staying in B&Bs. Two men and 5 women out-of-home with their families were staying in B&Bs, as were 4 lone parents.

The majority of respondents had been staying in their current accommodation (i.e. a specific B&B or hostel) for less than 1 year (50 respondents). Seventeen had been staying in their current accommodation for between 1 and 3 years and the remainder (3 male respondents) had been staying in their current accommodation for longer than 3 years.

Causes of Homelessness

The cause and nature of homelessness was explored with participants through the FGD and in-depth interviews. Findings illustrate the complexity and variety of factors that had contributed to or triggered periods of homelessness while also indicating the spectrum of the lived experience among homeless people.

There were a range of reported triggers for homelessness among interviewees[10]. For some, the incidence of homelessness related to structural factors of income inadequacy and poverty combined with lack of tenure security and housing rights.

> *"It was partly to do with greed and partially landlords and tenants. When I first moved [back] from England to Dublin on January 2nd this year I was in a guesthouse for 2 nights and then I moved to a tourist hostel because it was cheaper. It was for a short time. I saved some money … and moved into a shared house in the North side of Dublin.*
>
> *Now the landlord wanted cash and there was no contract because he didn't want to pay his taxes. I figured that was fine for me because when I start working I can pay cash monthly - but I found that I needed to get social welfare because things were a wee bit more difficult than I expected and I could not get the work I wanted I asked my landlord for a letter to [help] open a bank account. He seemed fine about this but did not give me the letter. Eventually I asked him again and the next thing I was asked to move out. I was [given] a week.*
>
> *I didn't have time to find anywhere else. I was moving around and staying at tourist hostels and my cost of living went up because I was eating out. I was taking time out of looking for work because I was taking time out to look for somewhere to live. Ended up low on funds and trying to claim social welfare with no address and [then] they said I had to go and stay in one of their homeless hostels"* (Interview 2 - Female Lone Parent with 3 children).

This experience of tenure insecurity as a private tenant, where sharp practices and illegal evictions remain commonplace for tenants on social welfare, was confirmed by another interviewee.

> *"I was homeless for 16 months - very long. My husband wasn't in work and we had rent allowance – it was in my name but then I got cut off by the dole. So it was just "get out!" It was a private landlord place, expensive but no security"* (Interview 4 - Married Female).

Other triggers for homelessness reflect the significant and ongoing impact of drug misuse as a cause of an individual's experience of homelessness:

> *"I was on drugs and I chose to move out of [family] home myself. So I moved out myself and then went into a bed and breakfast. Pay for it myself then I went to the Homeless Person's Unit in Gardiner Street and they put me out to Dun Laoghaire. Then they put that [property] up for sale. I was made homeless from there then I got digs but it was just 5 days in a B&B"* (Interview 6 - Single Lone Parent with 3 Children).
>
> *"I had a house in Coolock seven years ago and I left it after my son died I was on anti-depressants. He is 12 years dead and would have been 18 [in 2002]. Someone said to me 'take a few lines of this and it'll do you better than all these tablets'. I didn't know it was heroin. I didn't even smoke. So that was how it started and I went down to my mother's with my children and I said I have a heroin habit and I have to give up my house. Because if they [social landlord] find out I will never be housed again. I handed them [social landlord] the keys and they said I would be top priority if I ever wanted a house and that was 12 years ago.*

[10] For a more extensive discussion of the causes of homelessness see for example, Halpenny et al, 2002; Houghton & Hickey, 2000; Cox and Lawless, 1999; Fahey& Watson, 1995.

"I was sitting at [family] home with my feet up on the table ...and my Ma said 'take your feet off the table...you wouldn't like it if I put my feet on your head' and I said 'Yea do that and I'll kick your head in'. Now that's when she knew I was on heroin and she said to me square 'I don't want you in the house'... so I was on the streets from there" (Interview 6 - Single Lone Parent with 9 children)

Family breakdown and domestic violence against women were also recorded as triggers. As this interviewee with a child dependent recalled:

"Just a week before Christmas [2002] they put us in a place together with her dad. Stayed there until April and eventually I called the police because he beat me and broke my nose. They arrested him. Then they [HPU] said the room was too big and they moved me to another place in Gardiner Street. I was there for 6 months and then I was offered another place" (Interview 5 - Single Lone Parent with 1 child).

Health Status of Survey Respondents

i) General health

Respondents were asked to rate their own level of general health and their degree of satisfaction with their current health and their quality of life. These details are summarised in Table 5.4.

Table 5.4 Ratings of General Health Status, Satisfaction with General Health Status and Quality of Life

Health Rating	Frequency (%)	Satisfaction with health	Frequency (%)	Quality of Life	Frequency (%)
Excellent	5 (7)	Very satisfied	4 (6)	Very good	1 (1)
Very good	10 (14)	Satisfied	16 (22)	Good	12 (17)
Good	26 (36)	Neither satisfied or dissatisfied	15 (21)	Neither poor nor good	16 (22)
Fair	18 (25)	Dissatisfied	23 (32)	Poor	20 (28)
Poor	11 (15)	Very dissatisfied	13 (18)	Very poor	18 (25)
Missing Data	2 (3)	Missing Data	1 (1)	Missing Data	5 (7)
Total	72	Total	72	Total	72

Only 21 per cent of (15) respondents rated their general health as excellent or very good. Just 20 respondents (28 per cent) were satisfied or very satisfied with their general health and the majority of respondents (38 or 53 per cent) rated their quality of life as poor or very poor.

Forty respondents (56 per cent) had been for a general health check-up in the last three years and 38 (53 per cent) had seen a doctor or medical professional about a specific health problem in the 30 days prior to the survey.

Forty-seven (47) per cent of those who had seen a medical professional for a general health check-up or about a specific health problem had visited a GPs surgery. Twenty-two per cent had accessed a hospital service (e.g. Accident & Emergency or hospital outpatients unit), 16 per cent had sought treatment from an addiction treatment clinic while 2 respondents had sought treatment from the Multi-Disciplinary Outreach Team for Homeless People.

ii) Reported medical conditions

Forty respondents reported having at least one medical condition or illness. The most common self-reported illness was depression (28 respondents or 39 per cent). A further 9 respondents reported suffering from anxiety.

Seventeen women (68 per cent) and 20 men (43 per cent) reported suffering from anxiety or depression. Other self-reported illnesses included high blood pressure (11 respondents) and angina (3 respondents). Another respondent reported having medical problems as a result of a heart attack. One respondent had diabetes and one had had a stroke. Table 5.5 summarises.

Table 5.5 Self-reported Medical Conditions

Type of illness	Male	Female	Total
Angina	2	1	3
High blood pressure	8	3	11
Diabetes	0	1	1
Anxiety	6	3	9
Depression	14	14	28
Heart attack	1	0	1
Stroke	1	0	1
Total	32	22	54

iii) Medication

A total of 31 respondents (43 per cent) were regularly taking prescribed medications at the time of the survey. This represents 64 per cent of women and 32 per cent of men. The use of prescribed medicines was most common among the 26-45 year old respondents; 77 per cent of all women and 39 per cent of men in this age group were regularly taking prescribed medicines.

Twenty-two respondents who self-reported depression or anxiety are regularly taking prescribed medication, however 15 respondents who self-reported suffering from depression and anxiety were not taking any prescribed medications.

iv) Smoking

The majority of both men and women smoke, 87 per cent (41 respondents) and 84 per cent (21 respondents) respectively. Ninety-six per cent of men in the 26-45 year age group smoke cigarettes regularly. Table 5.6 summarises.

Table 5.6 Prevalence of Smoking among Survey Respondents

Age category	Male		Female	
	Smoker	Non-smoker	Smoker	Non-smoker
18-25 years	8	1	10	1
26-45 years	22	1	11	2
46-65	10	4	1	0
66+	1	0	0	0
Total	41	6	22	3

v) Drug Misuse

Twenty-three men and 11 women reported that they had never used illegal drugs while 14 men and 5 women reported that they were currently (in the last 30 days) using illegal drugs. Nine men and 9 women reported that they previously used illegal drugs but were not currently using. Table 5.7 illustrates the gender distribution of smoking and illegal drug use.

Table 5.7 Gender Distribution of Smoking and Illegal Drug Use

	Male			Female			Total
	Yes	No	In past	Yes	No	In past	
Do you smoke	41	6	0	21	4	0	72
Ever used illegal drugs	14	23	9	5	11	9	71*

* Missing data for 1 respondent

The most commonly used drug by former and current drug users was heroin by injection and/or smoking. Twelve respondents had injected and 12 had smoked heroin in the past. A total of 7 respondents had injected heroin and 4 had smoked it at some time in the 30 days prior to the survey.

Other common drugs used by respondents included cocaine (11 respondents in the past, 4 were currently using), ecstasy (10 respondents used in the past, 2 were currently using), cannabis (15 respondents used in the past and 16 were currently using) and amphetamines (9 respondents formerly used and 3 were currently using).

The level of poly-drug use was high, with 10 of the 19 respondents currently using one or more drugs. Eleven respondents were also taking methadone. Table 5.8 summarises.

Table 5.8 Number of Respondents Reporting Lifetime Illegal Drug Use

Drug Use	In past (Frequency)	Current Use (Frequency)
Heroin by injection	12	7
Heroin by smoking	12	4
Cocaine	11	4
LSD (Acid)	7	0
Ecstasy	10	2
Cannabis	15	16
Speed	9	3
Tranquillisers	3	2
Methadone	4	10
Others*	7	0

*Others include solvents and magic mushrooms

Dieting

Three men and 2 women were following special diets at the time of the survey. Two respondents were vegetarians (1 male and 1 female) and one female respondent reported being diabetic.

One male respondent reported being on a low cholesterol diet and one male respondent reported he was following a diet, but did not specify for what reason. None of the respondents were on a weight-reducing diet. Seven respondents were pregnant at the time of the survey.

Body Mass Index

Body Mass Index (BMI) is a measure of body fat based on height and weight that applies to men and women. Experts generally consider a BMI below 18.5 to be underweight and a BMI of between 18.5 and 25 to be healthy. BMIs of 25 to 30 are considered overweight, while a BMI of over 30 is considered obese.

The BMI figure was calculated by dividing the weight (in kilograms) of an individual by their height squared (in meters). Body mass indices in this study were estimated using self-reported heights and weights. While measured height and weight are preferred in calculating a BMI, this study had to rely on estimated heights and weights as more often than not the survey interview environments[11] were not appropriate for taking actual height and more particularly weight measurements. The details are summarised in Table 5.9 below.

Table 5.9 BMI by Age and Gender

	18-25	26-45	46-65	66+	Total
Male					
Underweight	0	1	0	0	1
Healthy	7	18	10	0	35
Overweight	1	4	3	0	8
Obese	1	0	1	1	3
Female					
Underweight	4	1	4		5
Healthy	5	7	1		13
Overweight	1	2	0		3
Obese	1	2	0		3
Missing data	0	1	0		1

A total of 71 respondents provided estimated weights and heights. Of those 6 (8 per cent) were underweight with a BMI of less than 18.5. Forty-eight respondents (66 per cent) had a BMI of between 18.5 and 25, which is a normal body weight.

Eleven (15 per cent) had a BMI of between 25 and 30, that is overweight and 6 (9 per cent) had a BMI of over 30, indicating obesity. The mean BMI for the group was 23.31, which was in the normal range. The mean BMI for male respondents was 23.57, with a range of between 15.58 and 33.93. The mean BMI for female respondents was 22.81, with a range of between 14.38 and 34.73.

[11] All of the interviews were conducted in public spaces, most often in food centres around Dublin city.

Conclusion

The majority of our survey respondents were male (67 per cent). More than half of our female respondents were lone parents. The mean age was 36 and the median length of time out-of-home was 36 months. Approximately 49 per cent of respondents were staying in hostels, 21 per cent were staying in B&Bs, 18 per cent in the Crosscare night shelter, and 13 per cent were sleeping rough.

The majority of respondents rated their general health as good, their satisfaction with their health as dissatisfied and their quality of life as poor. Notably, fewer homeless people (21 per cent) rated their general health as excellent or very good when compared with the general population (55 per cent) (Centre for Health Promotion Studies, 2003).

Eighty-seven (87) per cent of male and 84 per cent of female respondents reported that they smoked. While these rates are high in comparison to the prevalence of smoking in the general population with rates of 28 and 26 per cent in the general male and female population respectively (Centre of Health Promotion Studies, 2003), our survey findings are consistent with the findings from other recent Irish studies with homeless adults. For example, Feeney et al (2000) reported that 84 per cent of homeless men smoked and Smith et al (2001) reported in their study a prevalence rate of 91 per cent among women.

Fifty-one per cent of our respondents 'had ever' or 'were currently' using illegal drugs (49 per cent of men and 56 per cent of women in our sample). Lifetime illegal drug use was more common among younger respondents than older, a finding consistent with Feeney et al (2000).

Twenty-two per cent of homeless adults reported taking cannabis in the 30 days prior to the survey, and although not strictly comparable because of different timeframes, the National Health and Lifestyle Survey (2003) shows that 9 per cent of the general population reported using cannabis. Lifetime usage of cocaine among homeless adults was 15 per cent compared with 3 per cent among the general population (Centre for Health Promotion Studies, 2003).

The mean BMI among the full survey group was 23.31, which falls within the normal range. Walsh (2002, unpublished) also found a BMI of 23 among homeless adults in Galway. This Dublin-based study found a similar incidence of respondents underweight when compared with the Walsh study, 8 per cent and 7 per cent respectively.

Notably, the incidence of obesity (8 per cent) and being overweight (16 per cent) among this sample was lower than that found in the general population in the National Health and Lifestyle Survey 2003 (13 per cent obese and 34 per cent overweight).

The following chapter presents survey findings on food consumption, nutrition intake and the quality of diet among respondents.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 6

Research Findings 2: Data on food consumption, nutrition and quality of diet

Introduction

In this chapter we look at four categories of findings arising from the FFQ. They are:

1. Meal consumption and their frequency;
2. Percentage of sample complying with the recommended number of servings from each shelf of the food pyramid;
3. Food quantities consumed; and
4. Nutrient intake of food consumed.

These four categories of data have been analysed according to age; gender; cumulative length of time out-of-home; accommodation type; current drug use; and smoking.

In addition, the FFQ data has been compared to the findings from the Slán Survey (1999) for the general population and where the data is available, with Slán Survey findings on social class 5 and 6.

Meals and Frequency of Consumption

Respondents were asked how often in the 7 days prior to the survey they had eaten breakfast, a hot main meal, a hot or cold small meal such as soup, sandwiches or salads, or supper. Table 6.1 summarises the findings.

Table 6.1 Respondents Daily Meal Consumption by Accommodation Type

Meal Type	B&B Residents %	Hostel Residents %	Night Shelter Residents %	Rough Sleeper %
Breakfast	27	43	46	33
Hot meal	40	51	38	22
Small meal (hot/cold)	47	43	8	55
Supper	20	31	77	0

More respondents ate at least one hot meal than any other type of meal during the 7 days prior to the study. Approximately 90 per cent ate at least one hot meal in the 7 days prior to the study, 83 per cent ate breakfast, 79 per cent ate a small meal (hot or cold), and 53 per cent of all respondents ate supper.

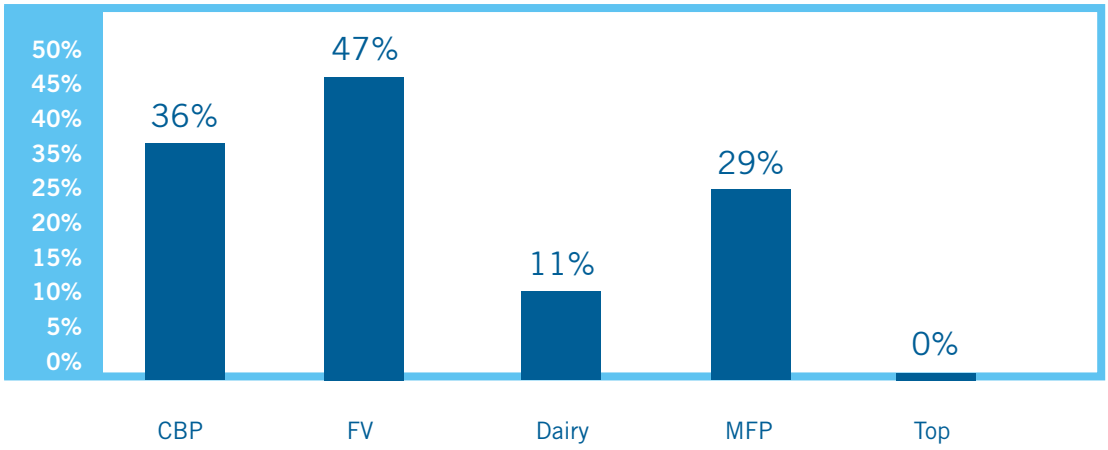
Fewer of the night shelter residents and rough sleepers ate breakfast, a hot meal or a small meal during the 7 days preceding the study than respondents staying in other accommodation types. Although the levels of weekly consumption of each the meals was quite high, daily consumption levels were low. For example, only 27 per cent of B&B residents consumed breakfast while only 22 per cent of rough sleepers ate a daily hot meal and only 8 per cent of the night shelter residents ate a small meal (hot or cold).

Approximately 77 per cent of all the night shelter residents consumed a daily supper. This finding reflects the food provision practice of the night shelter where the interviews were conducted.

Compliance with the Food Pyramid

Data analysis of our FFQ data found that the greatest level of respondent compliance with the food pyramid requirements for a healthy and balanced diet was with the fruit and vegetable shelf of the pyramid. Thirty-four respondents (47 per cent) complied with the recommended 4 or more servings per day from this shelf. Figure 6.1 summarises this analysis.

Figure 6.1 Compliance with the Food Pyramid



CBP = Cereals, breads & potatoes, FV = Fruit & vegetables, Dairy = Milk, cheese & yoghurt, MFP = Meat, fish & poultry, Top = Foods high in fat and sugar.

The second best level of compliance was with the cereals, breads and potatoes shelf. Twenty-six respondents (37 per cent) complied with the recommended 6 or more servings per day.

A total of 21 respondents (29 per cent) complied with the recommended 2 servings per day of meat, fish or poultry and just 8 respondents (11 per cent) complied with the recommended 3 servings of milk, cheese and yoghurt per day.

A significant number of our respondents consumed more than the recommended number of servings from the dairy shelf and the meat, fish and poultry shelf. Forty-six respondents (46) consumed more dairy products than recommended and 28 consumed more meat, fish and poultry products than is recommended.

None of the respondents in this study complied with the recommendation that less than 3 servings per day of high fat and high sugar foods be consumed.

More men than women complied with food pyramid recommendations for the meat, fish and poultry, dairy and fruit and vegetables shelves. In contrast, more women than men complied with the recommendations for the cereal, bread and potato shelf. However, significant statistical differences were not observed between gender and compliance with the different levels of the food pyramid.

Respondents staying in the night shelter accommodation showed the poorest levels of compliance with the food pyramid. For example, only 8 per cent complied with the recommendations on daily meat servings. Twenty-three per cent complied with the recommendations for dairy consumption, 8 per cent with recommendations on consumption of cereals and only 8 per cent complied with the recommendations regarding consumption of fruit and vegetables.

Hostel dwellers showed the greatest level of compliance with the meat, fish and poultry shelf, the cereals shelf and the fruit shelf with 40 per cent, 46 per cent and 63 per cent meeting recommended targets for each of these foods respectively.

Statistical differences were observed between accommodation type and compliance with the food pyramid recommendations for all shelves, except dairy, at p =0.05 (see Appendix 1).

None of the respondents in this study complied with the recommended 3 or less servings of foods high in fat and sugar. In fact, the mean number of servings per day was 13.15 servings (see Appendix 1 for more details).

Quantities of Food Consumed

The FFQ data was analysed to assess the level of consumption of particular foods on a daily basis. Individual foods in the data set were recoded and combined to provide specific food groupings e.g. beef, lamb and pork were combined to give a quantity level for red meats and into more general food groupings e.g. meat products included red meat, processed meat and offal. This was done for all foodstuffs included in the FFQ. Table 6.2 summarises some of the consumption data from the FFQ for all respondents.

Table 6.2 Mean and Standard Deviation of Daily Intake of Foods for all Respondents (g/day)

Food groups	Frequency(n=72)	Percent	Mean amount per day (std deviation)
White bread	67	93	71.76g (30.49)
Brown bread	41	57	35.60g (49.22)
High fibre (inc. porridge, bran etc)	26	36	14.87g (37.16)
Boiled potatoes	48	66	144.26g (134.49)
Roast potatoes	46	64	24.23g (32.35)
Chips	53	74	45.40g (61.51)
White rice	30	42	14.59g (29.34)
White/green pasta	35	49	25.81g (43.53)
Brown rice	3	4	2.66g (15.74)
Wholemeal pasta	3	4	0.67g (3.55)
Green vegetables	66	92	54.29 (44.16)
Other vegetables	68	94	72.56g (54.29)
Pulses	46	64	27.02g (33.15)
Citrus fruit	19	26	10.24g (25.40)
Other fruit	60	83	106.69g (132.97)
Tinned fruit	25	34	9.22g (18.94)
Full fat milk – glass	72	100	247.63g (251.43)
Full fat milk–added to tea/ coffee/hot drinks	67	93	21.81g (7.76)

Food groups	Frequency(n=72)	Percent	Mean amount per day (std deviation)
Full fat butter	48	67	13.89g (11.57)
Sunflower oil spreads	26	36	7.04g (10.50)
Cheddar cheese	55	76	22.04g (25.77)
Soft cheese	10	14	2.13g (7.75)
Egg products	48	66	18.63g (26.69)
Red meat	68	94	134.55g (92.31)
Processed meat	63	87	27.53g (33.23)
Offal	7	10	1.96g (7.59)
Poultry	63	88	31.0g (30.01)
White fish	32	44	12.62g (20.01)
Oily fish	25	35	8.64 (18.08)
Fish products	13	18	1.05g (3.06)
Shell fish	1	1	0.12g (1.01)
Soups	49	68	75.55g (141.26)
Sauces	60	83	28.93g (22.15)
Extracts	5	7	0.35g (1.92)
Spreads	32	44	3.61g (6.33)
Cakes & biscuits	55	76	45.47g (54.16)
Dairy desserts	54	75	43.07g (52.57)
Confectionery	66	92	45.48g (46.25)
Savoury snacks	71	99	18.70g (26.15)
Hot drinks	68	93	3.78g (2.25)
Malt drinks	11	15	0.79g (2.74)
Wines	16	22	14.05g (45.53)
Beers	45	63	291.18g (323.41)
Spirits	26	36	13.79g (30.23)
Fizzy drinks	58	79	191.4g (207.62)
Low calorie fizzy drinks	12	17	28.51g (103.16)
Juices	47	65	60.89g (77.20)
Hot drinks	68	93	3.78g (2.25)

More homeless women than homeless men drank alcohol regularly. However, the mean amount of alcohol consumed by men was significantly higher than that consumed by women ($p<0.001$).

Significant differences in the consumption of beers and spirits were also observed between respondents staying in different accommodation types. Respondents staying in the night shelter accommodation and/or sleeping rough consumed more beer and spirits than respondents in other types of accommodation ($p<0.001$).

The night shelter users reported the lowest quantities consumed across nearly all the food groups including cereals, potatoes, rice and pasta, breads, fruits and vegetables and sweets and cakes. B&B residents reported eating the lowest quantities of red meat, white meat, butter, milk[12], soups and sauces. Respondents staying in B&Bs and/or hostels consumed significantly more vegetables than those staying in the night shelter accommodation and/or sleeping rough ($p<0.006$).

Rough sleepers reported consuming the lowest quantities of fish and the highest quantities of confectionery. Drug users reported consuming significantly greater quantities of sweets and confectionery products than non-drug users ($p<0.005$). Hostel dwellers reported consuming the lowest quantities of cheese (Appendix 2).

The FFQ consumption data was also analysed according to gender, age, current accommodation type, total length of time homeless, current illegal drug use and smoking.

The strongest associations were observed between consumption of alcohol and age, length of time in current accommodation, total length of time homeless, gender, and accommodation type.

The night shelter users consumed significantly greater quantities of wine, spirits and beer than participants staying in other accommodation types ($p<0.05$).

A strong positive relationship ($p=0.001$) between alcohol and age was also observed. That is consumption of alcohol increased with age. There was a significant negative correlation ($p = 0.01$) between age and consumption of confectionery and between age and consumption of fizzy drinks ($p = 0.05$). That is the mean daily amount of cakes and sweets and fizzy drinks consumed decreased with age. Drug users consumed significantly more quantities of confectionery products than non-drug users ($p< 0.005$).

Nutrient Intake among Dublin's Homeless

Our survey was able to establish the nutrient intake of each respondent. The main macro and micronutrient intake for our sample was estimated using the food frequency data and the McCance and Widdowson food tables (Food Standards Agency and Institute of Food Research, 2002). We were able to compare it against the recommended daily allowances for Irish men and women. The Irish recommended dietary allowances (RDAs) for nutrient intake for men and women are set out in Appendix 4. Table 6.3 below summarises data findings on the RDAs and median intake for all macro and micronutrients derived from the FFQ. These are then discussed in more detail in the following section.

[12] A caveat must be added to the analysis of the consumption of full fat dairy products. While respondents were asked to report on the quantities and types of milk and butter consumed during the 30-day period of the FFQ, it should be noted that in many instances respondents were unable to report whether they had consumed full fat or low fat milk and/or butter when eating in food centres or hostels. In many food centres and hostels milk is placed on tables or counters in jugs or flasks and butter is divided into unlabeled or unpackaged portions, therefore, customers do not necessarily know what kind of milk or butter is being served.

Table 6.3 Nutrient Intake of all Respondents from the FFQ (Irish RDAs and median values for macronutrients and micronutrients)

Nutrient	All respondents Median daily intake	Male median intake – g/day (RDA)	Female median intake – g/day (RDA)
Energy (kcals)	2,404	2,457 (2,000-2,500)	2,276 (1,500-2,000)
Protein (g)	93.40	101.61 (.75)	83.97 (.75)
Fat (g)	100.07	104.31	93.77
Carbohydrate (g)	277.8	265.96	294.88
Alcohol (g)	7.9	23.68	0.0
MUFA (g)	29.65	32.63	27.40
PUFA (g)	13.07	13.48	11.88
SFA (g)	41.73	42.63	37.43
Sugar (g)	142.11	128.05	181.69
Starch (g)	129.98	124.54	142.15
Fibre (g)	18.69	18.44 (25-35)	21.56 (25-35)
Vitamin A equivalent (µg)	611.95	666.17 (700)	493.92 (600)
Vitamin B6 (mg)	2.61	2.81 (2.2)	2.09 (2.0)
Vitamin B12 (µg)	5.77	6.06 (1.4)	3.73 (1.4)
Vitamin C (mg)	74.08	73.85 (60)	74.32 (60)
Vitamin D (µg)	2.62	2.87 (0-10)	2.19 (0-10)
Vitamin E (mg)	5.75	5.56 (10)	6.85 (10)
Riboflavin (mg)	1.87	2.09 (1.6)	1.60 (1.3)
Thiamine (mg)	1.64	1.71 (1.1)	1.33 (1.1)
Folate (µg)	251.99	270.46 (300)	231.12 (300)
Calcium (mg)	926.74	1018.48 (800)	866.33 (800)
Iron (mg)	10.83	10.99 (10)	10.37 (14)
Phosphorous (mg)	1552.47	1657.94 (550)	1403.91 (550)
Zinc (mg)	11.58	11.98 (9.5)	9.31 (7)
Selenium (µg)	57.57	59.5 (55)	49.21 (55)

MUFA = Monounsaturated fatty acids
PUFA = Polyunsaturated fatty acids
SFA = Saturated fatty acids

i) Macronutrient intake of homeless people in Dublin

The median daily intake for homeless men in our sample was 2,475 kilocalories (Kcals). This was within the recommended daily range for men and women of 2,000-2,500 Kcals. However, the median intake for women was 2,275 Kcals, higher than the daily recommendation.

The night shelter residents reported the lowest intake levels of fat, carbohydrate and fibre, and rough sleepers reported the lowest median intakes of protein (see Appendix 3 for more details).

Significant variations in alcohol consumption were found between the sexes, between age groups and between respondents staying in different accommodation types ($p<0.01$). For example, the median intake of alcohol among male respondents was 23.68g/day. Alcohol consumption was highest among older men and women (aged 46 plus) while men aged 46 and over recorded the highest median intake of alcohol.

Respondents staying in the night shelter reported the highest median intake of alcohol of all the accommodation type groups. For residents of the night shelter, the median intake among this group was 51.42g/day compared with 7.44g/day for hostel residents and 23.08g/day for respondents sleeping rough. The median daily intake of alcohol among B&B residents was zero (Appendix 3).

ii) Macronutrient intake and contribution to energy

The relative contribution to energy intake among our survey respondents was calculated for protein, fat, carbohydrate and alcohol. The median percentage contribution of each of these macronutrients to energy was less than recommended in the case of carbohydrate and fat and higher than recommended for protein. A similar finding was observed among Walsh's (2002) study of homeless adults in Galway. Table 6.4 summarises these details.

Table 6.4 Macronutrient Contribution to Energy by Gender

Macronutrients	Total % (Mean)	Recommended %	Male %	Female %
Protein	15.51	10	16.19	14.22
Fat	35.7	35	35.55	35.98
Carbohydrate	46.81	55	43.74	52.58
Alcohol	4.9	—	7.28	0.47

Median carbohydrate intake contributed to 46.9 per cent of total energy intake. This is lower than the recommended quantity of 55 per cent. Median male and female carbohydrate contributions to energy intake were quite different with a higher contribution to energy among women (52.1 per cent) then men (42.3 per cent). The median contribution of carbohydrate to energy intake was lowest among the night shelter residents and highest among B&B residents. Notably, both median contributions were lower than recommended (Appendix 3).

Fat contributed to 36.6 per cent of energy intake (median contribution). There was little variation in the contribution of fat to energy intake between the genders, the age groups and respondents staying in different accommodation types (Appendix 3).

The median protein intake contributed to 15.1 per cent to total energy intake. There was little variation in the contribution of protein to energy intake between the genders, the age groups and respondents staying in different accommodation types (Appendix 3).

The median daily alcohol intake for the total sample contributed to 1.9 per cent of total energy intake. There were significant differences found between men and women. For men, alcohol contributed 6.05 per cent of total energy intake yet for women the contribution was zero per cent. The median contribution of alcohol to energy intake also showed considerable variation across the accommodation

types, with the night shelter residents reporting the highest contribution of alcohol to energy (14.1 per cent) and B&B residents the lowest median contribution (zero per cent).

There was a significant positive correlation between age and protein and alcohol contribution to energy ($p = 0.01$) and a negative correlation between age and the carbohydrate and fat contribution to energy ($p = 0.01$ and $p = 0.05$ respectively). A statistically significant association was also observed between accommodation type and alcohol intake and between accommodation type and the contribution of alcohol to total energy at $p = 0.01$.

iii) Micronutrient contribution to energy

Our survey results for micronutrient intake do not take into account additional nutrient contributions from vitamin or mineral supplements and are based on reported dietary intakes only.

All our survey respondents were found to have lower median daily intakes of a number of micronutrients. For example, vitamin A equivalence, vitamin D, vitamin E and folate were lower than the Irish RDAs. Lower median daily intakes of iron and selenium were also observed among women (see Appendix 3 for full details).

Some sharp differences were observed for micronutrient intake levels between respondents staying in the four different accommodation types (see Appendix 3 for more details).

Notably, hostel dwellers consistently reported the highest levels of micronutrient intakes. The night shelter users (all male) reported the lowest daily intakes for a range of micronutrients including vitamin A equivalence, vitamin C (intakes below the RDA), vitamin E, thiamine, calcium (intakes below the RDA) and iron (intakes below the RDA). B&B residents also reported low median daily intake levels across a range of micronutrients including vitamin B6, vitamin B12, vitamin D and riboflavin.

The FFQ nutrient data was analysed according to gender, age, current accommodation type, total length of time homeless, lifetime illegal drug use and smoking.

The strongest associations were observed between age and daily intake of a range of nutrients. Strong negative associations were observed between age and daily energy, fat, fibre, vitamin E, and calcium intakes. That is intake of these nutrients decreased with age. The contribution of fat to total energy also decreased with age.

In contrast, daily intakes of alcohol and vitamin B12 increased with age, as did the percentage contribution of both protein and alcohol to total energy (see Appendix 3 for more details).

Pregnant women in our survey sample consumed significantly less of a range of macro and micronutrients than women who were not pregnant, including fat, starch, vitamin B12, vitamin D, iron and selenium ($p<0.01$)[13].

Current drug use also proved to be a significant factor in the consumption of a range of macro and micronutrients. Current drug users consumed significantly more kilocalories, protein, fat, carbohydrates, sugar, thiamine, riboflavin, vitamin A, phosphorous, calcium and zinc than non-drug users.

[13] It should be noted that the number of pregnant women in the sample was only 7.

Conclusion

Our analysis of the survey data clearly showed that homeless adults in Dublin were vulnerable to a poor diet. The data indicated poor compliance levels with the recommendations of the Irish food pyramid, higher consumption of foods high in fats and sugars and lower intakes of a range of micro and macronutrients than the general population and social class 5 and 6.

The level of compliance across all shelves of the food pyramid was poor and none of our respondents complied with the recommendations on foods high in fats and sugars. Significantly, accommodation type was found to influence compliance with the food pyramid. Our survey findings confirmed that the night shelter users and rough sleepers were least likely to comply with the food pyramid recommendations.

The findings from Walsh's (2002) study among homeless men and women in Galway also indicated low levels of compliance with the top shelf of the pyramid. Notably, the Walsh study showed that compliance with the dairy and meat, fish and poultry shelves was considerably higher at 80 per cent and 50 per cent respectively.

The level of compliance with food pyramid recommendations among our sample of homeless households was lower across all the food groups when compared with 1999 Slán Survey data for social class 5 and 6 in the general population. For example, the level of compliance with the dairy shelf of the food pyramid among our respondents was 11 per cent. This was considerably below the reported 21 per cent level of compliance among social class 5 and 6.

For quantities of food consumed the night shelter users reported the lowest consumption levels across nearly all the food groups including cereals, potatoes, rice and pasta, breads, fruits and vegetables, and sweets and confectionery.

Age proved to be a significant variable in the consumption of a variety of foods and beverages. Younger people were more likely to consume confectionery, cakes and biscuits and fizzy drinks than their older counterparts whereas older men, in particular were more likely to drink alcohol. It was found that drug users consumed significantly more quantities of confectionery products than non-drug users.

The quantities of white bread, full fat butter, poultry, and fruit consumed by homeless respondents in Dublin were very similar to the amounts consumed by homeless men and women in Walsh's (2002) Galway survey. Although, respondents in Galway reported consuming higher quantities of vegetables at 157 g/day compared with 126.85 g/day in Dublin. Consumption of fizzy drinks, confectionery, cakes, biscuits and dairy deserts was higher in Dublin than in Galway.

It was found that the proportion of homeless adults consuming white bread, fried potatoes, red meat, processed meat, confectionery, savoury snacks, beer and fizzy drinks was higher than that reported among the general population. The mean daily amounts consumed of these foods were also higher among homeless respondents than in the general population.

The mean daily amounts consumed of brown bread, brown rice and pasta and high fibre foods as well as the actual percentages of our survey respondents eating these food items was considerably lower than that found among the general population.

Consumption of all types of fish was particularly poor among homeless respondents. Less than half reported eating white fish compared with nearly 80 per cent in the general population. The mean daily amount of fish consumed by homeless respondents was approximately one-third the mean daily amount consumed by the general population.

Although the percentages of homeless respondents that reported consuming green vegetables, other vegetables, pulses, other fruit, and tinned fruit were comparable with general population frequencies for consumption of these foods, the actual mean daily amounts consumed by homeless adults were considerably lower than was found among the general population.

In the consumption of macronutrients, median protein intake was higher than the recommended quantity of 10 per cent, but lower than that reported for the general population (17 per cent). However, the median protein intake among rough sleepers in our survey was similar to levels found in a recent UK study among homeless adults (Evans & Dowler, 1999).

Intakes of protein, carbohydrate and fibre were all lower among homeless adults than intake levels found in social class 5 and 6 of the general population. However, daily median fat intakes were higher than that reported for social class 5 and 6.

The fat contribution was slightly higher than that found for the general population but was very close to the recommended proportion of 35 per cent as set down in the Framework for Action Nutrition Plan (Health Promotion Unit, 1991).

We found lower intakes of starch, fibre, vitamin A equivalence, vitamin D, vitamin E, folate and iron, which indicated low consumption levels of pasta and rice products, wholegrain cereals, fruit and vegetables especially green leafy vegetables, fish especially oily fish, cereal products, and diary products.

Age proved to be a significant variable in the consumption of a range of macro and micronutrients. Older men and women had lower intake levels of fat, fibre, vitamin E and calcium than younger men and women.

Accommodation type also proved important. Respondents staying in the night shelter consistently reported lower intakes of a range of micronutrients. Significant differences were observed between accommodation type and consumption of alcohol, fibre and vitamin B12 ($p<0.05$).

Substance misuse was found to be a significant factor in the consumption of foods high in sugar and in the consumption of a range of macro and micronutrients including fat, protein, sugar, carbohydrates, starch, phosphorous and calcium.

Low intakes of folate, fibre and vitamin E were also observed among homeless respondents in Walsh's (2002) Galway study.

Significantly, although micronutrient consumption among our survey respondents met or exceeded Irish RDAs for a range of vitamins and minerals (e.g. the B vitamins, vitamin C, calcium, zinc and iron), the reported median daily intake levels among our sample of homeless adults remained lower than that found among both the general population and among social class 5 and 6 in the1999 Slán survey (Friel et al, 1999).

The following chapter presents findings on the lived experience of food poverty among our study participants.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 7

Research Findings 3: Data on the lived experience of food poverty among people who are homeless

Introduction

This chapter looks at the findings arising from our survey questionnaire and the series of in-depth interviews about issues of access to kitchen facilities, food preparation and food storage facilities, and the coping mechanisms respondents used for their individual situations. It also presents details of food expenditure and the shopping patterns and practices among our sample of respondents.

Access to Kitchen Facilities

Out of a total 72 survey participants, only 29 (40 per cent) had access to some type of kitchen or food preparation area. Of those 29 with access, 25 had access to a communal or shared facility, 3 had private kitchen facilities and 1 respondent had an area in his bedroom in which to prepare basic foods.

Sixty-seven (67) per cent of respondents staying in B&Bs and 51 per cent of hostel dwellers had access to kitchen facilities. One respondent who was sleeping rough had access to shared kitchen facilities in a day-centre that he attended. Twenty (20) per cent of B&Bs users had access to a private kitchen. The respondent with food preparation facilities in his bedroom was staying in a hostel. Table 7.1 summarises.

Acc. type	Communal	Private	Area in bedroom	Total (per cent)
B&B	8	2	0	10 (67)
Hostel	16	1	1	18 (51)
SR	1	0	0	1 (1)
Total	25	3	1	29 (40)

Survey respondents were asked to report on their ability to access a range of food storage and preparation facilities and cooking utensils. Thirty-one respondents (43 per cent) had access to an electric kettle, 28 (39 per cent) had access to a hot plate or hob cooker and, 12 (17 per cent) had access to a microwave. Respondents staying in B&Bs were more likely to have access to a kitchen/food preparation area. See Table 7.2 below.

Table 7.2 Access to Cooking Utensils

Cooking utensils	Frequency (n=72)	Per cent
Hot plate/hob cooker	28	39
Oven	24	33
Microwave	12	17
Electric kettle	31	43

Cooking utensils	Frequency (n=72)	Per cent
Stove kettle	2	3
Toaster/grill	30	42
Refrigerator	22	30
Freezer	8	11
Pots/pans	24	33
Plates/cups/cutlery	23	32

Issues of access to food storage, preparation and cooking facilities in emergency accommodation - particularly hostels and B&Bs - were explored in more detail through the in-depth interviews and FGD.

What emerged was a range of varied experiences, some illustrated difficulties faced by homeless person's residing in emergency accommodation whereas others reflected somewhat more positively. For example, some interviewee's were very direct about the overall quality of experience offered by some hostels:

> *"The hostels? Some are terrible. The system is loaded against single people. If you are not a family unit, you pay more. My family unit now has gone - split up, we are split up for a simple reason. We can't get a house. Going on for five years now. This battle has gone on since then and I am getting a house next week – signing the licence on Friday. But 'P' is now with my mother-in-law. The kids are there five years I have not seen or slept with my kids in a house since Christmas five years ago and that is our family unit split"* - Focus Group Interviewee

> *"The XXXX[14] - Oh that's a dangerous place that one - full of junkies. They would knife you like. That's right! You have to go in looking bad. You have to bring everything you possess to the shower with you because you cannot trust anyone. Sleep in your clothes. There's no food. You are not allowed to bring any in. A terrible experience - you are in fear of your life. Show a bit of weakness and they are like wolves in a pack. Tear you to pieces"* - Focus Group Interviewee

Other interviewees offered an alternative overall perspective. One interviewee concluded:

> *"I feel the [hostel] system, has been good to me over here. In all fairness they did make sure I had somewhere to stay and a shower and food when I needed it, which I don't think you would get in England – not so easily available"* - Interviewee 7

> *"About 12 is when the dinners come in. Every morning there's cornflakes, Weet-a-bix, fresh bread and sugar, tea bags and so on. Its grand but sometimes people use all the milk"* - Interview 6

Some very strong expressions of discontent were articulated through the in-depth interviews about the type of facilities available in emergency accommodation, particularly in B&Bs. Notably, issues concerning food preparation and hygiene, safe and secure food storage and cooking facilities and opportunities to cook were to the fore of interviewee's dissatisfaction. Commonly, there were shortages of appropriate cooking facilities sufficient to the numbers residing in the accommodation. As one interviewee put it:

> *"There are four gas cookers and eighty rooms in the B&B - all full. Know what I mean? There is no fridge or freezer [in the kitchen] just four cookers and a sink. It is untidy and I worry about*

[14] For the purposes of this report, the names of hostels, food centres, and cafés have been anonymised

hygiene. To be honest with you I wouldn't cook there. As you know yourself it's illegal to leave three kids on their own in a room - I can't go down to the kitchen so I have to take them out. I am feeding them out every day" - Interviewee 2

Other interviewees raised a number of points about the general conditions of some of the B&Bs they had experienced. These related to the size of rooms, the bathing and toilet facilities and the number of people residing in rooms, often in overcrowded conditions:

"There is a toilet and a shower room. There are bars on the doors. You get more freedom in a prison. He's [partner] in the bed with the two boys and I am in the single bed with the baby. He's only a new baby and there is a girl on the opposite side to me with a new baby. So you get screaming and shouting and its not helping. I have to keep them in constantly or I have to take the three kids up to Ballymun every day. Up to me Ma's if it's fine - stay in me Ma's for a couple of hours. Just to get out" – Interviewee 2

Food Storage

Only 39 per cent of our survey respondents had access to and use of a hot plate or hob cooker, 30 per cent had access to and use of a refrigerator, while only 11 per cent had access to and use of a freezer. These deficiencies were noted again in interviews, where the most common complaints related to the lack of food storage and cooking facilities:

"Storage? You just keep it [food] in your room" - Interviewee 5

"You keep your food in the room. You can't keep dairy products 'cos they go off. So you have to buy stuff that is long life and it's got additives or you can stick it out on the window ledge and let the pigeons shit on it. That's the choice – desperate" - Focus Group Interviewee

"There were no cooking arrangements in XXXX [hostel]. In the morning, you get cereal and any sandwiches that are left over from the night before. It's a token breakfast – yeah, "continental!" You aren't having a cooked meal. It's generally OK but clinical, institutional - with security guys at the door. You could bring [food] things in, but you had to keep it on your person" - Interviewee 7

Communal Facilities

The overwhelming majority of the survey respondents that had access to and use of kitchen facilities were sharing those facilities with other residents (approximately 86 per cent). Communal and shared storage, cooking, preparation and washing facilities were viewed as causing significant problems. The most commonly identified problem was theft of food – particularly food interviewees had purchased themselves:

"The people at the hostel put a bit of pizza in the fridge for me and the next night I could have killed for my pizza but it was gone … such and such a girl had said it was hers. So I went over and said to her "that's mine". Two hazelnut yoghurts also – they left the two flakes there, but they took the yoghurt. I wouldn't mind but the staff go in the room with you when you get things from the fridge but why couldn't they cop on that [food] was mine?" - Interviewee 6

"It was a shared kitchen. It was OK. You had your cooker and your washing machine but when the washing machine broke it took three weeks to get it fixed [laughs]. We had a small fridge for 8 people and there was one shelf for the family. The sharing was difficult. I was in a small room with nowhere to store food…it could get very frustrating, in anyway, when they are getting the same money as you and they are spending it on tablets and eating your food. I found the people who stole were the tablet users - they were happy with cornflakes. If they had children the

yoghurt would go - but we did not have that for a while because I got annoyed with one girl so much that anyone who came in I told them straight off no stealing from the fridge. It sounds awful, but if I was nice to them they would take 10 miles." – Interviewee 4

"People would steal anything from you – especially food, mobile phones, cigarettes. If you had a packet of cigarettes you would keep them closely guarded because people were always asking you for a cigarette. No point complaining, nothing's done" - Interviewee 7

Issues of hygiene and the implementation of regulations governing the use of shared cooking facilities were also commented upon forcefully.

"People stand there smoking while they are cooking food. I have no choice. If I was doing potatoes or chicken or veg soup I have to bring everything back down to the bedroom to lift it up [to eat]. Ridiculous".

"It's on the rules that if you make a mess you clean it. I get very paranoid if there is any dirt and I clean it up right away – it's where the kids are eating so I said to him [landlord] you want me to feed my kids in that? Well no. God only knows I am using bathroom water for the baby – the kitchen closes at half eight. And after that I can't get water and I am using bathroom water, which I have to boil three times. But he [baby] has been constipated a lot and I think its through the water - so I am going down at twenty five past eight just before he closes the kitchen to fill the kettle so that I can give him [baby] his bottle during the night and then I go down again in the morning when he opens the kitchen. It isn't fair on the kid" - Interviewee 2

"It was disgusting – no hygiene. You had to share a bathroom and shower and there would be all blood on the towels – it was hard; syringes under the toilet. Then we kept asking to get moved" - Interviewee 5

Where hygiene, food storage and kitchen cooking facilities were not considered injurious and unhealthy for interviewees it was agreed that this was rare and usually associated with the combined efforts of B&B management and residents.

However, the rate of throughput of different persons in emergency accommodation was identified as a disruptive influence to such efforts and could often lead to a diminishment of good practices by B&B management.

Rough Sleeping

For interviewees with an experience of rough sleeping, their approach to food consumption was part of a wider set of coping practices indicative of survival strategies for living on the street. Ability to cope is strengthened by way of increased knowledge of what food services are available. One interviewee demonstrated significant determination to remain self sufficient while 'learning the ropes' in this regard.

"When I was sleeping rough at first I was carrying a stove, fuel, food, cutlery, and it was too heavy so I stopped. I was carrying a big bag. Too much. You have to cook in the open and of course you have to buy the stuff. If I know [now] where to go to get a hot drink in the morning then I don't have to carry a flask. Sometimes I have an orange in the bag or a bar of chocolate. I do not normally have [carry] food now because I can get fed elsewhere" - Focus Group Interviewee

For another interviewee, the experience of sleeping rough more or less eliminated the ability to maintain a healthy and regular diet.

"I was [sleeping rough] for about five months. Sleeping with other people. It makes things safer but there is no eating with people - just trying to stay warm and go to sleep" - Interview 1

Expenditure on Food

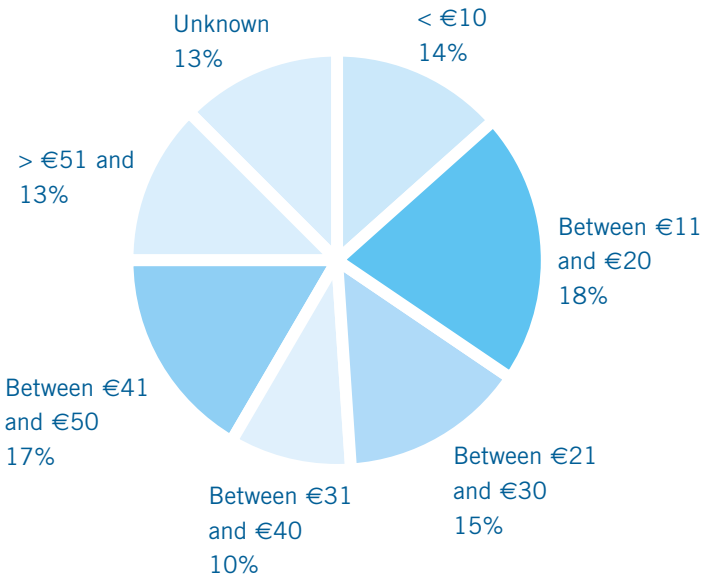
Survey respondents reported on their food expenditure during a typical 7-day period, they were also asked to consider the types of foods they regularly bought and where they bought these foods. These themes of cost, access and availability were further explored during the FGD and in-depth interviews. There was considerable variation in expenditure on food. Ten (10) respondents (14 per cent) spent less than €10 per week on food while at the other end of the spectrum 9 respondents spent more than €51 per week.

Women spent more on food than men and a negative association between age and food expenditure was observed, that is the older the homeless person the less was spent on food on a weekly basis.

The majority of respondents that spent in excess of €41on food per person per week were adults caring for children. Six lone parent households and 2 dual-parent households spent in excess of €41on food in a typical week. The majority of the 10 respondents that spent less than €10 per week on food were single with no dependents (8 respondents).

Hostel dwellers included in our survey were found to have spent the least on food. This may be because in many hostels meals were provided as part of the accommodation fee. One in four of the hostel dwellers included in our survey spent less than €10 or between €11 and €20 in a typical 7-day period on food – confirmation that some form of food provision is associated with this category of accommodation. Figure 7.1 summaries the data.

Figure 7.1 Amount Spent on Food in Typical 7-day Period



By comparison, a larger proportion of rough sleepers and B&B users spent a greater amount of money on food during a typical 7-day period than any other group. Fifty-five per cent of rough sleepers and 53 per cent B&B dwellers spent in excess of €31 on food on a weekly basis.

The amount of money spent on food among the male night shelter population was also very low. The male night shelter respondents interviewed for this study were using a low-threshold shelter (i.e. residents with high support needs will be admitted) that accommodated chronic street drinkers on a night-by-night basis. Many of these men relied solely on the food provided by the night shelter and any disposable income appeared to be spent on alcohol. Table 7.3 summarises these findings.

Table 7.3 Weekly Food Expenditure by Accommodation Type

Amount spent on food	B&B	Hostel	Night shelter	SR	Total
<=€10	1	3	5	1	10
Between €11 and €20	2	11	0	1	14
Between €21 and €30	3	7	0	1	11
Between €31 and €40	1	2	1	3	7
Between €41 and €50	4	7	0	1	12
>€51	3	5	0	1	9
Don't know/can't remember	1	0	7	1	9
Total	15	35	13	9	72

The cost of food and the amount of disposable income that was spent on food was a central issue explored by FGD participants and in-depth interviewees. The reality for our interviewee's was that net disposable income for expenditure on food was constrained by overall income inadequacy – poverty in other words. The cost of food was therefore of significant ongoing concern.

> *"I get €214 a week and I have to make sure there is money there all the time. I say to the welfare officer "You try living on it". I said you try it with three small toddlers. I don't think so. I used to spend €60 for Dunne's or Tesco's - that was my limit and that was my shopping in from one end of the week to the next"* - Interviewee 2

> *"If you are paying for a hostel and you are paying for food [at the hostel], then you have to use the rest of your money to buy more food. You have to pay rent [to the hostel] and for the meal – so you shouldn't have to go hungry but you do. It's not fair that that the little bit of money that you get is wasted [on extra food]. You can't even afford to clothe yourself then"* – Focus Group Interviewee

Case Study One

Jane is 25 years old and the mother of a 2-year old toddler. She and her daughter have been homeless for 9 months and are currently staying in a city centre hostel, costing approximately €9.00 per week. Jane and her daughter eat breakfast at the hostel but she generally likes to get out during the day and usually eats at one of the food centres in town - although it is sometimes difficult to manage a toddler in that environment. Jane is able to cook at the hostel in one of the communal kitchens and she does so most nights. Jane spends approximately €90.00 on food per week for her family - Jane tends to shop in one of the larger chain supermarkets or the local market. She receives approximately €175.50 per week in statutory payments including lone parents allowance (€124.80), dependent child allowance (€19.30) and a children's allowance payment (€29.40). After her weekly food and accommodation costs are met, Jane and her daughter have €85.50 per week left from their welfare income to meet other costs.

The affordability and cost of food, particularly staple foods is becoming more of a consumer issue for Irish society yet the real impact of 'unaffordable' food on the poor can be illustrated when issues of the cost of a health-related diet are considered in the context of overall income inadequacy.

> *"I used to get €138 and when your baby is on baby food and on a special diet – low fat food because of her heart condition - and I am only left after nappies with €15 a week. Now I know I smoke but less than ten a day. You can't borrow off anyone because they won't trust you. When you are homeless for so long you lose all your confidence to ask anyone for anything. I haven't had food for days and never asked anything off anybody"* - Interviewee 6

Case Study Two

John is 46 years old. A single man he has been homeless for 5 years. John is currently paying €45.50 per week to stay in a dormitory room in a city centre hostel. John receives €124.80 per week on the dole. Although meals are provided at his hostel, John spends about another €35.00 per week on food, drinks and snacks. John is left with approximately €44.30 to meet the costs of his remaining weekly expenditure.

Financial exclusion is another common experience for homeless people. With no access to formal banking or credit facilities, money management is challenging and homeless people regularly become indebted to pay for basic food and clothing items. This is despite the fact that many people adjusted their food consumption patterns to fit their food budget.

> *"I get my [welfare] cheque on Wednesday. Yesterday I was short and I don't smoke or drink. It used to cost me €40 a week to smoke. If you are on €118 that leaves €80. A drink for one night in a pub costs €40 because you might have chips too. You might be €3 in for the bus fare and that leaves you €40. I don't know how people with children do it. But things are bad and you have to rely on tic [credit] with moneylenders"* - Interviewee 3

Notably, not all homeless persons will spend scarce resources on food. Sometimes people will resort to petty larceny to meet their needs, supplement their diet or purchase more expensive and preferred foodstuffs.

> *"Because I wasn't paying I used to get the really nice orange juice like Tropicana. Just stole loads of food - we ate well and you are talking all day around. I would not have been able to do it [eat well] without robbing"* – Interviewee 5

Case Study Two

Mark and Paula have been homeless with their 2 children for the last 13 months. They are currently staying in a B&B just outside the city centre. Mark and Paula receive approximately €304 per week; €124.80 from the dole, €82.80 qualified adult allowance, €33.60 child dependence allowance and a further €62.80 children's allowance. Mark and Paula have access to a communal kitchen in their B&B and since few of the food centres or subsidised cafes have opening hours that are convenient for them with the children's school times, they mostly cook in the B&B. They spend about €175 per week on food. The nearest shop to the family is a convenience shop attached to the local petrol station, but they only buy milk and bread there if they run out because it is so expensive. Although they have no car Mark and Paula generally try to do a weekly shop in the nearest large supermarket which can be reached by bus or taxi.

Shopping for Food

Our survey respondents were presented with a list of 8 general food items and asked to consider if they bought these food types regularly[15] and if so, where they bought them. Respondents were asked to consider these purchases in terms of consumption or preparation of these foods and to exclude purchases made in food centres, commercial or subsidised café's. Food purchases made in these in centres were excluded as the food is usually provided free or at a reduced price and does not always reflect the true costs of food shopping. Foods included in the list were:

- Milk/tea/coffee
- Bread
- Sweets/cakes
- Fresh meat/poultry
- Fresh fish
- Fresh fruit and vegetables
- Dried goods (e.g. pasta, rice etc)
- Dairy produce (e.g. cheese, yoghurt etc)
- Canned foods (e.g. vegetables, fruit etc)
- Microwave foods (e.g. ready meals etc).

Fresh fruit and vegetables were the foods most regularly purchased by respondents with 46 respondents purchasing them regularly. Thirty-six (36) respondents (50 per cent) regularly purchased sweets and cakes, 35 respondents (49 per cent) regularly purchased milk/tea/coffee and 29 respondents (40 per cent) regularly purchased bread. The results are presented in Table 7.4.

Table 7.4 Regularly Purchased Foods

Food items	Frequency (n = 72)	Percent
Milk/tea/coffee	35	49
Bread	29	40
Sweets & cakes	36	50
Fresh meat/poultry	13	18
Fresh fish	3	4
Fresh vegetables & fruit	46	64
Dried goods	9	13
Dairy products	38	53
Canned foods	14	19
Microwave foods	10	14

Respondents who regularly purchased the food items listed in the table above tended to source them from a variety of retail outlets. Most commonly used outlets included chain supermarkets including Tesco's, Dunnes Stores, Superquinn or Supervalu (40 respondents). Other commonly used outlets included local supermarkets such as Spar, Centra and Mace (27 respondents), low-cost supermarkets such as Lidl, Iceland and Aldi (8 respondents) and finally, the markets in and around Dublin city centre were frequently used by respondents to purchase fresh fruit and vegetables (14 respondents).

[15] Purchase of one or more of these food types at least once per week

The interview enquiries highlighted a number of issues in relation to the shopping and retailing habits and patterns of homeless people. Unlike most 'ordinary consumers' they faced issues other than choice of brand considerations when they went shopping. Many factors impacted on the shopping and retailing experiences of homeless people, for example the ability to store food safely and securely often determined whether a homeless person went shopping at all.

> *"We buy ourselves food sometimes. It's not great. Everything gets stolen really" [refers to theft of food from communal kitchen/ fridge]* - Interview 6

Notably, knowledge of how to maximise value-for-money by using discount bulk providers (e.g. Aldi or Lidl) or other discount shops (e.g. Iceland for frozen food) did not offer as easy a solution to the purchasing needs of interviewee's as it may do to other consumers. This was primarily due to an inability to store food safely and in a secure manner or to consume the bulk purchase prior to it spoiling. Also, these retail outlets did not offer the full choice of foodstuffs or the range of brands of food-type required or demanded by the individual or household:

> *"I find Iceland is better than all of them [for value for money] but the problem is I do not have a fridge"* - Focus Group Interview

> *"I tried Aldi's but it wasn't good. The stuff was quite OK but you could not do all your shopping there"* - Interview 4

An individual item may be cheaper when purchased in bulk but as one interviewee put it 'there are only so many beans you can eat'. Notably, all interviewees had a keen awareness of issues of value, choice and convenience when it came to 'high-street' food retailing. For example, Marks and Spencer's was considered to offer the highest quality food and greatest convenience but at the highest cost. Tesco's was considered to have the best range of products but Dunne's was considered cheaper for the staple foods and products that form the majority of the household's weekly basket of goods, particularly for households with children. Spar, Centra, Mace and other convenience stores were considered expensive and poor value for money but were relied upon for later opening hours and when transport and mobility curtailed the amount of shopping done in one trip.

> *"I like Marks and Spencer – quality. But with Tesco's you can do all your shopping in one place"* - Interview 3

> *"Dunne's are cheaper than Tesco's. I go in there for nappies and its three bags I'm buying and its €40 to €50 whereas in Tesco's its €70 or €80"* - Interview 2

> *"I only shop at Spar or Centra – it's a rip off but they're the only ones open when I need them"* - Focus Group Interview

The experience of the use of convenience stores was more common among single adults who were homeless. Notably, the use of local stores was not uncommon, especially where a customer was able to build up a relationship with a local vendor and seek out credit facilities via the use of a 'slate'.

> *"I want to tell you about XXXX in Dun Laoghaire. He is a little tiny shop but he doesn't close - even on September 11th [he didn't]. He doesn't have a door - only a shutter and he sleeps at the back of the shop. If you go at 1 o'clock he gives you a free paper. I don't go around looking for cut down prices but I had 60 cent in my pocket and I didn't have enough for a bar of chocolate in Centra – so I got it with him cheaper. This is a big multi-national Centra and they can't give you chocolate at the same price as the little shop"* - Interview 3

The use of fruit and vegetable markets was also common among respondent's some of whom stated they would seek out fresh fruit and vegetables on a daily basis via the markets. Value for money was a big factor in the use of markets but so too was the ability to develop a relationship with a stall-holder who offered discounts on certain items or additional amounts of food for a lesser price.

> *"Can I say something that you might find interesting? I have a wife and five kids living in Drumcondra with my mother-in-law and XXXX [ex-wife]; she would do her shopping in Tesco in Phibsboro, and often I help her, help her carry it home. I cannot believe the bills at the checkouts that she pays and then I think Holy God that would do me for .... I am thinking of myself you know, thinking of what I am surviving on and I just can't, like I can't ...and I think ... the trouble is it's the only place that she can go to. So I regularly bring stuff down from Thomas Street [market]. Regularly bring stuff down. I can get a bag of fruit up there for her for half what she pays"* - Focus Group Interview

Interviewees also reported that they were regularly faced with issues of access as they seek to shop for food and clothes. It was a common experience for interviewees to be refused access to shops on the basis of their attire and appearance or on the basis of suspicion of theft and shoplifting. One interviewee reported that she was refused access to a shop by security on the basis that she would not be able to afford to buy anything that was for sale within.

> *"I still do the cereal and milk thing but I got barred from one shop because I took a plastic spoon and yer man, security man said I am taking your name. I said if you want to call the Guards, call them. He said you are barred. I had to buy a multi-pack of plastic spoons!"* - Interview 3

> *"I walked into a shop the other day and they told me I was after being radioed down from one end of town to the other 'Youse are no go'. You can't shop in peace"* - Interview 6

Conclusion

What becomes apparent from our quantitative and qualitative analysis of survey and interview data, is that the extent and experience of food poverty among homeless people is not only conditioned by issues of income inadequacy and other socio-economic and cultural determinants, but particularly, by access to accommodation, as well as the quality of that accommodation (in terms of its utility functions and service provision).

Our questionnaire survey research found that a strong relationship exists between the extent and experience of food poverty and the type of accommodation a homeless respondent had both access to and use of. This was the case for respondents accessing a spectrum of accommodation. Forty (40) per cent of respondents had access to kitchen facilities. Respondents staying in B&Bs were more likely to have access to kitchen facilities than other respondents.

However, respondents expressed concerns on a number of issues about communal kitchen facilities including food theft, poor hygiene, over-crowding and lack of privacy, and regulations governing hours of access. These same issues have been raised in previous studies, for example Halpenny et al's study (2002) of homeless children and their parents explored some of these issues in relation to the appropriateness of B&B accommodation for families with children.

The issue of cost influenced the food shopping practices and patterns among interviewees. Of our sample, only two persons were in employment, one part-time and the other full-time. The incomes of the rest of the respondents were all based on social welfare entitlements. This helps place the poverty position of our respondents into context. The main changes to welfare in Budget 2003 increased personal payments from between €6 and €10 per week. This was equivalent to a 5-7 percent rise. Child dependent allowance rates did not change (as they have since the mid-1990s) but child benefit was increased by €8 per month (a weekly equivalent of €1.84). The income thresholds for family income supplement were increased by €17 per week (worth up to €10.20 per week in cash terms).

Although the increases were in the range of 5 to 7 per cent - in line with the expected rate of annual inflation of 5 per cent, other policy decisions, for example higher indirect taxes and VAT, in Budget 2003 have eroded the poverty position of our respondents and have disproportionately impacted on lower-income groups.

However, cost was not the only issue that influenced shopping practices; personal mobility, location and restricted access due to staff perceptions were also key concerns.

The following chapter details the participant's experiences of using homeless services in Dublin.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 8

Homeless Food Provider's Services: Issues of access, use and quality

Introduction

This chapter introduces the findings from our survey/audit of homeless food service providers. The findings from the audit placed the physical provision of services into the broader context of service access and use as highlighted by our survey respondents and interviewees.

This chapter presents details of the participant's experiences of using homeless food services in Dublin, also included are details of where respondents ate their meals.

Audit of Dublin Homeless Food Service Providers

This study sought to explore issues of access to homeless food service providers and their use by our survey participants and interviewees. In parallel, we also undertook a small-scale questionnaire-based audit of food centres and homeless service providers in Dublin city.

A total of 18 key food providers in and around Dublin city were identified and included in the audit of homeless food service providers. The purpose of the audit was to illustrate the type of service provision available to people out-of-home and the types of foods on offer.

A total of 15 food providers responded to the questionnaire-based audit. Seven services were food services only and 8 provided food and accommodation.

All services provided food for homeless households, but four services reported that they also catered for other households in poor circumstances. Five of the services audited provided food for all types of homeless households, including those with children. Two food services provided for homeless adults only, two more for homeless men only and another two for homeless women only. Both of the latter services were delivered as part of hostel accommodation.

Eight of the services included in the audit were open 7-days a week, all year round. Three were open 7-days a week except on bank holidays, two were weekday services only. Another two services were available from Monday to Saturday only.

Eight of the services charged for the food provided. In three service providers the food served to customers/clients was made available as part of the accommodation service. Four service providers were identified where food was available free of charge. The mean cost charged for food (hot lunch or dinner) was €1.25.

The cost of food charges ranged from €0.25 to €2.50 across those providers that levied a charge. Table 8.1 summarises.

Table 8.1 Typology of Homeless Food Service Providers

Services available	
Food service only	6
Food & accommodation service	8
Day Centre	1
Service user profile	
All homeless households	5
Homeless adults only	2
Homeless men only	2
Homeless women only	2
Homeless households & those in poor circumstances	4
Frequency of service	
Daily	8
Daily except bank holidays	3
Weekdays only	2
Monday-Saturday	2
Charge for food	
Yes	8
Food provided as part of accommodation package	3
No	4

Food Provision

The majority of homeless food service providers appeared to offer a good range of foods to their service users/ customers. They offered a range of breakfast cereals high in fibre (7 out of 15 services) and also offered the choice of brown bread (9 out of 15 services). Almost all food providers served vegetables and just over two-thirds served fruit. The provision of red meats, poultry and fish - all good sources of protein and a range of vitamins and minerals - appeared to be good, with 10 out of 15 service providers offered a range of these products to their customers.

In contrast, there was limited availability of low-fat dairy products including milk, butter and/or yoghurt while nearly all service providers provided sweets, confectionery and savoury snacks from the top shelf of the food pyramid.

Use of Homeless Food Service Providers

Survey respondents sourced meals from a variety of locations including the respondent's own accommodation, through subsidised cafés such as Focus Ireland or Failtiú, commercial cafés and occasionally in the homes of friends or family. Table 8.2 summaries these findings.

Table 8.2 Place of Meal Consumption

Place of consumption	Breakfast (Per cent)	Hot Meal (Per cent)	Supper (Per cent)	Small Meal (Per cent)
In accommodation	38 (53)	17 (24)	15 (21)	31 (43)
Subsidised Café	9 (13)	30 (42)	6 (8)	1 (1)
Commercial Café	1 (1)	2 (3)	8 (11)	2 (3)
Home of friends / family	1 (1)	1 (1)	1 (1)	0
On the street	1 (1)	0	11 (15)	2 (3)
More than one provider	10 (14)	15 (21)	16 (22)	2 (3)
Not consumed	12 (17)	7 (10)	15 (21)	34 (47)
N	72	72	72	72

The majority of respondents that ate breakfast and/or supper consumed these meals in their own accommodation. For example, 63 per cent of respondents that reported eating breakfast at least once in the 7 days preceding the study did so in their accommodation. Eighty-two per cent of those who had eaten supper did so in their own accommodation.

Approximately 46 per cent of respondents who had consumed a hot meal during the 7 days prior to the study did so in a subsidised café. A further 24 per cent obtained their main hot meal from a variety of sources including subsidised cafés, commercial cafés and in the homes of family or friends.

Satisfaction with Homeless Food Service Providers

The audit showed that provision of recommended foods from the food pyramid appeared to be adequate. Nevertheless, the mere provision of such foods did not necessarily imply satisfaction with the foods available or indeed imply a satisfactory diet among consumers using the service.

There were a number of factors that influenced the use of homeless services in this regard, not least of which were availability, suitability, variety, choice and quality. Interviewees were invited to comment upon food provision by homeless services in Dublin. They discussed their daily routine when 'eating out' or 'eating in'.

All bar one interviewee relied heavily upon homeless food and day centres for regular meals. The choice of food provider was limited by issues of provision, access and cost and many interviewees stated that their diet was very dependent upon access to these services.

In general interviewees were positive about the fact that food service provision to meet their needs does exist in Dublin. At the same time interviewees indicated that quality services are limited:

"There's nowhere like it you can go to get a proper meal and you get sick of burgers so XXXX is deadly and you feel you are doing something right and you are not spending loads of money. If you want a proper dinner you have to spend €12. I was just eating in crappy places" - Interview 5

Knowledge of where food provider services are located as well as how to eat well but cheaply was gained through experience and exchange with other homeless people:

"Through meeting other people in the hostel you could find a place during the day to get a cooked meal and in some cases for free or for €1 or €2. Finding out about things like that is generally word of mouth without asking an organisation where to get free food. There is one place, which is run by nuns. For €1, you get a three-course meal and there are napkins on the table. Waitresses. You have to say your prayers first though. The food is good and the pudding is good" - Interview 7

Other interviewees reflected upon the vagaries of 'eating out' when sleeping rough:

"We used to depend on the soup run – every night at 9 o'clock at Heuston Station. When I think back we were like scavengers trying to jump on the sandwiches - when I think back I think… God. There'd be crowds around just grabbing, grabbing and then hot cups of tea and soup – even us we were like as if we were never fed - like animals, like Somalia or somewhere. Scavengers" - Interview 6

One issue common to all discussion on 'eating out' at café's or restaurants referred to the issues of access and cost.

"Sometimes I would treat myself at a café or coffee shop. But it's a rip-off, we don't have much [money] and it would be €19 for just one meal. There are not enough good places to eat cheaply" - Interview 4

While it may be obvious to state that cost is always a factor in the choice of food outlet, what was understandable from our interviewees was the difficulty they experienced gaining access to food outlets even when they were confident they could afford to eat off the menu:

"In a normal café it's costly – it's when they find out who you are and how much you earn. Last week I would pay the prices and sit there and sicken them but now I wouldn't. It's to try and get you to leave the restaurant because it's only a €8 meal. This is up at XXXX. She says I could not eat here. So we ended up leaving anyway but it was horrible - the way we were treated" - Interview 6

"You get security guards looking at you and telling you, you can't come in. You can't go here and there and 'you're barred!" - Interview 1

Mobility is another issue that defines a homeless person's ability to access homeless food service providers. Many comments were made on the difficulties of getting to a place on time to be served a meal of choice such as lunch or dinner:

"Sometimes I can't get in here [city centre] from Dun Laoghaire – it's a time thing to do with my accommodation or sorting my welfare and last week it [dinner] was only served from 12 pm to 2 pm and I missed it loads [of times]" - Interview 3

Interviewees were asked to discuss their feelings and opinions on what they thought about the quality of service on offer in dedicated food centres. In short, feelings were mixed.

Many commented that they had preferred dedicated food outlets and considered the staff in these outlets to be both courteous and considerate and the service they received to be somewhat unique and also impressive:

> *"I went to XXXX Night Service one night ... They brought us over to the other part of the building [Food Service] and I am not joking you could have had anything you wanted. There was a waiter service. That's what we got that particular night - we were sitting at tables and there were young girls running around the place - I don't mean young girls, I mean young ladies - and they ran around and they said "Would you like fish or would you like this" and I just couldn't believe it"* - Focus Group Interview

Alternatively, a common opinion among our interviewee's was that, upon reflection, they didn't agree that the social function of food service providers was positive at all times and pointed out that they would avoid certain food service providers because of the type of user group availing of the service:

> *"I would never eat at XXXX as that's where the drug user's hang outside and there is always dealing going on"* - Interview 1

One interviewee expressed significant reservations about using any of the food services provided in Dublin. When questioned as to whether she had eaten at such services, this interviewee replied:

> *"Good God no! [laughs at her own response] I stayed clear of those places"* - Interview 4

Additionally, some interviewees felt that by only using dedicated food services a certain dependency might develop and through constant association with people who were homeless, a sense of isolation from wider society could emerge:

> *"I am not being a snob, I was going to the dinner house ...but the more I was going to the dinner houses the more I was meeting a circle. It's like a social circle. People go from one dinner house to the next and round and round. That's all – they are looking at their watches and timing it and their life is like that. Eating crap food along with it"* - Focus Group Interview

> *"From my own point of view – I went round the circuit to the eating-houses and to be perfectly honest I found it a wee bit degrading. I was frightened out of my life that I would bump into someone that knew myself or knew the family or whatever. So I do my best to avoid them and that is why I go to supermarkets or shops or even going to a cheap diner - wee cheap restaurant like XXXXX on George's Street. I used to go there and I got to know the staff in there. Breakfast for €4 - a really good breakfast"* - Focus Group Interview

This feeling of isolation and anomie was most clearly articulated by one interviewee whose response summed up a common perspective among respondents.

> *"Service providers need to learn about the bed and the meal but the hardest battle is the psychological one. If you are given food, you appreciate it but if the social environment isn't conducive to positive attitudes then a lot of people are going to slip back into it [drug or alcohol abuse].*
>
> *It's hard to eat the right food and socially you don't always want to eat at these places, you get a feeling of depression and that you're in a downwards spiral. There are places like the XXXX – things like a pot of tea for 85 cent is very cheap and you go in there and it's a nice environment.*
>
> *You do need to go to other places that are not just for homeless people otherwise you become a little downbeat. It's nothing against homeless people it's the same for them. You need to mix with*

people from all walks of life" - Interview 7

Issues of Choice and Preference in Relation to Food Services

In addition to the foregoing, interviewees were asked to consider issues of preference and choice in relation to food service providers. They were also asked to state what they liked to eat in terms of taste.

In terms of food choices, many chose food that they felt was desirable on the basis of personal taste. Notably, however, some interviewees reported that they would select food of a higher quality outside their income range and budgets if given a free choice. If they could consume such foods on a daily basis, they would. Others however expressed a poor, undeveloped appetite and a preference for foods that would not necessarily form the basis of a balanced and healthy diet:

> *"I drink a lot of milk and water. Maybe it's not that good to drink so much milk. I wanted to do organic but I was giving my head to much bother with thinking about it"* - Interview 3

Interviewees reported that the range and variety of food available to them as hostel residents was generally considered to be sufficient on the whole. As illustrated elsewhere, interviewees report a range of problems in relation to food and hostels. These related to issues of management, facilities, practices and procedures with relation to food. In particular, the menu and variety of foods available came in for significant criticism.

> *"As I say, they do an evening meal and a breakfast. Breakfast is cereal, tea, coffee, toast, boiled or scrambled egg, which is good as far as it goes. Evening meal never changes so the diet never changes. Monday is always a chop, we have chop, potatoes, cabbage, that's it. Tuesday's might be coddle and it's disgusting. If it's cooked properly it might be OK but it's rotten. Friday you might get mince and potatoes or shepherds pie. Not great. To cut a long story short it's the same thing from day to day and it never actually varies that much"* - Focus Group Interviewee

> *"I was in an open prison in England and the food was better. There should be a bit of variety but you get what you pay for – cheap food comes cheap. You don't expect it to be otherwise"* - Focus Group Interview

> *"They have meats - they have ham, corned beef and cheeses and we make sandwiches. Toasted sandwiches. They supply the ingredients and we make them ourselves. When I was in XXXX they give you a dinner. It's not all right as it is. It could be better. They could have facilities where you could cook yourself. Normal stuff instead of it being handed out to you. And you could have cooking classes and stuff like that to help you"* - Interview 1

> *"You don't have a choice [in the hostel] - the element of choice is taken away – if the food is bad you have to compensate by buying food outside and that is a deterrent [to using the hostel]"* - Focus Group Interviewee

Conclusion

The majority of homeless food service providers appeared to offer a good range of foods to their service users/ customers at affordable prices. Almost all food providers serve vegetables and just over two-thirds serve fruit. The provision of red meats, poultry and fish appeared to be good. In contrast, there was limited availability of low-fat dairy products while nearly all the service providers provided sweets, confectionery and savoury snacks.

Dedicated food centres were commonly used by respondents for their meals, for example, 42 per cent reported eating their main hot meal in a subsidised café/food centre. In general, interviewees were positive about the fact that food service provision to meet their need does exist in Dublin. And hostel residents generally considered the range and variety of foods available to them to be sufficient on the whole.

During the course of the in-depth interviews a range of factors were found to influence the use of homeless services including availability, suitability, variety and choice, and quality of service. Other key issues that emerged regarding service use were access, cost and personal mobility.

Common factors that influenced the non-use of dedicated services included lack of control over personal choice and diet, concerns about personal security, the regulations relating to access, and the user group that characterise the service.

A significant issue for people was the alienation and isolation that they feel when homeless. For example, some interviewees felt that by only using dedicated food services and through constant association with people who were homeless, a sense of isolation from wider society could emerge.

The following chapter presents our recommendations with regard to improving the diet and nutrition of adults who are homeless and improvements in the provision of services and supports to them.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Chapter 9

Policy Development to Tackle, Prevent and Eliminate Food Poverty, Social Exclusion and Homelessness

Introduction

This chapter presents details of Focus Ireland's recommendations for starting to tackle the issue of food poverty, social exclusion and homelessness. The latter section of this chapter presents details of our specific recommendations for addressing this issue, while the first section sets out the broad policy frameworks that may be used to support and progress recommendations.

The Policy Framework

Food poverty manifests as one of a series of difficulties for policy decision-makers at central and local level that are engaged with the challenges of service provision to socially excluded groups and people in poverty. We know that food poverty in general terms is recognised by certain service providers. For example, it is an area of concern for health service provision to low-income households by Community Dieticians and is also reflected in public health promotion on food, diet and nutrition to the population in general.

For other areas of social provision, however, there appears significantly less awareness and understanding of the issue from both a policy development as well as service delivery perspective. We know from the findings of our research that the following factors contribute to the extent and experience of food poverty:

- Financial constraints, income inadequacy and financial exclusion
- Environmental access, choice and quality
- Accommodation status
- Knowledge and skills
- Service provision
- Cultural factors

There is no current agreed definition of food poverty in Irish social policy. Neither is there any dedicated food poverty policy or strategy. Notwithstanding this, elements from a considerable array of policy can be identified that offer a framework for action on food poverty and homelessness in Irish society.

Six policy areas have been identified across a range of policy areas including national policy on homelessness; the focus of policy, practice and service delivery in the Dublin region; social inclusion and anti-poverty; social welfare; health and health promotion; and planning and development. These policy frameworks are not mutually exclusive and can be developed to offer an overall policy framework to tackle and eliminate food poverty and homelessness.

Framework 1: National Policy on Homelessness

Policy on homelessness in Ireland has undergone a significant review and period of development since 1998 yet there are certain deficits identifiable in both national and local policy. A key feature of national policy as set out in *Homelessness – An Integrated Strategy (HAIS) (2000)* was the directive that each local authority in collaboration with health board officials and voluntary sector providers

developed and implemented local homeless action plans. The action plans were to have included proposals for the provision of services and accommodation appropriate to adults who are out-of-home. However, HAIS does not specifically mention food or other related forms of service provision outside of the context of their delivery – in this case primarily through the emergency accommodation system (hostels, refuges and B&B's).

Framework 2: Shaping the Future - the Dublin Homeless Agency Action Plan

The Homeless Agency[16] action plan on homelessness in Dublin *Shaping the Future* concludes at the end of 2003. It is a comprehensive and ambitious plan that has had a mixed but successful impact over the period since 2001. It is on course to deliver 200 new units of transitional housing and 300 additional long-term supported housing units for 2003.

Over the period since 2001, the plan has led to the delivery of additional emergency beds, and the expansion of street outreach teams and day services in Dublin. It has also been responsible for the delivery of guidelines on quality standards for homeless service delivery as well as research and training for staff employed in homeless services.

As part of its overall aim to improve the co-ordination and integration of responses to homelessness in Dublin, the Homeless Agency has adopted a set of principles known as 'continuum of care'. Among these principles is the delivery of high quality services in compliance with the quality standards for homeless service providers set out in *Putting People First* and general good practice.

Under the primary principles of continuum of care, *Shaping the Future* set objectives on the development and application of quality standards in all services on an ongoing basis. The plan commits to complete a programme for assessing services against standards.

Work in this area remains priority, particularly towards obtaining quality standards for hostels and temporary accommodation (e.g. Bed & Breakfast accommodation) as well as for food centres. Assessment of standards should seek to identify and remove barriers to the delivery of quality services in hostels, temporary accommodation and food centres, and should be relied upon to strengthen, deepen and broaden service agreements with providers as well as to regulate and improve private sector provision of emergency accommodation such as B&B accommodation. The Homeless Agency Training Programme is an important support to meeting objectives in this area.

Framework 3: National policy on social inclusion and anti-poverty

Under the aegis and leadership of the Department of An Taoiseach, the Cabinet Committee on Social Inclusion, in conjunction with the Office of Social Inclusion of the Department of Social and Family Affairs is responsible for the implementation and progress to meet commitments in the 2nd NAPS *Building an Inclusive Society*. There are 36 targets set out in the NAPS under policy areas that include income, health and housing, vulnerable groups and access to services.

Building an Inclusive Society contains very important targets on overall levels of consistent and relative income poverty, as well as income adequacy targets and commitments to reduce health inequalities, end child poverty and ensure improved access to quality public services.

Actions under each of these target areas have a direct relationship to the experience and extent of food poverty, especially among socially excluded and at risk groups. Key actions under this framework that have the potential to impact on food poverty include the following commitments:

- To reduce the numbers consistently poor below 2% and if possible eliminate consistent poverty. Specific attention will be paid to particular vulnerable groups.

16 The Homeless Agency has overarching responsibility for the management and coordination of responses to homelessness in the Dublin area.

- To achieve a target of €150 per week in 2002 terms for the lowest rates of social welfare to be met by 2007 and the appropriate equivalence level of basic child income support (i.e. Child Benefit and Child Dependent Allowance combined) to be set at 33-35 per cent of the minimum adult social welfare payment rate.

- To reduce the inequalities that exist in the health of the population by making health and health inequalities central to public policy, by acting on social factors influencing health, by improving access to health and personal social services for people who are poor and socially excluded and by improving the information and research base in relation to health status and service access for these groups.

- To reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10 per cent for circulatory diseases, cancers, injuries and poisoning by 2007.

- To eliminate child poverty and move to a situation of greater equality for all children in terms of access to appropriate education, health and housing, thus breaking the cycle of disadvantage and exclusion.

- To reduce the gap in low birth weight rates between children from the lowest and highest socio-economic group by 10 per cent by 2007.

The NAPS also makes commitments to improving access to quality public services for socially excluded groups and citizens. It commits to setting out detailed standards in relation to access to services, monitoring of these standards and to the establishment of accessible, transparent and effective mechanisms for ensuring the implementation of and adherence to these standards. According to the text of the NAPS:

> *"Citizenship rights encompass not only the core civil and political rights and obligations, but also social, economic and cultural rights and obligations that underpin equality of opportunity and policies on access to education, employment, health, housing and social services."* (NAPS,2002:20)

The NAPS also states:

> *"The principles set out in the International Covenant on Economic, Social and Cultural Rights and other international human rights instruments adopted by Ireland will inform the development of social inclusion policy"* (ibid:21)

Framework 4: Social Welfare Policy and Provision

In addition to its responsibilities under the NAPS, the Department of Social and Family Affairs delivers actions under the following policies that impact directly on the extent and experience of food poverty among socially excluded groups.

The Free School Meals Programme

The school meals programme provides meals to 60,000 children every day in approximately 400 schools mainly in urban areas. The programme has recently been reviewed and it has been demonstrated that a link between nutrition and learning ability exists, and that children who go to school without a breakfast or without an adequate breakfast are at a higher risk of educational disadvantage. This review has also led to a significant expansion of the scheme targeted at disadvantaged primary and secondary schools.

The effectiveness of the Free School Meals programme has been attested to by the experiences of the Early School Leavers Initiative (ESLI). The Dublin 17 Early School Leavers Initiative was established by the Northside Partnership in order to combat the high number of pupils in the area who were leaving school early. The Dublin 17 ESLI group state that the provision of breakfast and lunch has improved attendance and punctuality. The social skills of children, concentration levels and the capacity to learn have been improved for many children who arrive in school without breakfast or food for lunchtime.

A further example of the potential impact of targeted food programmes can be found in the Food Dude Healthy Eating Programme, a programme piloted by Bord Glás in selected primary schools. The encouraging initial findings from Gaelscoil na Mide in Kilbarrack, Dublin, indicate that the average percentage of vegetables consumed by the children increased from 24 per cent to 62 per cent and the average percentage of fruit consumed increased from 57 per cent to 72 per cent.

Breakfast Clubs
As part of the expanded School Meals Programme, breakfast clubs are dedicated to the provision of breakfast to children in target high-risk schools in disadvantaged areas.

Framework 5: National policy on health and health promotion

Two key national policy areas that have the potential to impact on food poverty and homelessness have been identified in the area of health. They are the new national health strategy *Quality and Fairness – A Health System for You* (2001) and the *Health Promotion Strategy* of 2000.

The national health strategy sets out four national goals, each with a corresponding number of objectives. The two goals considered most relevant to the elimination of food poverty are national goals 1 and 2, 'better health for everyone' and 'fair access' respectively.

There are certain key objectives to each policy goal. In turn, these support a number of stated actions towards their realisation. Goal 1 contains the following four objectives:

i) The health of the population is at the centre of public policy;
ii) The promotion of health and well-being is intensified;
iii) Health inequalities are reduced; and
iv) Specific quality of life issues are targeted.

Goal 2 contains the following three objectives:

i) Eligibility for health and well-being is intensified;
ii) Scope of eligibility framework is broadened; and
iii) Equitable access for all categories of patient in the health system is assured.

A range of actions are set out against each objective. In total, there are 121 specific actions under the stated goals of the policy. Of particular relevance to the issues of food poverty among homeless persons are:

Action 8
Initiatives to promote health lifestyles in children will be extended. Extension of substance abuse prevention programme and social, personal and health education programmes to all schools by 2005.

Action 18
A programme of actions to be implemented by 2007 to achieve NAPS health targets for the reduction of health inequalities that include:

- Target for premature mortality achieved
- Target for life expectancy for the Travelling community achieved
- Targets for health of Travellers, asylum seekers and refugees developed
- Targets for birth weight rates achieved

Action 19

- Initiatives to eliminate barriers for disadvantaged groups to achieve healthier lifestyles will be developed and expanded
- Implement fully existing policy in the *National Health Promotion Strategy*
- Introduce Community-level programmes

Action 21

- Initiatives to promote the health and well-being of homeless people will be advanced
- Ongoing implementation of Homelessness – An Integrated Strategy
- Implementation of the Youth Homelessness Strategy by end of 2003

State nutrition and health promotion programmes have been ongoing since the launch of the *Nutrition Framework for Action* in 1991. A key component of this work was the establishment of Community Nutrition Services at a regional level.

The policy framework for further health promotion interventions directed at low-income and socially excluded groups in Irish society include the cardiovascular health strategy *Building Healthier Hearts* (1999), and the *National Health Promotion Strategy* (2000).

A key strategic aim under the *National Health Promotion Strategy* (2000) is 'to increase the percentage of the population who consume the daily servings of food and maintain a healthy weight'. There are a number of stated objectives set out to meet this aim. They include work to promote healthy eating habits and healthy body image amongst school-going children and young people as well as a commitment to facilitate the development of a national healthy weight strategy. Equally important are additional commitments to 'work in partnership with lower socio-economic groups to develop' and to 'adapt eating well programmes' to ensure their better delivery to such groups.

Furthermore, the *National Health Promotion Strategy* commits to supporting the implementation of the Recommendations for a *National Food and Nutrition Policy* (1995), the *Recommendations for a National Food and Nutrition Policy for Older People* (2000) and the recommendations that focus on nutrition and eating well in *Building Healthier Hearts* (1999) and *Cancer Services in Ireland: A National Strategy* (1996).

Of particular relevance are the key recommendations of the Nutrition Advisory Group published in 1995 as precursors to an anticipated national food and nutrition policy. At the time of writing, this is the only identifiable government policy document directly concerned with issues of food and nutrition but importantly it remains underdeveloped in that no discrete national policy or strategy on food, poverty and nutrition has been adopted. Nonetheless, the key recommendations are repeated here for information on how health gain through improved nutrition may be obtained. They are:

- Food and nutrition policy development and implementation will require long-term, sustained commitment by government;
- Organisational structures relevant to food and nutrition policy should include a mechanism for consultation with food producers and consumers;
- The activities of state and semi-state agencies should be compatible with the national food and nutrition policy;
- National food consumption surveys of sufficient detail to meet the needs of both nutritional assessment and the monitoring of food safety should be carried out every five years;
- A proactive approach should be taken to the dissemination of nutrition information to the public;
- A community nutrition and dietetic service should be provided throughout the country; and

- Monitoring of changes in food consumption and in nutrition-related diseases is essential to the evaluation and on-going development of food nutrition policy in Ireland.

Healthy Eating Week

Healthy Eating Week is an awareness-raising programme of the Health Promotion Unit focusing on issues of food and nutrition and with a target focus on low-income groups. In 2002, the National Healthy Eating Campaign was themed 'More Fruit and Vegetables Every Day - The Healthy Eating Way' and focused on the importance of fruit and vegetables as part of a healthy diet. Fresh, frozen or tinned - eating one or more extra portions of fruit and vegetables each day was the key message, so that nationally the aim to meet the agreed recommendation of four or more portions of fruit and vegetables every day might be met.

Nutrition Guidelines and Education

The Department of Health and Children also issues Food and Nutrition Guidelines for pre-primary schools and supports curriculum development focused on food and nutrition education at primary school level as part of Social, Personal and Health Education.

Health Board Services

A Nutrition and Dietetic Service is now established in Health Boards. Health Board Community Dietician Managers have established Community Programmes with a specific focus on low-income diet.

Framework 6: Planning and Development Policy

The location and size of retail outlets impacts directly on the issue of access for socially excluded groups. Our study found that homeless person's use of retail outlets was highly contingent on their size, scale, nature and location and that the potential loss of inner-urban markets for food purchase due to the competitive pressures of out-of-town hyper or mega-markets was felt strongly by our respondents.

Since December 2000, the Department of Heritage, Environment and Local Government have put in place Retail Planning Guidelines for Planning Authorities. Two of the five policy objectives on which the guidelines are based are detailed below:

- Retail development should be promoted in locations that are readily accessible, particularly by public transport, which encourages multi-purpose trips on the same journey.
- Retail planning policy should seek to support the continuing role of town and district centres, which will reinforce investment in urban renewal.

The guidelines seek to establish local, efficient, equitable and sustainable retail provision, which is readily accessible, particularly to marginalised groups. Significantly, the guidelines have been used to reinforce the cap on the size of large-scale, out-of-town hypermarkets.

Building a Policy Framework to Tackle Food Poverty and Homelessness

The ability to obtain an adequate supply of food is contingent upon having an adequate income and living in an area well supplied with shops as well as having access to them. To transform access to food from what is effectively a privilege to a right is to establish a different type of claim. For example, health is a necessary condition for life and access to a standard and variety of diet that will create and sustain good health is within the expectation of basic needs and rights held by citizens. Therefore tackling food poverty means more than freedom from hunger but implies a right to food. In other words to tackle food poverty we must make access to a healthy diet a positive human right to food and not

simply a negative freedom from hunger.

> *'People have the right to an adequate supply of food. Government policy should be to recognise this right in law; to guarantee an income adequate to meet basic food needs; and to ensure easy access to and diversity of choice in local shopping facilities in deprived areas'(Leather, 1996, cited in National Food Alliance, 1998:8).*

Given the spectrum of frameworks for policy development and actual service provision that have an impact on food poverty and homelessness, the challenge of developing a dedicated policy framework to tackle this issue is a difficult one of innovation, co-ordination and integration. Nonetheless, the following components can be identified as building blocks for a policy to tackle food poverty and homelessness.

- A working definition of food poverty, including recognition of a rights perspective and a rights-based approach to poverty elimination
- Agreement on how policy will address issues of food poverty in general and among key at-risk groups e.g. the homeless
- Actions to meet policy commitments on key structural issues that prevent the elimination of food poverty, with a particular focus on key at-risk groups. Issues include:
  - Income inadequacy and poverty
  - Access to accommodation and housing
  - Health inequalities
  - Service provision and delivery
  - Food supply, quality and access
  - Health promotion on food, diet and nutrition with a specific focus on at-risk groups
  - Training and improvement in knowledge and skills (re: cooking and recipes, food hygiene, preparation and storage etc)
  - Policy on food surplus and re-distribution
  - Policy on homelessness, in particular on quality service provision and delivery among homeless service providers

Recommendations for Policy Actions to Tackle Food Poverty and Homelessness

National policy Homelessness – An Integrated Strategy

i) As part of an independent review of Homelessness – An Integrated Strategy, Focus Ireland recommends policy formulation to address issues of food poverty, health, and diet and nutrition among homeless persons be included. A focus for policy would be to address the current deficits of the HAIS in relation to food poverty, diet and nutrition. It should address the need to develop and provide a health education programme on diet and nutrition specifically for homeless service providers. This is considered to be especially important for accommodation providers where food provision is a secondary aspect of service provision.

ii) A review should consult with voluntary sector homeless service providers when setting the terms of reference and monitoring progress and outcomes and it should be published for general consideration among homeless service providers as well as by the Cabinet Committee on Social Inclusion, the Cross-Departmental Team on Homelessness, the National Office for Social Inclusion, and the Oireachtas Committee on Environment and Local Government.

iii) Policy development should be undertaken to detail, agree, resource, deliver, monitor and report on a dedicated community nutrition programme for homeless persons to tackle the issue of food poverty and improve the health related impacts of poor diet and nutrition. Such a programme requires the co-ordination of policy at national and local levels involving the following agencies:

- The Health Promotion Unit of the Department of Health and Children
- The Department of Family and Social Affairs and the Office for Social Inclusion
- The Department of Environment, Heritage and Local Government
- The Department of Justice, Equality and Law Reform
- The Department of Finance

iv) In addition to the above, the role of the established Cross-Departmental Team on Homelessness in facilitating the development of policy in this area needs examination and resource commitments as required. Local homeless actions plans offer a vehicle for the identification of development and implementation strategies on food poverty and offer a basis to identify and resource the local delivery mechanisms for a dedicated community nutrition programme targeted on homeless persons.

Recommendations for Homeless Service Provision

As part of its aim to reduce the level of rough sleeping and to improve emergency responses to homelessness, *Shaping the Future* set out actions relating to extending the opening hours of drop-in centres and examining their effectiveness in meeting the needs of rough sleepers, as well as reviewing the role of food centres in terms of meeting the needs of people out-of-home. Focus Ireland re-commits to working in partnership within the homeless sector in Dublin to expedite outstanding work in this area towards meeting the agreed objective of *Shaping the Future.*

The findings of this study provide an impetus towards strengthening and improving homeless services based on attainment of quality standards and the delivery of food programmes and menus designed to tackle food poverty and nutrition deficits among homeless persons.

Specifically, in terms of food provision to customers of homeless food service providers, the findings of this study support the consideration of the following actions. These actions are proposed for consideration within the homeless sector generally, but specifically in the Dublin region:

i) Consider increasing the range of low-fat and low-sugar foods available through food centres. In particular, this study's findings support the need to increase the provision of sun flower oil or olive oil spreads for cooking and use on bread and sandwiches; the use of fortified milk for cooking, drinking and adding to drinks and cereals etc. This recommendation is proposed in specific response to our finding on the contribution of fat to total energy and the incidence of obesity among our survey sample.

ii) Consider how foods and refined cereals with low-fibre can be replaced with those of high fibre. For example, the use of brown rice and pasta instead of white rice and pasta and the provision of breakfast cereals such as porridge and bran or wheat based products rather than sugar coated cereals.

iii) Consider how to increase the range and frequency of fish and fish products on food centre menus.

iv) Consider offering the choice of decaffeinated tea and coffee as a standard not an exception of food service provision

v) Consider reducing the provision of confectionery and savoury snacks in favour of more healthy options such as fresh fruit and yoghurts and include organic fruit and vegetables on menus.

vi) Consider ensuring a diversity in menu development for food centres that avoids reliance on high-fat, low-fibre foods, provides in season fruits and vegetables and presents menu choices as part of an identifiable cuisine (e.g. Irish, French, Italian etc)

vii) Consider promoting a healthy eating week in homeless food centres as part of a national health promotion policy and in anticipation of the establishment of a dedicated community nutrition programme for homeless persons. An emphasis could be placed on the provision of food that supports healthy and balanced diets as well as the delivery of nutritional advice and supports to parents and a healthy food promotion programme for homeless children using childcare facilities.

Shaping the Future aims to ensure that people who are homeless have speedy access to the full range of health board services. On a basis of partnership working and inter-agency co-ordination and service development the Homeless Agency has ensured that regional health boards developed plans to deliver services in the following areas:

- Mental health services
- Public health services
- Psychological and counselling services
- Social work services
- Elderly services
- Child care services
- GP services
- Dental services
- Immunisation programmes
- Services for people with drug and alcohol addiction
- Services for people with HIV and Hepatitis C
- Multidisciplinary teams

This spectrum of services are required to address the multiple health needs of people who are homelessness and the continued development of these services remains a priority for Focus Ireland working in co-operation with the sector.

On this basis, Focus Ireland commits to working to ensure that access to health advice and care from Community Dieticians and Nutritionists is provided. In particular, certain groups who are homeless are at a higher risk of malnutrition with lower immunity and a higher risk of infection from diseases. These groups need to be prioritised in the delivery of health services, including services that focus on diet and nutrition. The next planning period for the development of services in the Dublin area presents an opportunity for considering how this might be achieved.

In addition, we have identified training on the particular dietary difficulties facing homeless persons, in particular chronic street drinkers and drug users, rough sleepers and young single parents as an important area of ongoing work. Focus Ireland will engage with the homeless sector in Dublin to ensure this training is targeted at the multi-disciplinary Outreach teams and Community Dieticians.

Recommendations for National Policy to Tackle Food Poverty

Poverty and income inadequacy

i) The Government should meet the commitment set out in NAPS to achieve a rate of €150 per week (in 2002 terms) for the lowest rates of social welfare to be met by 2007 and the appropriate equivalence level of basic child income support (i.e. Child Benefit and Child Dependent Allowances combined) to be set at 33-35% of the minimum adult social welfare payment rate.

ii) Focus Ireland recommends that an investigation into what foods should be included in an average

basket of goods for a healthy and balanced diet be conducted. A policy objective of this study should be to examine the role of price controls for staple foods such that minimum social welfare payments are sufficient to cover the costs of this basket of goods.

iii) Consideration should be given to legislative reform allowing price orders to be set for staple foodstuffs that meet a nutritional value as part of healthy and balanced diet. The Prices Act, 1958 as amended by the Prices (Amendment) Act, 1972 allows the Director of the Office of Consumer Affairs to set Price Orders. Currently there are four Price Orders that cover pubs, restaurants, hairdressers and petrol and diesel units. These orders refer mainly to issues of labelling and packaging as well as pricing and the display of pricing.

Access to Public Services

Ensure access to quality services for all socially excluded groups, including homeless persons.

i) Detailed standards in relation to access to public services for socially excluded groups are to be set out as part of government commitments under the NAPS. To bring this forward, formal expressions of entitlements across the full range of public services for all persons socially excluded and in poverty need to be established as a matter of priority.

ii) Outstanding quality standards and guidelines regarding the standard of service delivery that can be expected should be established as soon as possible.

Health and health promotion

School Meals Scheme

i) Deepen the impact of the reform of the Free School Meals Programme by investigating and developing innovative food promotion and food delivery projects at primary and secondary levels.

ii) More resources are required to deepen the impact of the Free School Meals Programme and the implementation of innovative projects to improve the diet, nutrition and overall health of children at primary and secondary levels is essential.

Diet Supplement Scheme

It is recommended that government reconsider its decision to discontinue the diet supplement scheme over the next 4 years. This scheme, which existed, as part of the Supplementary Welfare Allowance Scheme was available to a person or his/her adult or child dependant(s) provided he/she satisfied certain conditions. This entitlement was determined by the Health Boards, and in making the determination consideration was given to the type of diet of prescribed, the household income and whether the person in respect of whom diet supplement was payable was an adult or child.

Institutional arrangements

Currently, Ireland does not have an integrated statutory body or agency with a remit to tackle and eliminate food poverty in Ireland. Instead, responsibility is split across a number of bodies that are not integrated nor indeed strategically linked to tackle food poverty issues. These include:

- The National Standards Authority of Ireland (NSAI),
- The Food Safety Authority of Ireland (FSAI),
- An Bord Glás (Horticultural Promotion) and
- An Bord Bia (Irish Food Promotion Board).

The establishment of a Food Standards Authority (FSA) in the UK and Northern Ireland since 2000 has led to improvement in food quality and cost. It shares joint responsibility with the UK Department of Health for food nutrition. The FSA has also established research and data on the extent of food poverty. It is leading a national diet and nutrition survey of people on low incomes - the first survey of its type in the UK since 1936. Therefore, based on learning from the UK and Northern Ireland, we recommend that government should:

i) Consider establishing a National Irish Food Standards Authority with a clearly stated objective to tackle and eliminate food poverty in Ireland
ii) Government plans to publish a Bill in 2004 to amalgamate An Bord Glás and An Bord Bia could be deepened by the specific integration of state agencies into Food Standards Authority and could be based on cross-border learning from Northern Ireland where such a body has been recently established since 2000.

Conclusion

While there is no agreed definition of food poverty within an Irish policy context nor any dedicated food poverty policy or strategy, the discussion above clearly shows that there do exist policy frameworks in which we can start to tackle the issue of food poverty, homelessness and social exclusion.

Existing national government strategies on homelessness and social inclusion can be broadened to include issues of food poverty, and diet and nutrition. National policies such as *Building an Inclusive Society, Homelessness: An Integrated Strategy,* the recent health strategy *Quality and Fairness* and the *Health Promotion Strategy*, together with dedicated services such as the School Meals Scheme and dedicated dietary supplements under the SWA system (or equivalent), might all be used to begin to tackle the issue of food poverty among homeless adults and families.

Local decision makers and homeless service providers also have a role to play in putting food poverty and issues of diet and nutrition on the agenda. Local homeless actions plan should include issues of food poverty and diet and nutrition and local service providers should consider broadening the range and type of foods made available to families and adults out-of-home to meet their dietary and nutritional needs and to take account of issues of choice, special dietary needs and cultural and ethical preferences.

Finally, tackling food poverty means more than freedom from hunger; it implies a right to food. To tackle food poverty we must make access to a healthy diet a positive human right to food and not simply a negative freedom from hunger.

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

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HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Appendix 1

Appendix 1

Percentage distribution of food pyramid compliance by all respondents, gender, age, accommodation & length of time out-of-home

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
CBP shelf	37	34	40	40	39	25	46	40	8	33	33	38	37
F&V shelf	47	51	40	45	44	56	63	40	8	57	67	38	41
Dairy products	11	13	8	10	8	19	6	13	23	11	14	8	11
MFP shelf	29	30	28	30	19	50	40	27	8	22	19	38	30
Top shelf	0	0	0	0	0	0	0	0	0	0	0	0	0

CBP = Cereals, breads and potatoes shelf
F&V = Fruit and Vegetables shelf
MFP = Meat, fish and poultry shelf
Top shelf = Foods high fat and high sugars

HUNGRY FOR CHANGE:

SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Appendix 2

Appendix 2

Descriptive Profile of Food Quantity Consumption; mean (std deviation), median by all respondents, gender, age, accommodation type and length of time out-of-home

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Meat	105.1 (79.4) 95.5	111.4 (77.1) 106.1	93.1 (83.9) 76.6	109.4 (79.3) 108.3	104.4 (83.9) 89.4	101.0 (73.6) 102.9	118.7 (85.5) 101.0	85.6 (60.6) 76.6	82.4 (58.4) 86.1	117.1 (104.1) 113.1	112.0 (92.3) 77.8	94.1 64.1) 98.4	109.4 (82.9) 113.1
Poultry	31.0 (30.0) 18.6	35.0 (33.3) 18.6	23.5 (21.3) 18.6	26.2 (23.0) 18.6	38.0 (35.1) 18.6	21.3 (21.7) 18.6	33.0 (27.8) 18.6	24.5 (23.6) 18.6	37.0 (44.8) 18.6	25.5 (23.3) 18.6	36.2 (31.3) 18.6	34.6 (35.9) 18.6	23.8 (21.9) 18.6
Processed meat	27.5 (33.2) 12.9	33.3 (37.5) 14.8	16.7 (19.7) 4.3	32.7 (41.3) 18.1	28.8 (31.4) 13.8	18.1 (25.2) 5.3	20.8 (25.4) 11.6	28.9 (45.3) 12.8	53.6 (33.9) 75.0	13.7 (15.0) 6.2	23.4 (26.9) 11.6	31.8 (41.4) 13.2	26.9 (30.1) 12.9
Offal	1.9 (7.6) 0.0	3.0 (9.3) 0.0	0.0 (0.0) 0.0	0.0 (0.0) 0.0	1.8 (7.5) 0.0	4.9 (11.3) 0.0	4.0 (10.6) 0.0	0.0 (0.0) 0.0	0.0 (0.0) 0.0	0.0 (0.0) 0.0	1.0 (3.3) 0.0	2.4 (9.1) 0.0	2.3 (8.6) 0.0
White Fish	12.6 (20.0) 0.0	15.7 (21.7) 10.3	6.9 (15.1) 0.0	16.2 (25.0) 3.3	12.0 (17.3) 3.2	9.5 (19.5) 0.0	10.9 (16.0) 0.0	17.9 (27.3) 0.0	13.1 (19.7) 0.0	9.9 (22.4) 0.0	12.3 (17.1) 0.0	11.6 (19.6) 0.0	13.8 (22.9) 0.0
Oily Fish	8.6 (18.1) 0.0	6.8 (12.8) 0.0	12.1 (25.2) 0.0	3.3 (11.4) 0.0	11.3 (21.2) 0.0	9.3 (16.8) 0.0	12.8 (22.2) 0.0	5.0 (13.4) 0.0	5.2 (14.4) 0.0	3.6 (6.0) 0.0	8.2 (15.1) 0.0	10.5 (24.4) 0.0	7.3 (13.7) 0.0
Fish Products	1.1 (3.1) 0.0	1.5 (3.7) 0.0	0.2 (0.9) 0.0	1.5 (4.8) 0.0	0.7 (1.8) 0.0	1.3 (2.5) 0.0	1.9 (4.1) 0.0	0.2 (0.8) 0.0	0.5 (2.0) 0.0	0.0 (0.0) 0.0	2.2 (5.0) 0.0	0.6 (2.0) 0.0	0.6 (1.3) 0.0

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Shellfish	0.1 (1.0) 0.0	0.2 (1.3) 0.0	0.0 (0.0) 0.0	0.0 (0.0) 0.0	0.2 (1.4) 0.0	0.0 (0.0) 0.0	0.2 (1.4) 0.0	0.0 (0.0) 0.0	0.0 (0.0) 0.0	0.0 (0.0) 0.0	0.4 (1.9) 0.0	0.0 (0.0) 0.0	0.0 (0.0) 0.0
White bread	71.8 (30.5) 87.5	72.8 (29.6) 87.5	69.9 (32.6) 87.5	67.7 (35.5) 87.5	78.2 (24.0) 87.5	62.2 (35.2) 87.5	72.3 (29.1) 87.5	71.8 (33.0) 87.5	72.7 (29.3) 87.5	68.3 (38.1) 87.5	73.0 (27.5) 87.5	66.2 (34.9) 87.5	75.7 (28.9) 87.5
Brown bread	35.6 (49.2) 5.0	35.6 (48.5) 5.0	35.4 (51.6) 5.0	42.3 (47.5) 24.0	39.4 (55.6) 3.7	18.4 (31.3) 2.5	42.3 (49.7) 15.0	30.0 (46.2) 2.3	0.7 (1.5) 0.0	68.9 (61.5) 73.0	36.6 (42.7) 15.0	28.2 (49.2) 2.3	41.3 (54.7) 2.4
Other bread	4.1 (15.0) 0.0	4.0 (17.1) 0.0	4.1 (10.2) 0.4	1.9 (4.0) 0.0	3.1 (9.0) 0.0	8.9 (28.8) 0.0	6.6 (21.0) 0.4	2.6 (5.6) 0.0	0.5 (2.0) 0.0	1.4 (2.5) 0.0	3.0 (10.8) 0.0	2.8 (5.6) 0.0	6.0 (22.2) 0.0
High fibre cereals	14.9 (37.2) 0.0	13.3 (30.8) 0.0	17.7 (47.5) 0.0	27.3 (52.1) 8.3	8.2 (20.7) 0.0	14.3 (42.3) 0.0	16.4 (35.3) 0.0	28.7 (58.9) 5.7	3.2 (7.9) 0.0	2.5 (5.6) 0.0	19.3 (40.6) 0.0	22.1 (49.4) (0.0	4.9 (13.1) 0.0
Refined cereals	11.2 (12.5) 6.4	12.2 (12.9) 12.9	9.2 (11.6) 4.3	13.5 (11.6) 12.9	9.4 (12.7) 1.9	12.0 (13.4) 8.6	12.7 (12.0) 12.9	10.5 (12.7) 4.3	6.3 (11.1) 0.0	13.3 (15.8) 0.0	14.9 (13.1) 12.9	10.7 (13.7) 0.0	8.6 (10.5) 4.3
Boiled potatoes	144.3 (134.5) 150.0	156.1 (102.1) 150.0	121.9 (180.9) 75.0	76.6 (79.5) 37.5	169.6 (153.8) 150.0	171.9 (118.2) 175.0	160.1 (97.1) 162.1	125.9 (225.5) 11.3	157.9 (124.1) 150.0	93.5 (58.6) 75.0	154.1 (99.2) 150.0	130.9 (185.9) 65.2	148.5 (104.8) 150.0

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Fried potatoes	69.6 (67.0) 52.1	69.8 (50.1) 52.1	69.4 (91.9) 39.2	106.3 (98.0) 85.0	62.7 (46.8) 61.4	39.3 (32.7) 32.5	61.6 (48.5) 70.7	80.8 (60.4) 70.7	53.3 (52.4) 52.1	105.8 (130.0) 70.7	72.0 (40.9) 70.7	70.9 (64.3) 52.1	66.7 (85.4) 52.1
Whole rice/pasta	3.3 (16.0) 0.0	4.6 (19.4) 0.0	1.0 (5.1) 0.0	3.2 (14.4) 0.0	1.3 (4.9) 0.0	8.1 (29.4) 0.0	6.1 (22.4) 0.0	0.0 (0.0) 0.0	0.0 (0.0) 0.0	2.8 (8.6) 0.0	1.0 (3.2) 0.0	0.0 (0.0) 0.0	8.1 (25.6) 0.0
White rice/pasta	40.4 (58.1) 14.9	37.7 (57.0) 11.6	45.5 (60.9) 26.4	73.3 (78.5) 58.6	35.8 (48.4) 11.6	9.5 (12.2) 0.0	40.9 (48.9) 25.7	79.0 (86.6) 58.6	6.5 (17.2) 0.0	23.0 (34.2) 11.6	46.1 (63.2) 11.6	46.4 (71.7) 20.3	30.6 (37.6) 14.8
Dairy	77.2 (88.7) 53.6	54.1 (60.3) 22.9	120.7 (115.3) 98.2	104.2 (96.0) 65.7	80.0 (95.6) 46.8	37.1 (39.1) 19.4	102.4 (93.7) 73.2	66.5 (90.8) 23.8	20.1 (44.4) 0.0	79.6 (82.7) 53.6	78.8 (83.1) 60.0	71.0 (88.8) 19.4	81.5 (95.7) 54.5
Cheddar cheese	22.0 (25.7) 17.1	27.3 (28.9) 17.1	12.2 (14.2) 5.7	15.6 (15.3) 17.1	23.9 (27.0) 17.1	26.0 (32.5) 17.1	16.0 (19.6) 17.1	17.1 (15.9) 17.1	47.0 (39.7) 40.0	17.8 (14.3) 17.1	17.8 (22.4) 17.1	26.4 (28.2) 17.1	21.5 (26.3) 17.1
Soft cheese	2.1 (7.8) 0.0	2.4 (8.5) 0.0	1.7 (6.3) 0.0	2.0 (7.1) 0.0	3.0 (9.6) 0.0	0.3 (1.4) 0.0	2.0 (7.3) 0.0	5.1 (12.6) 0.0	0.0 (0.0) 0.0	0.6 (1.90) 0.0	2.7 (8.7) 0.0	1.6 (6.5) 0.0	2.1 (8.2) 0.0
Egg products	18.7 (26.7) 7.1	19.5 (29.7) 7.1	17.1 (20.2) 7.1	14.3 (16.2) 7.1	19.4 (22.9) 7.1	22.2 (42.1) 3.2	24.0 (32.1) 7.1	17.2 (19.8) 7.1	5.1 (9.0) 0.0	19.7 (26.6) 7.1	13.6 (19.4) 3.2	20.9 (29.7) 7.1	20.5 (29.1) 7.1

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Salad dressings	1.3 (3.3) 0.0	1.2 (3.2) 0.0	1.4 (3.6) 0.0	0.7 (2.9) 0.0	1.6 (3.7) 0.0	1.2 (3.2) 0.0	1.4 (3.1) 0.0	0.8 (3.3) 0.0	1.0 (3.6) 0.0	1.6 (4.2) 0.0	1.6 (3.9) 0.0	0.9 (2.8) 0.0	1.3 (3.4) 0.0
Butters	13.9 (11.6) 17.5	13.9 (11.5) 10.0	13.9 (11.9) 25.0	12.2 (12.1) 7.1	15.3 (11.3) 25.0	12.8 (11.7) 10.0	15.3 (11.7) 25.0	9.3 (11.8) 0.0	11.4 (10.3) 10.0	19.9 (10.1) 25.0	12.6 (11.6) 10.0	12.5 (12.1) 10.0	16.2 (11.2) 25.0
Sunflower oil spreads	7.0 (10.5) 0.0	7.5 (10.8) 0.0	6.2 (10.1) 0.0	7.7 (10.8) 0.0	7.1 (10.8) 0.0	5.9 (10.0) 0.0	6.9 (10.4) 0.0	7.0 (10.1) 0.0	6.5 (10.9) 0.0	8.3 (12.5) 0.0	8.2 (11.2) 0.0	7.9 (10.7) 0.0	5.4 (9.9) 0.0
Milk	247.7 (251.4) 196.4	274.3 (257.9) 250.0	197.6 (235.6) 107.1	333.8 (257.7) 250.0	221.9 (252.4) 107.1	197.8 (228.6) 107.1	247.7 (256.3) 107.1	212.9 (234.2) 107.1	224.9 (252.5) 250.0	338.2 (279.1) 196.4	261.6 (253.1) 250.0	177.9 (222.7) 107.1	298.7 (268.5) 250.0
Citrus fruits	10.4 (25.4) 0.0	6.8 (18.3) 0.0	17.2 (34.5) 0.0	4.0 (10.9) 0.0	14.1 (30.2) 0.0	10.0 (26.3) 0.0	10.5 (22.2) 0.0	14.4 (35.4) 0.0	9.7 (28.0) 0.0	4.8 (14.3) 0.0	7.5 (15.8) 0.0	12.4 (24.4) 0.0	10.9 (32.1) 0.0
Other fruits	106.7 (132.9) 61.3	97.9 (104.9) 90.9	123.2 (175.3) 57.7	105.8 (99.3) 80.6	108.5 (158.4) 43.6	103.7 (112.5) 96.8	120.5 (103.8) 111.7	101.1 (200.6) 40.3	55.3 (102.7) 16.0	136.6 (136.9) 112.0	112.9 (81.7) 111.7	95.3 (114.7) 57.4	111.9 (177.0) 44.3
Tinned fruits	9.2 (18.9) 0.0	9.7 (19.9) 0.0	8.2 (17.2) 0.0	8.9 (15.8) 0.0	11.3 (22.4) 0.0	4.8 (13.2) 0.0	16.3 (24.8) 0.0	4.5 (7.1) 0.0	1.3 (4.7) 0.0	1.0 (2.6) 0.0	10.0 (19.6) 0.0	10.7 (23.3) 0.0	7.2 (14.0) 0.0

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Green vegetables	54.3 (44.2) 45.8	56.7 (42.0) 49.3	49.8 (48.4) 36.8	39.6 (37.3) 32.1	62.3 (51.2) 40.8	54.6 (30.1) 66.0	65.2 (46.0) 62.1	49.8 (40.9) 36.8	33.7 (26.7) 35.8	49.1 (55.4) 34.2	76.2 (54.9) 65.5	40.4 (23.4) 38.7	49.6 (44.0) 38.7
Other vegetables	72.6 (54.3) 64.9	75.4 (53.4) 65.1	67.1 (56.6) 56.0	63.1 (56.1) 47.5	84.0 (54.8) 77.2	58.6 (48.2) 46.2	88.2 (52.9) 80.6	77.7 (53.7) 68.6	30.8 (31.5) 26.6	63.4 (60.7) 64.6	86.2 (46.5) 80.6	66.5 (57.2) 47.5	67.3 (57.2) 64.6
Pulses	27.0 (33.1) 11.6	27.7 (31.2) 19.3	25.7 (37.1) 8.7	19.3 (23.8) 8.7	33.3 (38.7) 19.3	22.6 (28.0) 13.2	26.0 (32.4) 13.2	34.2 (46.4) 0.0	18.5 (19.9) 19.3	31.4 (26.3) 29.3	27.9 (32.2) 8.7	30.7 (36.3) 19.3	23.0 (31.7) 10.0
Cakes & biscuits	45.5 (54.2) 26.8	45.9 (59.9) 27.9	44.7 (42.5) 24.2	75.6 (69.1) 56.4	35.4 (46.6) 18.4	30.4 (32.8) 19.1	37.6 (41.3) 25.7	69.0 (70.2) 53.6	20.7 (40.3) 0.0	72.6 (67.7) 42.9	42.9 (52.0) 28.1	41.7 (50.7) 24.6	50.9 (60.1) 27.9
Dairy desserts	43.1 (52.6) 32.0	48.2 (60.5) 32.1	33.5 (31.7) 31.9	63.0 (65.1) 45.5	34.5 (42.1) 27.1	37.3 (53.2) 13.9	49.1 (57.1) 27.1	34.8 (33.2) 32.1	16.5 (19.8) 10.7	71.8 (76.2) 32.1	48.3 (47.0) 32.1	35.4 (55.2) 13.9	45.8 (55.4) 32.0
Confectionery	45.5 (46.3) 24.4	39.6 (42.4) 22.1	56.6 (51.8) 27.9	87.4 (55.6) 65.7	33.3 (32.8) 19.7	20.5 (18.4) 17.1	43.5 (45.3) 22.5	58.0 (54.4) 56.0	20.0 (19.4) 15.0	68.9 (50.4) 62.9	30.0 (22.5) 22.5	46.5 (52.8) 19.3	56.6 (51.5) 36.4
Savoury snacks	18.7 (26.2) 6.3	16.0 (23.1) 5.2	23.8 (30.9) 12.9	32.0 (31.5) 30.0	17.1 (25.2) 6.3	5.6 (8.7) 1.0	17.8 (24.1) 8.1	27.0 (33.2) 12.9	8.8 (21.7) 1.0	22.8 (25.5) 16.1	10.3 (11.5) 4.3	29.3 (35.0) 9.0	15.8 (22.6) 7.5

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Soups	75.6 (141.3) 31.4	82.6 (165.9) 31.4	62.4 (77.4) 14.2	43.4 (67.0) 0.0	97.0 (186.5) 31.4	67.5 (70.7) 47.1	96.8 (189.6) 31.4	33.8 (53.5) 14.2	60.0 (76.2) 31.4	85.2 (69.3) 94.3	116.4 (235.7) 31.4	42.5 (60.6) 14.2	73.1 (78.4) 31.4
Sauces	28.9 (28.3) 22.2	30.1 (29.6) 27.9	26.8 (26.0) 13.6	35.6 (26.8) 30.0	23.7 (26.0) 12.9	32.5 (34.1) 27.9	31.4 (32.2) 22.1	25.7 (23.7) 22.1	29.6 (29.7) 13.6	23.5 (17.5) 27.9	35.9 (32.7) 27.9	27.8 (29.6) 15.3	24.5 (23.0) 13.6
Meat extracts	0.3 (1.9) 0.0	0.4 (2.2) 0.0	0.3 (1.3) 0.0	0.1 (0.5) 0.0	0.6 (2.7) 0.0	0.0 (0.0) 0.0	0.3 (1.1) 0.0	0.0 (0.0) 0.0	1.1 (4.2) 0.0	0.0 (0.0) 0.0	0.9 (3.3) 0.0	0.3 (1.3) 0.0	0.0 (0.0) 0.0
Spreads	3.6 (6.3) 0.0	3.4 (6.7) 0.0	4.1 (5.7) 1.0	3.4 (5.0) 0.0	4.3 (7.7) 0.0	2.3 (4.2) 0.0	4.9 (8.1) 0.0	2.8 (3.7) 1.0	1.1 (4.2) 0.0	3.6 (3.4) 6.4	4.6 (8.6) 1.0	3.1 (5.2) 0.0	3.3 (5.2) 0.0
Hot drinks	3.8 (2.3) 2.5	4.2 (2.4) 3.4	3.1 (1.9) 2.5	3.2 (1.6) 2.5	4.1 (2.5) 3.1	3.8 (2.3) 2.9	4.4 (2.3) 3.4	2.3 (0.9) 2.5	3.1 (2.5) 2.5	4.8 (2.0) 5.0	4.0 (2.0) 3.4	3.5 (2.4) 2.5	3.8 (2.3) 2.5
Malt drinks	0.8 (2.7) 0.0	0.5 (1.7) 0.0	1.3 (4.1) 0.0	0.9 (2.4) 0.0	0.5 (3.0) 0.0	1.2 (2.6) 0.0	0.6 (1.8) 0.0	0.4 (0.9) 0.0	0.0 (0.0) 0.0	3.4 (6.4) 0.0	0.5 (1.7) 0.0	1.0 (0.3) 0.0	1.6 (4.1) 0.0
Wines	14.1 (45.5) 0.0	21.1 (55.2) 0.0	0.8 (4.3) 0.0	6.2 (27.9) 0.0	12.5 (27.7) 0.0	27.3 (82.2) 0.0	12.9 (53.6) 0.0	6.5 (25.3) 0.0	14.6 (34.0) 0.0	30.1 (54.2) 0.0	11.8 (30.1) 0.0	0.7 (3.6) 0.0	27.7 (67.7) 0.0

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Beers	291.2 (323.4) 123.0	422.1 (327.3) 717.5	45.0 (85.8) 0.0	134.2 (258.3) 0.0	296.6 (330.5) 123.0	475.3 (294.3) 717.5	265.3 (305.7) 123.0	16.1 (33.0) 0.0	632.3 (213.8) 717.5	357.6 (348.9) 225.5	241.0 (316.5) 41.0	329.5 (340.8) 123.0	296.1 (320.0) 225.5
Spirits	13.8 (30.2) 0.0	20.9 (35.5) 0.0	0.4 (1.1) 0.0	1.2 (3.5) 0.0	17.9 (34.8) 0.0	20.3 (34.5) 1.1	0.8 (1.5) 0.0	0.6 (1.4) 0.0	70.0 (34.3) 87.5	5.0 (7.5) 0.0	5.4 (19.1) 0.0	20.1 (36.0) 0.0	14.7 (31.2) 0.0
Fizzy drinks	191.5 (207.6) 85.7	178.8 (208.6) 85.7	215.3 (207.9) 85.7	297.7 (216.1) 350.0	166.9 (201.9) 85.7	113.9 (163.9) 57.1	173.2 (202.3) 85.7	217.0 (215.9) 85.7	268.1 (233.2) 200.0	109.2 (160.1) 85.7	164.4 (199.1) 85.7	245.2 (212.4) 200.0	164.9 (208.1) 85.7
Diet fizzy drinks	28.5 (103.2) 0.0	30.1 (105.6) 0.0	25.6 (100.4) 0.0	4.3 (19.2) 0.0	34.0 (116.4) 0.0	46.3 (130.8) 0.0	4.0 (15.3) 0.0	45.6 (129.2) 0.0	92.3 (189.1) 0.0	3.2 (9.5) 0.0	5.4 (19.4) 0.0	75.5 (169.5) 0.0	4.7 (17.2) 0.0
Juices	60.9 (77.2) 22.9	58.9 (80.1) 22.9	64.6 (73.0) 22.9	61.4 (68.8) 36.4	59.1 (65.8) 26.4	64.4 (109.9) 5.1	61.7 (67.9) 30.0	50.3 (67.9) 0.0	35.0 (59.4) 10.3	112.7 (124.9) 68.6	78.0 (102.0) 30.0	51.4 (60.6) 22.9	56.1 (68.3) 22.9

HUNGRY FOR CHANGE: SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Appendix 3

Appendix 3

Descriptive Profile of energy and nutrient intake; mean (std deviation) and median by total respondents, gender, age, accommodation type and length of time out-of-home

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Calories (kcals)	2585.7 (1009.2) 2404.5	2632.3 (968.5) 2475.0	2498.2 (1096.6) 2275.7	3004.9 (1112.8) 2805.1	2510.1 (1120.4) 2252.5	2649.8 (1009.4) 2395.7	2614.9 (1106.6) 2475.0	2533.3 (884.7) 2407.5	2219.6 (591.0) 2294.9	3088.9 (1195.3) 2456.7	2486.3 (1030.8) 2210.2	2590.4 (1056.3) 2512.4	2659.1 (981.4) 2363.3
Protein (g)	100.5 (43.4) 93.4	106.3 (40.4) 101.6	89.6 (47.5) 83.9	103.6 (45.3) 97.7	95.3 (46.2) 88.9	105.3 (51.6) 101.8	106.0 (49.1) 100.8	89.9 (36.0) 89.9	92.7 (29.2) 91.1	107.9 (48.9) 80.0	101.1 (49.9) 96.8	98.5 (41.3) 91.6	101.8 (41.3) 91.1
Fat (g)	104.5 (46.8) 100.1	105.1 (43.1) 104.3	103.3 (53.9) 93.8	125.7 (53.6) 114.9	102.9 (52.1) 94.0	105.3 (45.0) 102.8	104.7 (47.7) 106.0	104.5 (43.0) 96.9	84.5 (26.6) 82.6	132.5 (62.5) 104.3	99.8 (45.7) 89.9	103.6 (46.9) 101.5	108.9 (48.8) 101.2
MUFA	33.3 (16.8) 29.6	33.5 (15.7) 32.6	33.1 (19.1) 27.4	42.0 (19.8) 38.0	32.7 (19.5) 27.4	33.9 (15.7) 33.8	32.9 (17.2) 32.6	33.4 (12.6) 31.9	26.5 (8.7) 26.6	44.9 (25.1) 38.0	30.5 (14.6) 28.0	33.6 (17.2) 31.5	35.4 (18.3) 31.8
PUFA	13.5 (7.8) 13.1	13.5 (6.9) 13.5	13.4 (9.5) 11.9	16.0 (7.5) 15.2	13.9 (8.3) 13.6	15.3 (9.2) 14.7	14.0 (8.5) 13.5	14.1 (6.2) 14.7	10.0 (7.1) 7.6	15.6 (8.4) 14.0	14.3 (7.6) 14.7	14.3 (8.2) 12.4	12.2 (7.8) 9.4
SFA	43.2 (19.2) 41.7	43.9 (18.7) 42.6	41.9 (20.4) 37.4	52.1 (24.0) 49.0	42.6 (22.2) 39.5	40.3 (15.7) 39.9	41.7 (19.1) 41.7	42.2 (18.3) 42.6	39.1 (12.0) 37.5	56.7 (26.1) 47.3	39.1 (17.9) 34.9	42.8 (19.9) 43.4	46.7 (19.5) 41.8
Carbohydrate (g)	303.2 (131.3) 277.8	294.7 (135.7) 265.9	319.3 (123.7) 294.9	379.2 (129.4) 343.6	293.2 (145.6) 276.2	320.6 (122.7) 254.9	314.0 (142.4) 283.7	326.3 (104.3) 318.9	207.9 (78.5) 191.8	360.4 (136.1) 323.5	295.6 (123.4) 276.8	304.9 (145.3) 281.4	307.7 (128.9) 275.6

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Alcohol (g)	15.2 (17.7) 8.0	22.4 (18.1) 23.7	1.8 (3.2) 0.0	5.3 (10.8) 0.0	14.9 (18.9) 1.0	11.3 (15.1) 6.1	10.2 (10.9) 7.4	1.3 (2.3) 0.0	44.3 (11.4) 51.4	16.1 (14.6) 23.1	10.8 (14.4) 2.9	17.3 (20.7) 4.4	16.9 (17.1) 10.2
Cholesterol (mg)	332.6 (195.6) 291.2	361.0 (199.4) 304.7	279.1 (180.1) 239.5	306.9 (171.6) 291.1	304.3 (201.1) 268.5	359.3 (203.0) 303.6	387.7 (239.3) 335.2	264.6 (125.3) 265.3	270.2 (83.4) 271.2	321.6 (172.6) 239.5	294.7 (174.5) 282.8	354.6 (235.1) 308.5	342.3 (174.6) 285.9
Sugar (g)	151.4 (73.1) 142.1	142.5 (71.9) 128.1	168.2 (73.9) 181.7	191.6 (79.2) 187.4	142.8 (81.6) 127.9	160.0 (67.4) 147.7	155.9 (75.4) 138.4	154.1 (69.4) 181.6	115.7 (56.7) 116.4	180.9 (83.3) 170.5	139.1 (69.1) 127.4	153.7 (82.5) 157.1	159.1 (68.7) 167.6
Starch (g)	150.1 (77.3) 130.0	150.5 (77.9) 124.5	149.3 (77.7) 142.1	184.8 (83.5) 191.9	148.7 (84.4) 133.8	159.1 (74.0) 130.0	156.4 (81.4) 139.4	170.0 (65.1) 154.2	91.4 (41.7) 96.1	176.9 (86.4) 142.9	154.9 (63.9) 142.5	149.6 (81.9) 142.6	146.6 (84.8) 121.9
Fibre (g)	20.4 (10.7) 18.7	20.2 (10.7) 18.4	20.8 (10.7) 21.5	23.9 (11.2) 25.7	20.1 (11.4) 18.2	23.5 (11.1) 22.0	21.7 (11.2) 19.6	23.0 (9.4) 24.2	11.1 (6.1) 11.5	24.3 (9.5) 18.8	20.4 (8.2) 18.8	21.2 (11.9) 19.3	19.6 (11.6) 18.6
Vitamin A equivalence (mg)	990.5 (1464.7) 611.9	1225.8 (1767.5) 666.2	548.1 (215.9) 493.9	611.7 (247.9) 543.2	1106.9 (1923.3) 611.9	950.1 (984.2) 665.2	1417.9 (2018.0) 744.1	521.2 (206.8) 482.2	572.3 (151.4) 593.5	714.3 (201.7) 661.4	758.8 (703.4) 532.8	1043.8 (1754.5) 554.0	1123.3 (1640.2) 698.8
Thiamine (mg)	1.6 (0.8) 1.6	1.7 (0.8) 1.7	1.5 (0.8) 1.3	1.7 (0.7) 1.8	1.6 (0.8) 1.6	1.8 (0.9) 1.7	1.8 (0.9) 1.8	1.5 (0.5) 1.5	1.3 (0.7) 1.1	1.7 (0.5) 1.7	1.7 (0.8) 1.8	1.6 (0.8) 1.5	1.6 (0.7) 1.6

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Riboflavin (mg)	2.0 (0.9) 1.9	2.2 (0.9) 2.1	1.8 (0.9) 1.6	2.2 (0.9) 2.0	2.0 (1.0) 1.9	2.1 (0.9) 2.0	2.3 (1.0) 2.4	1.6 (0.6) 1.6	1.6 (0.6) 1.6	2.3 (1.0) 2.2	1.9 (0.9) 1.8	2.0 (1.0) 1.8	2.1 (0.8) 2.1
Vitamin B6 (mg)	2.6 (1.1) 2.6	2.8 (0.9) 2.8	2.3 (1.1) 2.1	2.6 (1.1) 2.5	2.5 (1.2) 2.6	2.7 (1.2) 2.8	2.8 (1.2) 3.0	2.2 (0.7) 2.3	2.3 (0.8) 2.5	2.8 (1.0) 2.5	2.6 (1.1) 2.7	2.7 (1.1) 2.5	2.5 (1.1) 2.5
Vitamin B12 (mg)	6.9 (6.7) 5.8	8.1 (7.9) 6.1	4.8 (3.2) 3.7	5.3 (2.6) 5.1	7.2 (8.6) 5.4	6.8 (4.9) 6.2	9.1 (9.0) 7.4	4.4 (2.0) 3.8	4.9 (1.9) 5.6	5.6 (2.8) 4.5	6.0 (3.7) 5.8	7.0 (7.5) 5.7	7.6 (7.9) 5.7
Folate (mg)	276.3 (119.2) 251.9	292.9 (111.7) 270.5	245.2 (128.5) 231.1	276.7 (115.4) 276.2	274.9 (117.3) 271.3	294.3 (145.5) 284.5	300.9 (134.3) 295.5	245.1 (94.9) 239.1	222.7 (90.3) 228.1	310.2 (104.3) 302.5	288.5 (118.7) 309.2	276.5 (131.7) 233.7	266.7 (111.2) 272.1
Vitamin C (mg)	79.7 (50.3) 74.1	76.0 (45.5) 73.9	86.5 (58.7) 74.3	79.4 (41.8) 81.3	81.8 (52.9) 76.7	91.2 (53.9) 78.1	88.1 (51.5) 78.6	81.6 (51.6) 74.7	43.8 (28.1) 39.4	95.3 (51.7) 98.5	89.5 (58.8) 81.0	76.1 (44.9) 63.4	75.2 (48.6) 74.3
Vitamin D (mg)	3.4 (2.5) 2.6	3.4 (1.7) 2.9	3.4 (3.5) 2.2	2.5 (1.7) 2.2	3.3 (2.6) 2.7	4.0 (2.9) 3.1	3.9 (3.0) 2.9	2.7 (1.8) 2.4	3.2 (2.1) 2.7	2.6 (1.0) 2.8	3.4 (1.9) 2.6	3.7 (3.2) 2.7	3.1 (2.1) 2.5
Vitamin E (mg)	6.1 (3.3) 5.8	5.9 (3.2) 5.6	6.5 (3.7) 6.8	7.3 (3.6) 7.0	5.9 (3.7) 5.1	7.1 (3.4) 7.1	6.7 (3.7) 6.4	6.4 (3.1) 6.8	4.0 (2.1) 3.7	6.6 (2.7) 6.2	5.6 (2.9) 5.4	6.8 (3.9) 6.8	5.9 (3.2) 5.9

Food Group	Total	Gender		Age			Accommodation type				Length of time out-of-home		
	n=72	Male n=47	Female n=25	18-25 n=20	26-45 n=36	46+ n=16	Hostel n=35	B&Bs n=15	Night Shelter n=13	Rough Sleeping n=9	Short n=21	Medium n=24	Long n=27
Phosphorous (mg)	1602.9 (610.2) 1552.5	1686.4 (599.9) 1657.9	1446.2 (610.3) 1403.9	1777.2 (657.9) 1696.9	1551.7 (673.9) 1492.2	1644.2 (646.5) 1587.7	1663.2 (693.6) 1657.4	1456.9 (464.1) 1440.4	1422.3 (381.7) 1543.9	1873.0 (688.3) 1829.1	1538.8 (656.4) 1564.8	1595.4 (644.6) 1468.9	1659.6 (557.9) 1657.4
Calcium (mg)	1031.5 (464.5) 926.7	1073.5 (470.7) 1018.5	952.4 (451.1) 866.3	1173.1 (490.5) 937.4	1015.1 (486.1) 904.6	1038.5 (433.6) 1021.6	1039.1 (495.6) 1018.5	945.8 (412.3) 800.7	933.2 (331.2) 792.0	1286.6 (552.9) 1239.4	980.7 (480.3) 884.7	965.8 (472.6) 791.7	1129.3 (445.0) 1170.7
Iron (mg)	12.1 (5.4) 10.8	12.6 (5.1) 11.0	11.3 (5.9) 10.4	12.9 (4.8) 12.4	11.9 (5.9) 10.8	12.8 (5.9) 11.0	12.9 (6.3) 11.0	11.7 (3.5) 12.2	9.1 (3.3) 9.1	14.3 (5.7) 11.2	11.8 (4.8) 11.7	12.5 (5.8) 10.6	12.0 (5.6) 10.5
Selenium (mg)	56.2 (20.9) 57.6	58.9 (19.7) 59.5	51.1 (22.6) 49.2	51.4 (21.0) 55.0	54.1 (21.0) 56.9	60.4 (25.6) 59.5	60.8 (21.7) 61.5	49.4 (17.4) 50.0	51.4 (18.6) 54.4	56.9 (25.2) 61.9	56.3 (21.5) 61.5	55.7 (21.1) 58.0	56.6 (21.2) 53.8
Zinc (mg)	12.3 (5.9) 11.6	13.1 (5.6) 11.9	10.9 (6.5) 9.3	13.0 (6.3) 12.0	11.9 (6.6) 10.4	12.6 (6.7) 12.5	12.9 (6.7) 11.6	11.1 (4.5) 11.7	11.2 (4.0) 11.7	14.0 (7.6) 10.8	12.1 (6.5) 11.5	11.9 (5.8) 11.6	13.0 (5.9) 11.3

HUNGRY FOR CHANGE:

SOCIAL EXCLUSION FOOD POVERTY AND HOMELESSNESS IN DUBLIN

Appendix 4

Nutrient	Male RDA	Female RDA
Energy (kcals)		
Protein (g)		
Fat (g)		
Carbohydrate (g)		
Fibre (g)	25-35	25-35
Vitamin A equivalent (µg)	700	600
Vitamin B6 (mg)	2.2	2.0
Vitamin B12 (µg)	1.4	1.4
Vitamin C (mg)	60	60
Vitamin D (µg)	0-10	0-10
Vitamin E (mg)	10	10
Riboflavin (mg)	1.6	1.3
Thiamine (mg)	1.1	1.1
Folate (µg)	300	300
Calcium (mg)	800	800
Iron (mg)	10	14
Phosphorous (mg)	550	550
Zinc (mg)	9.5	7
Selenium (µg)	55	55

Notes

Notes