Abridged Report

Food Access and Nutritional Health among Families in Emergency Homeless Accommodation

Michelle Share · Marita Hennessy

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“

This situation has broken me

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

”

Note on report

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

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Published by Focus Ireland

ISBN 978-1-9997657-2-9

Design by Identikit Design Consultants

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The views expressed in this report are those of the authors and do not necessarily reflect those of the funders, the Department of Children and Youth Affairs and the Department of Health, or the study commissioners, Focus Ireland.

Suggested citation

When referencing this document please use the following citation:

Share, M. & Hennessy, M. (2017). Food Access and Nutritional Health among Families in Emergency Homeless Accommodation: Abridged report. Dublin: Focus Ireland.

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Acknowledgements

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

We wish to acknowledge the Key Informants who gave insight into food and nutrition issues for families from a service provider context.

We wish to thank Dr Sarah Sheridan, Research Officer, Focus Ireland and members of the Homeless Action Team who provided important advice and support to the researchers throughout the study period. Thanks also to the members of this study's research advisory group who provided feedback on earlier drafts of this report.

The Department of Children and Youth Affairs and the Department of Health funded this research. The views expressed in this report are those of the authors and do not necessarily reflect the views of the funders, or of Focus Ireland.

Dr Michelle Share

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May 2017

Introduction

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

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

The study objectives were to:

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

Methodology and methods

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

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

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

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

Key findings and conclusions

Family characteristics, pathway to emergency accommodation and current living circumstances

Table S1 · Participant demographic characteristics (n=10)

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

Pathway to emergency accommodation

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

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

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

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

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

Duration of homelessness

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

Current living circumstances

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

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

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

Table S2 · Accommodation categories and facilities provided

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

Note: N/A = not applicable

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

Food provision

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

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

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

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

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

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

Food storage

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

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

Figure 2 · Storage constraints

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

Figure 3 · Window-sill refrigeration

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

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

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

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

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

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

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

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

Figure 5 · Conveying ingredients to a shared kitchen

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

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

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

Cooking facilities

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

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

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

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

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

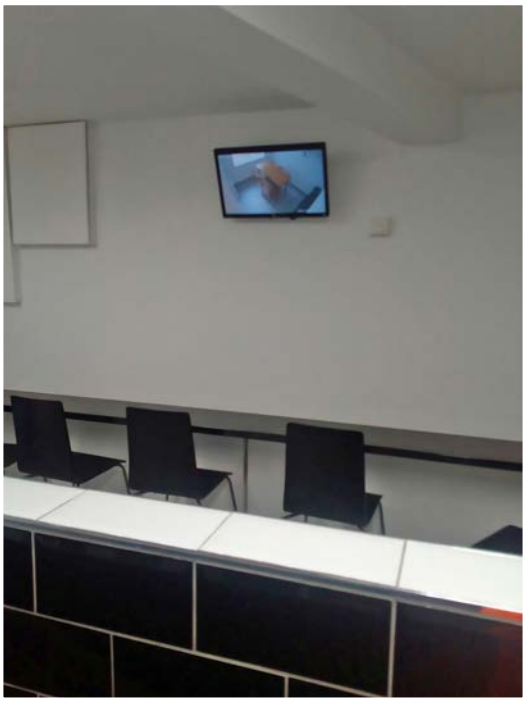

Figure 7 · Under surveillance

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

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

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

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

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

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

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

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

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

Another parent, P8 faced similar difficulties and remarked:

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

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

Figure 8 · Dining on the floor

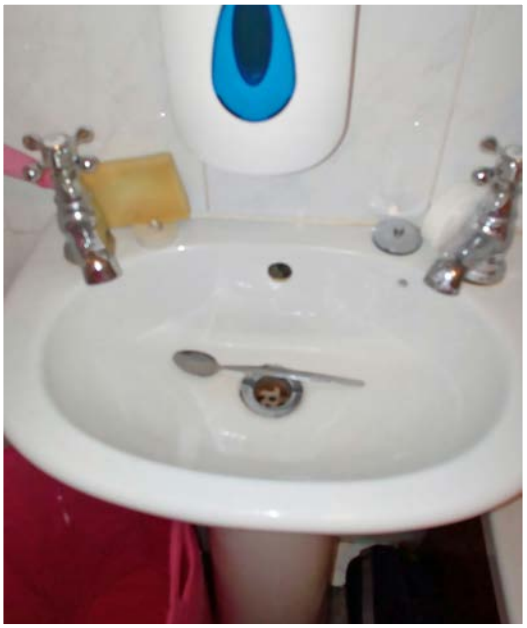

Figure 9 · Bathroom sink for washing dishes

Physical health

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

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

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

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

Figure 10 · Takeaway on bed

Child wellbeing

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

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

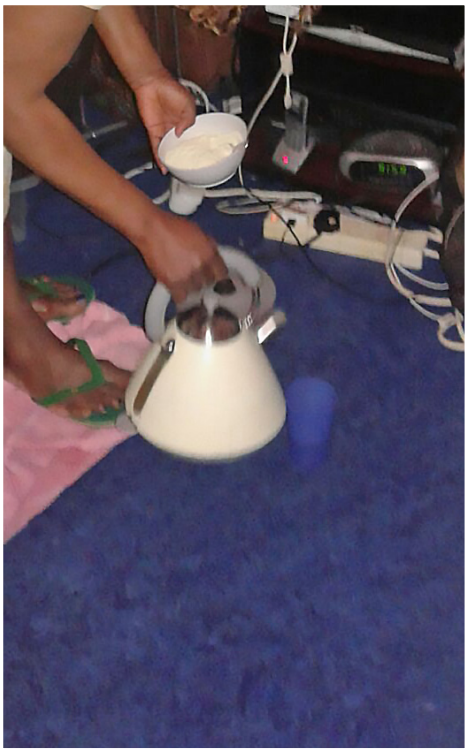

Figure 11 · Child safety

Child food practices

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

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

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

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

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

Figure 12 · Reverting to artificial baby food

Figure 13 · Baby food for toddlers

Family strategies in negotiating emergency homeless living situations

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

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

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

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

Standards in emergency accommodation

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

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

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

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

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

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

Emergency accommodation as a temporary measure

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

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

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Main Report

Food Access and Nutritional Health among Families in Emergency Homeless Accommodation

Michelle Share · Marita Hennessy

Challenging homelessness. Changing lives.
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“

This situation has broken me

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

”

A PDF of this publication is available at: https://www.focusireland.ie/research/

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Published by Focus Ireland

ISBN 978-1-9997657-3-6

Design by Identikit Design Consultants

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The views expressed in this report are those of the authors and do not necessarily reflect those of the funders, the Department of Children and Youth Affairs and the Department of Health, or the study commissioners, Focus Ireland.

Suggested citation

When referencing this document please use the following citation:

Share, M. & Hennessy, M. (2017). Food Access and Nutritional Health among Families in Emergency Homeless Accommodation. Dublin: Focus Ireland.

Main Report

Food Access and Nutritional Health among Families in Emergency Homeless Accommodation

Michelle Share · Marita Hennessy

Acknowledgements

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

We wish to acknowledge the Key Informants who gave insight into food and nutrition issues for families from a service provider context.

We wish to thank Dr Sarah Sheridan, Research Officer, Focus Ireland and members of the Homeless Action Team who provided important advice and support to the researchers throughout the study period. Thanks also to the members of this study's research advisory group who provided feedback on earlier drafts of this report.

The Department of Children and Youth Affairs and the Department of Health funded this research. The views expressed in this report are those of the authors and do not necessarily reflect the views of the funders, or of Focus Ireland.

Dr Michelle Share

Ms Marita Hennessy

May 2017

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Summary

Introduction

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

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

The study objectives were to:

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

Methodology and methods

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

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

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

Key findings and conclusions

Family characteristics, pathway to emergency accommodation and current living circumstances

Table S1 · Participant demographic characteristics (n=10)

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

Pathway to emergency accommodation

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

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

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

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

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

Duration of homelessness

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

Current living circumstances

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

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

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

Table S2 · Accommodation categories and facilities provided

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

Note: N/A = not applicable

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

Food provision

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

As with breakfast provision, families may not always access the accommodation provider dinner. Dinner was usually available in the late afternoon, between 4:30pm and 5:30pm. This constrained families, particularly when they had to travel from an outer suburb where their child(ren) attended school. Furthermore, the timing also meant that families had to spend longer in the evenings than desired in their one-room space. Families with dinner provision also tired of the communal dining arrangements and would return to their room where they ate on the bed. Such regimented meal times and restricted food choices in homeless accommodation services have also been found to negatively influence children's dietary intake (Richards & Smith, 2006a).

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

Food storage

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

B&B and hotel accommodation, particularly in budget-type premises that are used for homeless families, are not intended for long-term dwelling. All but one family[1] shared one room, and in some cases children shared a bed or single parents shared with their child/baby. Storage for personal possessions was extremely limited and parents faced particular challenges with baby equipment, toys and washing.

In addition to these constraints, parents also tried to store food in their rooms and experienced great difficulties in doing so. Families with meal services stressed that there was a need to be able to provide food for their children outside of the two hours of service. While some had a small fridge in their room, others did not, and some used the windowsill to keep perishable items cool. Service providers also highlighted that although there were many opportunities for families to avail of food hampers etc, lack of storage meant that they could not use them.

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

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

None of the families with access to a kitchen had a personal, lockable cupboard, and some were required to share a fridge/freezer with other families. These circumstances caused many other difficulties, such as experiencing food theft, having insufficient space in the shared fridge, and of having to use makeshift storage and transportation equipment for their food. Such facts have been well documented nationally and internationally in research that has examined the food situation of homeless people.

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

[1] A family of seven where two rooms were allocated in which the mother stayed with two children and the father with three; neither room had a fridge

Cooking facilities

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

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

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

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

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

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

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

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

Having procured a takeaway meal, or made an improvised convenience meal in one's room, participants described the difficulties of eating in the room. For some there was no table or chair, or only one chair. All families used the bed as a table and one used the floor, with an improvised tablecloth of aluminium foil. Having to dine on the bed or the floor placed great pressure on keeping the living and sleeping space clean, particularly with babies and toddlers. They tried to make environmental adaptations: some tried to 'normalise' the situation with their own plates and cutlery, particularly for children, yet this generated further challenges with washing up in a bathroom sink without a draining board.

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

Physical health

Diet-related physical health issues reported by participants included constipation and weight gain. Such issues have also been found in other research with homeless families where diets are dominated by high fat and low vegetable consumption (Davis et al., 2008). In terms of weight gain, for one participant years of dwelling in one hotel room without cooking facilities resulted in a spiral effect as she felt trapped in a small room and had a lack of opportunities to exercise, which led to grazing. Lack of storage for perishable items, and concerns about food waste, also led to overeating. Participants' accounts demonstrated a lack of control over their food situation and of poor quality food choices that impacted their physical health. This was particularly acute for those with lengthy periods in emergency accommodation and as one key informant observed 'you can see the physical changes manifested on them'. (KI1)

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

Child wellbeing

Parents' descriptions of their room space and of the challenges of storing and preparing food clearly articulated that child safety was a concern for them, particularly in relation to babies and toddlers. Being in a confined space that mainly comprised beds meant that parents had to use inappropriate spaces for kettles and for food storage, which made children vulnerable to accidents. Some parents had to carry a baby or handhold a toddler up and down flights of stairs to access the shared kitchen while simultaneously carrying ingredients. Parents in these circumstances also had concerns about their child's safety.

Child food practices

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

Two mothers described regression in terms of their children's diets, with toddlers being fed jars of baby food intended for four-to six-month-old babies, and two-year-olds being returned to artificial milk. Both parents had concerns about children's food intake and both had serious constraints in their accommodation with food storage and preparation.

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

Family strategies in negotiating emergency homeless living situations

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

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

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

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

Standards in emergency accommodation

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

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

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

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

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

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

Emergency accommodation as a temporary measure

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

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

Main Report

Chapter 1: Introduction

Food research among homeless populations has mainly been confined to descriptions of the nutritional health and dietary practices of single males. Such studies clearly indicate that a shift from independent living to that of dependency on others for food can compromise nutritional health (Evans & Dowler, 1999).

While some studies have examined the food situation of homeless families living in sheltered accommodation (Koh, Bharel, & Henderson, 2016; Lewinson, 2010; Richards & Smith, 2006a), the families who have shared their experiences in such accounts tend to have multiple and complex needs and intergenerational experiences of disadvantage.

In 2003, a Focus Ireland study of food poverty and homelessness in Dublin reported a significant increase in the number of homeless families, from 540 in 1999 to 640 in 2002 (Hickey & Downey, 2003). Over that period the number of dependent children in these families rose from 990 to 1140, with over half under five years of age. The study reflects that 15 years ago family homelessness was an issue of concern.

Recent data indicates that family homelessness remains a prominent issue nationally, but this report confines itself to homeless families who live in emergency accommodation in the Dublin region. In this region in April 2016, 1723 children were recorded as homeless and, by April 2017, this figure had increased by 24% to 2134, representing a total of 1069 families (Department of Housing, 2017). Increased attention to family homelessness must be contextualised within a more recent phenomenon in Ireland, where family homelessness extends beyond families with multiple, complex needs and histories of disadvantage to those that have become homeless as they are unable to access affordable private rented or local authority housing.

The statistics on family homelessness represent those who have been designated officially homeless by local authorities. Such a designation obliges the local authority to provide emergency accommodation. This may be a hotel room; a room in a hostel with shared facilities; a Bed and Breakfast service [B&B]; or self-catering accommodation. There has been much anecdotal evidence and considerable media attention on the constraints faced by families in emergency homeless accommodation, with particular reference to food access.

In October 2016, Focus Ireland invited proposals to undertake a research study on 'Food access and nutritional health among families experiencing homelessness in the Dublin region'. Following a competitive tendering process, the contract to undertake the research was awarded to Dr Michelle Share, Principal Investigator [PI] (School of Education, Trinity College Dublin) in collaboration with Ms Marita Hennessy, School of Psychology, National University of Ireland, Galway.

The research objectives (ROs) established by Focus Ireland were to:

- Understand the prevalence of food poverty among families experiencing homelessness who reside in emergency accommodation [RO1]
- Understand families' access to food, storage and cooking facilities in the context of emergency homeless accommodation [RO2]
- Explore the impact homelessness and emergency accommodation has on daily food habits, nutrition, health and well-being among parents and also children [RO3]
- Consider family strategies in negotiating emergency homeless living situations [RO4]
- Make recommendations for policy-makers as well as front-line service providers to improve food security among families experiencing homelessness [RO5]

In addition to an empirical study of families in emergency homeless accommodation in the Dublin region, Focus Ireland required the researchers to undertake a literature review of international research evidence relating to food poverty/instability among families experiencing homelessness and to conduct a review of policies and best-practice interventions that target the nutritional or dietary need of families experiencing homelessness.

Chapter 2 details the research objectives and mixed-methods research strategy employed to examine these. We describe the research methods, data analysis and ethical considerations.

Chapter 3 reviews the research evidence on food issues among homeless families and on interventions that target food issues among homeless families.

Chapter 4 presents findings derived from the two-stage interviews with parents:

- In section one, we outline the results of the first interview. This focused on family demographics and parents' current food practices.
- In section two, we turn to the photo-elicitation interviews to describe families' everyday food worlds in emergency accommodation in terms of their food choice and access to food, storage and cooking facilities and how living in emergency accommodation impacts on health and wellbeing of parents and children.

Chapter 5 reports on the findings from the interviews with Key Informants who provide health and social services to homeless families.

Chapter 6 concludes the report and outlines policy and practice recommendations.

Chapter 2: Methodology and methods

The study commenced in November 2016. Data collection occurred during the period December 2016 to April 2017 and involved two participant groups: Parents resident in emergency homeless accommodation in Dublin; and Key Informants who provide health and social services to families in emergency homeless accommodation. Using a mixed-methods research design the study comprised the following methods:

Parent interviews

Parents (n=10) resident in emergency homeless accommodation in Dublin participated in two successive interviews [ROs 2, 3 & 4]

Interview one: A short quantitative structured questionnaire was administered in a one-to-one interview. This captured data on demographic background; household living circumstances (including access to cooking facilities, food shopping habits and expenditure); health issues; and the pattern of food consumption (food frequency data). Participants were given guidance on, and asked to take, photographs of meal-time/cooking /food shopping events for one week to be used at interview two. Interview one lasted approximately 40–45 minutes.

Interview two: An in-depth semi-structured one-to-one interview using the photo-elicitation method. Participants' photographs were used as prompts to reflect on food practices in their everyday lives in emergency homeless accommodation. Each interview lasted between 45 and 90 minutes. These interviews examined access, storage and cooking facilities in terms of:

- Challenges confronted on a daily basis in procuring, cooking and storing food among mothers and for their children
- Impact of the daily routine of receiving meals in an emergency accommodation setting
- How participants feel about the food provided in emergency accommodation settings
- Use of other agencies/family/charities for food procurement
- Going without; food hoarding; stretching resources.

Key informant interviews

The Key Informant interviews served as a sensitising technique for the study (Strauss & Corbin, 1998). Following Fetterman (1998), key informants are individuals with special knowledge on the topic, articulate, and with the potential to reflect on the broader picture.

Key informants (n=6) who provide services to families in emergency homeless accommodation participated in a one-to-one semi-structured interview that examined [RO2]:

- Food and nutrition issues amongst those living in emergency homeless accommodation
- Barriers and facilitators to food access, including availability and affordability
- Role played by service providers and any food/nutrition services/ programmes provided
- Opportunities to enhance service provision related to food and nutrition.

Desk-based research of national and international literature (RO1)

A review of literature aimed to examine national and international policy and practice issues in relation to food issues among homeless people and evidence of best practice in the provision of services. The review entailed systematic searches of the following databases:

- CINAHL Complete (EBSCOhost; 1994–)
- Embase® (Elsevier; 1980–)
- MEDLINE (Ovid®; 1966–)
- PsycINFO (Ovid®; 1978–)
- PubMed (1996–)
- Scopus (Elsevier; 2005–)

Conference proceedings and other grey literature included: Open Grey (INIST-CNRS; 2011–) and Web of Science™ (Thomson Reuters; 1950–). ProQuest Dissertations & Theses Global, and ProQuest Dissertations & Theses – UK and Ireland were used to identify eligible dissertation and thesis studies internationally.

In addition, websites of relevant national and international organisations were searched: Dublin Region Homeless Executive, Crosscare, Focus Ireland, Simon Community, SafetyNet, Department of Health, Department of Children and Youth Affairs, Community Food and Health Scotland, WHO; and national open access repositories such as lenus.ie, drugsandalcohol.ie.

Ethical considerations

Research ethics approval was obtained from the Research Ethics Committee of the School of Education, Trinity College Dublin.

Recruitment of participants living in emergency homeless accommodation occurred through a two-step process:

1. Key workers at Focus Ireland were provided with information about the study and provided this to potential participants
2. Key workers passed on the contact details of families that had expressed interest in participation and had agreed to their contact details being passed to the research team.

At first and second interviews participants were provided with the study information sheet. This outlined the research to be undertaken; the benefits of the research for individuals and organisations; what their participation would involve; and issues of confidentiality.

In terms of the use of photographic data, participants were provided with guidelines on how to approach this and that they should not take photos of people without permission and should focus on the meal/cooking/shopping event. Participants were requested to sign a release form for use of their photographs in the report/presentations/other publications. Participants transferred their photographs via WhatsApp or Bluetooth to the PI in advance of their second interview.

Data analyses

Demographic data

Given the small sample size of 10 participants, demographic characteristics and food frequency data are presented descriptively to provide context to the qualitative interview findings.

Interview data

Data management and analysis involved a six-stage reflexive and iterative process (Halcomb & Davidson, 2006):

- Stage 1: digital audio-recording of each key informant and parent interview and contemporaneous note-taking
- Stage 2: summary written notes of each interview's content and reflections on conduct
- Stage 3: each recording was reviewed and re-reviewed and adjustments and elaborations were made to the summary notes

- Stage 4: preliminary deductive content analysis of summary notes and a re-listening to recordings
- Stage 5: secondary content analysis in which the preliminary analysis was reviewed by the second researcher followed by the agreement of themes
- Stage 6: an inductive analysis of themes identified in the previous stage and the identification of illustrative examples, including images, to demonstrate the meaning of the themes from the participants' perspectives.

Study strengths and limitations

It is important to consider the strengths and limitations of the research. The study was comprehensive in terms of its application of a mixed-methods approach. This comprised a structured quantitative survey of homeless parents; qualitative interviews with homeless parents, and qualitative interviews with stakeholders who provide services to homeless families. It was further strengthened by the use of a photo/voice/elicitation technique that allowed participants to voice their food worlds through their own pictures of their food environment. This approach has a number of benefits not only in terms of establishing the 'authenticity' of their situation, but also through photographs that provide 'a platform from which interviewees could expand on aspects of their experience that might otherwise have been inaccessible' (Croghan, Griffin, Hunter, & Phoenix, 2008, p. 355). This provided greater context to our understanding of participants' situation.

Given its small scale, the research does not claim to represent the experiences of all families resident in emergency homeless accommodation in the Dublin region. The scope of the study was such that it was not possible to include families who face the day-to-day challenges of one-night only accommodation and those who are living in self-catering apartments. The social characteristics of the sample of families do represent couples with children; lone parents; low income/social welfare recipients; and those who have become homeless as a result of the inability to find affordable housing and those having left negative domestic circumstances. We suggest that these experiences are likely to be comparable to other homeless families living in similar circumstances.

Chapter 3: Literature review

Introduction

This chapter presents the findings of a review of research evidence on food issues among homeless families and of interventions that target food issues among homeless families. The prevalence of food poverty among families experiencing homelessness who reside in emergency accommodation is discussed. Families' access to food, storage and cooking facilities in the context of emergency homeless accommodation, and their strategies in negotiating emergency homeless living situations, is then explored. Finally, a review of interventions to improve food security among families experiencing homelessness is presented.

Prevalence of food poverty among families experiencing homelessness who reside in emergency accommodation (RO1)

Homelessness and housing insecurity[2], is associated with increased food insecurity and poor nutrition (Cutts, Pheley, & Geppert, 1998; Furness, Simon, Wold, & Asarian-Anderson, 2004; Gundersen, Weinreb, Wehler, & Hosmer, 2003). Using data from the Fragile Families and Child Wellbeing Study[3], King (2016) found that food insecurity was associated with housing instability and that material hardship (e.g. did not pay utility bills on time and got disconnected) explained about half of this association (King, 2016).

Definition of terms and measures

Food poverty refers to the inability to have an adequate and nutritious diet due to issues of the affordability of and access to food (Dowler, 1998). There is no standard definition of food poverty in use within Ireland. Slight variations of Dowler's definition are used by a number of agencies (Healthy Food for All, 2016; Institute of Public Health in Ireland, 2017; safefood, 2017). Measures of food poverty in Ireland have been proposed by various writers (Carney & Maître, 2012; King, Lee-Woolf, Kivinen, Hrabovszki, & Fell, 2015).

Measures of 'hunger' are also used within the national and international literature to describe the experience of food poverty and/or food insecurity. For example, the Health Behaviour School-aged Children [HBSC] study defines food poverty as occurring for those schoolchildren who responded always, often or

[2] High housing costs in proportion to income, poor housing quality, unstable neighbourhoods, overcrowding, or homelessness (Cutts et al., 2011).

[3] n=2481 families

sometimes to the question 'Some young people go to school or to bed hungry because there is not enough food at home. How often does this happen to you?' (Molcho, Nic Gabhainn, Kelly, Friel, & Kelleher, 2007). In the 2014 Irish survey, 22% of children reported ever going to school or to bed hungry because there was not enough food at home; rates were higher amongst children from lower social class groups. Elsewhere, for example, France and the US, the term 'food insecurity' is more commonly used than 'food poverty', with various measures used.

Ireland

There is a dearth of Irish evidence on the extent of food poverty amongst homeless families, and homeless people in general. Carney and Maître (2012) proposed a composite measure of food poverty based on a lack of one or more of three food deprivation items as measured by the Survey on Income and Living Conditions [SILC] (Carney & Maître, 2012). Applying this methodology, they found that in 2010 10 per cent of the Irish population was in food poverty. SILC is a private household survey, so does not capture vulnerable groups such as the homeless, Travellers, people in institutions and asylum seekers, who may be more likely to experience greater rates of food poverty. The proportion of those living in food poverty in emergency accommodation is likely to be much higher (Coufopoulos, McDowell, Roe, & Maden, 2012; Rose & Davies, 2014). Almost 15 years ago, Hickey and Downey's (2003) pilot study of food poverty among homeless people in Dublin illustrated that homeless adults were vulnerable to poor nutrition and underweight. While this ground-breaking study did consider families resident in B&Bs and hostels, just 4 of the 72 interviewed were families with children. Subsequent Irish studies have reported similar issues but none have quantified the prevalence rates of food poverty within this population.

Most studies reported in this literature review come from the US. A wide range of terms, definitions and measures related to food poverty are used. Studies report on aspects of food poverty such as lacking food in general, going to bed hungry, hunger, and food insecurity. Nevertheless, one recent large cross-sectional study estimated the prevalence of food insecurity in homeless sheltered families in Paris in 2013[4]; rates of food insecurity were high: 77% of parents and 69% of children (Vandentorren et al., 2016).

In a study of the food consumption and eating behaviours of 73 homeless preschool children residing in homeless shelters in Baltimore, Maryland, one-third of mothers reported that they sometimes lacked adequate food for their children (Taylor & Koblinsky, 1994). Smith and Richards (2008) found that just over half (55%) of young people aged 9–18 years living in homeless shelters in Minneapolis, Minnesota (n=202) reported not enough food in the house and 25% reported going to bed hungry.

[4] They surveyed 10,280 families using the Household Food Security Survey Measure developed in the US (Radimer & Radimer, 2002).

Other identified US studies focus on the measurement of food insecurity within low-income families, not homeless families specifically, and have investigated the rates of food insecurity amongst those with a history of homelessness.

A study of the prevalence and predictors of food insecurity among 1,898 low-income households in Los Angeles County[5] found a prevalence of food insecurity of 24% (Furness et al., 2004). Households with a history of homelessness were almost six times more likely to be classified as food insecure compared to those who did not[6] (28% *vs* 16%, respectively). Households with children were almost twice as likely to be food insecure as those without children (56% *vs* 22%, respectively).

Summary

The international literature indicates a wide range of definitions and measures of food poverty. There is also a lack of prevalence data on food poverty of families in emergency homeless accommodation in Ireland. While some relevant data is available on certain aspects of food poverty, the diversity of definitions and measures in use makes synthesis difficult.

Families' access to food, storage and cooking facilities in the context of emergency homeless accommodation (RO2)

The challenges faced by homeless families living in sheltered accommodation and in B&Bs were well documented in the UK during the 1990s (Stitt et al., 1995; Stitt et al., 1994) and in Ireland during the early 2000s (Halpenny et al., 2002; Hickey & Downey, 2003; Smith et al., 2001). Barriers to accessing food, storage and cooking facilities amongst homeless people, particularly those with children, have been noted in several studies, including those conducted in Ireland, the UK, and the US.

Access to food

The negative impacts of regimented meal times and food choices on the dietary intakes and behaviours of homeless families living in shelter accommodation have been reported in a series of studies in the US (Dammann & Smith, 2010; Dammann, Smith, & Richards, 2010; Smith & Richards, 2008). In a study of the factors that affect food choice and health beliefs among low-income women in the US[7], homeless participants in shelters where food was offered reported strict rules regarding food storage in their rooms, lack of food choice and the constraints of structured mealtimes (e.g. meals served too early, meals too close together resulting in snacking at night) (Dammann & Smith, 2009). Children's food choices were often unhealthy due to barriers to food availability and to restrictions on foods allowed in rooms, with non-perishable snacks only being permitted.

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[5] The Six-Item Short Form of the US Department of Agriculture's Household Food Security Scale (Blumberg, Bialostosky, Hamilton, & Briefel, 1999) was used to measure food insecurity.

[6] Within the previous five years.

[7] With at least one child aged 9–13 years in the household.

In an Irish context the situation of homeless families in emergency accommodation can be compared with that of asylum seekers in government Direct Provision centres. Although they are not defined as homeless, asylum seekers in Irish Direct Provision Centres experience challenges with appropriate food provision, stressful non-family-friendly dining room environments and conditions that impact negatively on breastfeeding and infant feeding practices (Barry, 2014; Manandhar, Share, Friel, Walsh, & Hardy, 2006).

Focus group discussions with homeless female residents of a US Transitional Living Centre (TLC) revealed many constraints for the women and their children in accessing and consuming a healthy balanced diet (Davis, Weller, Jadhav, & Holleman, 2008). Participants described the food at centres as inadequate to address the diverse nutritional needs of teenagers, children and adults, particularly those with chronic illnesses. For some, the TLC food impacted on their quality of life in terms of weight gain, constipation and anxiety about the consumption of too much salt. The routine of receiving meals at the shelter impacted on their emotional wellbeing to the extent that they sought freedom and comfort through junk food rewards for themselves and their children.

The cost of good food was cited as one of the barriers to achieving good nutrition among homeless people in Dublin (Hickey & Downey, 2003). Similarly in the US, families and children living in shelter accommodation experience barriers to their food choice from inflated prices and poor food quality and variety (Richards & Smith, 2006b, 2007).

Food storage

Problems with the safe and secure storage of food by homeless families living in emergency accommodation, particularly B&Bs and hotels, are well documented in the national and international literature.

Issues concerning food preparation and hygiene, and the safe and secure storage of food within emergency accommodation in Dublin, particularly B&Bs, were highlighted by Hickey and Downey (2003). In the US, Wiecha et al (1993) report greater problems concerning food storage for families living in hotels compared with families living in shelters. Those who lived in hotels reported purchasing food more frequently, were more likely to use food pantries, and had fewer food items on hand. They were also significantly less likely to be satisfied with their diets, access to food, and facilities for cooking and food storage (Wiecha, Dwyer, Jacques, & Rand, 1993).

A study from Liverpool (UK) reported that homeless families living in B&Bs had inadequate food storage facilities (Stitt et al., 1995; Stitt et al., 1994). Similarly, Jenkins (2014) found that storage of fresh and frozen food was difficult for families living hostels, with 57% sharing a standard-size fridge with one or more families.

Food storage limitations and restrictive policies have also been cited as factors that impact negatively on the food-related practices of women on a low income, including women living in homeless shelters in Minnesota (Wiig & Smith, 2009).

The women prioritised their food purchases differently than if they had a home base, mainly because of food storage issues. For the women in the shelters, where three hot meals were served daily, to avoid attracting pests in their rooms, as mandated by shelter policy, they resorted to spending their food money on non-perishable, individually packaged beverages and snacks. Fresh fruits were not allowed as an in-room snack option (Wiig & Smith, 2009). Some women lived in a homeless shelter where rooms were furnished like an apartment, with either a cook-top or stove with an oven, a small or regular-sized fridge and a microwave. They tended to shop more frequently because they had limited space to store perishable items and many fried or microwaved foods if they did not have an oven (Wiig & Smith, 2009).

Individuals and families who are not technically homeless, but who live in single-room occupancy dwellings (hotel or apartment buildings where individuals can rent small dormitory-style rooms on a daily, weekly, or monthly basis, typically with shared bathrooms and no kitchen/cooking facilities) or in otherwise fringe housing circumstances, also face challenges related to food access, including food storage and preparation (Bowen, Bowen, & Barman-Adhikari, 2016; Lewinson, 2010). Their living situations may be considered comparable to what may be seen amongst families residing in emergency accommodation. Similar issues concerning food storage have been reported by those living in Direct Provision centres in Ireland (Barry, 2014).

Cooking facilities

Hickey and Downey (2003) found that access to cooking facilities (particularly for those with children) was a barrier to achieving good nutrition among homeless people in Dublin. Interviewees expressed dissatisfaction about the lack of cooking facilities and opportunities to cook in emergency accommodation. Inadequate preparation, cooking, and dining facilities for homeless families living in B&Bs were also highlighted in a study conducted in Liverpool (Stitt et al., 1995; Stitt et al., 1994). As previously mentioned, compared with families living in shelters, respondents in Wiecha et al's (1993) study who lived in hotels in the US were significantly less likely to be satisfied with their cooking facilities. Also in the US, Richards and Smith (2006a) found that homeless families living in shelter accommodation experienced poor storage and cooking facilities, as well as regimented meal times and food choices, all of which influenced their dietary intake. Cooking was more challenging for women in the homeless shelters in Dammann and Smith's (2009) study, but they reported eating together as a family more often than other participant groupings. A report on the food experiences of those living in Direct Provision centres in Ireland highlighted the difficulties families experienced in providing adequate food for their children and how sometimes they had to resort to cooking, which was not permitted. The lack of role modelling around cooking meals was also noted by these families (Barry, 2014).

Services provided to homeless families in shelters and hotels may influence food expenditures, food procurement, and women's diets. Wiecha et al (1993) examined food habits of homeless families in Boston-area hotels and family shelters (n=77). Mean monthly food expenditures were significantly lower for those in shelters that provided standard kitchen facilities and substantial food support compared with those who lived in hotels without these amenities.

Storage space and privacy

In Ireland Halpenny et al (2002) conducted qualitative interviews with parents and their children[8] to examine the impact of living in emergency B&B and hostel accommodation on the daily life routines of families. Parents and children voiced concerns about lack of space: having to share living areas with each other, not having space to play nor for their personal belongings, and a lack of privacy. Parents described their frustration at trying to maintain normal family routines (cooking, washing clothes, preparing children for school) and for many families this led to increased conflict, both between parents, and parents and their children. They voiced feelings of loss of dignity and respect, and of having let their children down by failing to provide them with their own home.

The unsuitability of emergency accommodation (B&Bs and hostels), including lack of space, lack of facilities and unsafe conditions, particularly for young families, was also raised in a study conducted in the former Eastern Region Health Authority (ERHA) area in Ireland (Smith et al., 2001). Similarly, in Leicestershire (UK) a clinical audit project of a number of hostels providing temporary housing for homeless families and individuals found that families were living in cramped conditions with shared facilities and no safe play areas for their children (Riley, Johnson, & Pearson, 2001).

Comparable issues have been noted in research with families who are not homeless, but who live in single-room occupancy dwellings. A qualitative study conducted in the US found that families who live in extended-stay accommodation report experiencing psychological, physical and social stressors (Lewinson, 2010). Psychological stressors include negative emotions related to staying at the hotel for longer than anticipated and associated feelings of guilt, depression and embarrassment (ibid). Limited space was a commonly reported physical stressor, while finding and maintaining personal space was cited as a social stressor, including the inability for couples to secure privacy for intimacy (Lewinson, 2010).

[8] 20 parents and 319 children.

The impact of homelessness and emergency accommodation on daily food habits, nutrition, health and well-being among parents and children (RO3)

General health impacts of homelessness on children and families

The connection between housing and health is well established. In adulthood children who have experienced housing instability or homelessness have a 25% greater risk of poor health and have higher mortality rates than individuals who reside in stable housing as children (Weitzman et al., 2013). Homelessness is associated with negative impacts on child development, physical and mental health (including hunger and poor nutrition) and education (Primas et al., 1993; Rafferty & Shinn, 1991; Vandentorren et al., 2016; Wiecha et al., 1993; Wood, Valdez, Hayashi, & Shen, 1990).

In a US study, current homelessness was associated with shorter height-for-age and a greater prevalence of iron deficiency anaemia than in never homeless (and previously homeless in the case of the latter) children in the same age group (Partington, 1998). A study of homeless families in Paris found high levels of anaemia (50% of mothers and 38% of children), overweight (38% of mothers and 22% of children), obesity (32% of mothers and 4% of children) and depressive disorders (30% of mothers and 20% of children) amongst participants (Vandentorren et al., 2016).

Maternal depression has been shown to be associated with housing inadequacy, and even more strongly associated with multiple hardships in the forms of housing inadequacy and housing instability and/or food insecurity (Corman et al., 2016).

Homelessness, especially family homelessness, is associated with risk for higher BMI in young people (Cutuli et al., 2015). High rates of overweight and obesity (45%) were found in homeless children aged 9–13 (n=159) at shelters in Minneapolis (Richards, Smith, & Eggett, 2013). Schwartz et al (2007) contend that overweight and obesity are the major forms of malnutrition in homeless families. In their study of the nutritional status of homeless caregivers (n=31) and their children (n=60) from six homeless shelters and transitional houses in Baltimore, Maryland forty-two percent of the children had a BMI-for-age classifying them as at risk for overweight (18%) or overweight (23%); none were underweight (Schwarz et al., 2007).

Health impacts of living in emergency homeless accommodation

During the late 1980s the health risks associated with families living in poor quality B&B accommodation in the UK were documented by Conway in Prescriptions for Poor Health (Coufopoulos, 2009). This report noted that families were often compelled to share bathroom and cooking amenities with ten or more people and living conditions resulted in numerous physical and mental health problems (Conway, 1988).

Morris and Strong (2004) in an interview study of 34 homeless parents with 87 children revealed that children experience many health problems and dangers, and experience external locus of control[9], deterrents to health, economic barriers and lack of support. An Irish study examining the impact of living in emergency B&B and hostel accommodation found that many parents were concerned about the effects of being homeless on the mental health of their children in term of anxiety, depression and isolation (Halpenny et al., 2002). High levels of stress and clinical morbidity[10] in homeless mothers and their children living in a supported temporary housing project in Ireland have previously been noted (Waldron, Tobin, & McQuaid, 2014).

Concerns have also been raised about the health-related behaviours and healthcare experiences and neonatal outcomes of pregnant women (Richards, Merrill, & Baksh, 2011), and the birth weights and mortality rates of infants living in hotels for the homeless in New York City (Chavkin, Kristal, Seabron, & Guigli, 1987). Researchers recommended that the city provide on-site health education and care, social and nutrition services in the hotels and refrigerators for mothers with new-born children.

Homelessness, food insecurity and diet

Numerous studies have demonstrated the links between homelessness and food insecurity, and poor dietary intakes and behaviours, with some examining these issues amongst families in emergency housing/hostels.

Various UK studies have documented the dietary intakes of women and children living in emergency homeless accommodation and highlighted concerns. Coufopolus and Hackett (2009), in a study of women and children living in temporary accommodation in north-west England, found that homeless women and children had similar issues to other low-income groups in accessing and consuming a diet in line with healthy eating guidelines. Diets were often poor, with many women failing to meet the recommendations for energy, protein, fibre, calcium, iron, vitamin C and folate (Coufopoulus & Hackett, 2009). Yet, when it came to support for families, Coufopoulos and Mooney (2009) found that practitioners who worked with homeless families tended to overlook dietary quality and took a 'broad brush' approach that focused on whether or not people were getting 'enough' to eat.

A pilot study of the diets of homeless families in Liverpool in B&B accommodation reported on the extreme gaps between dietary intakes and national recommendations within this population (Stitt et al., 1994). Also in the UK, a nutritional assessment of 40 hostel dwelling families reported that they consumed lower proportions of fruits, vegetables and dairy products than recommended (Jenkins, 2014).

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[9] Locus of control is the extent to which people believe that they have control over the outcome of events in their lives. Individuals with an external locus of control believe that external forces beyond their control determine the outcomes of events in their lives.

[10] The presence of mental health problems of sufficient severity to merit referral for treatment.

US research also highlights concerns about the adequacy of the diets of families living in emergency homeless accommodation (Derrickson & Gans, 1996; Richards et al., 2013). A study of homeless children aged 9–13 (n=159) at two shelters in Minneapolis found that children had low intakes of fruits and vegetables and very high intakes of foods from the fats and sweets food group (Richards et al., 2013). A study of homeless preschool children in emergency shelters (n=35) and transitional housing (n=28) in Baltimore, Maryland reported both groups consumed less than the USDA-recommended number of servings of dairy products, fruits and vegetables and grain products; interestingly, those living in emergency shelters consumed significantly lower amounts of grain products and provitamin A-rich fruits and vegetables and significantly more vitamin C-rich foods than those living in transitional housing (Taylor & Koblinsky, 1994).

Davis et al (2008) assessed the dietary intake of 81 homeless women residing at a US Transitional Living Centre (TLC). The women's diets were similar to those of other low income marginalised groups and were characterised by high fat content and low fruit and vegetable consumption. A study of the nutritional status and nutrient intake of 96 single mothers and their 192 dependent children, in marginal housing[11] found that all age groups consumed less than 50% of the Recommended Dietary Allowances (RDA) for iron, magnesium, zinc, and folic acid, while adults consumed less than 50% of the RDA for calcium (Drake, 1992). The type and amounts of fats consumed were in higher than desirable quantities for a significant number of subjects of all ages. Health risk factors of iron deficiency anaemia, obesity and hypercholesterolemia were prevalent.

Goyings and Csete (1994) compared the dietary intakes of homeless families (n=135) at shelters and motels with those of low-income families who used free community meal sites (n=129) in Wisconsin. Interestingly, the diets of homeless adults and children were found to be more adequate than the diets of the non-homeless comparison group. Nevertheless, adults in homeless families at motels had poorer intakes than adults at shelters, but this difference was not found for their children (Goyings & Csete, 1994).

While the extent of food provision in emergency accommodation facilities varies, some studies have found the nutritional adequacy of meals served in these facilities to be inadequate. Silliman & Wood (2001) analysed sample meals (n=106) at thirteen emergency facilities. They found that the meals, on average, provided less than 33% of the Recommended Daily Allowances/ Dietary Reference Intakes for folate, calcium, magnesium and zinc. The meals, on average, were high in calories and fat and low in fibre. Deficits in the nutritional quality of US shelter-provided foods and soup kitchens have also been by reported by Kelly (2001) and Hamm & Holden (1999).

[11] Housing for those without legal rights to their housing facilities.

Family strategies in negotiating emergency homeless living situations (RO4)

Parents seek to provide for their children's basic needs, including shelter, food, clothing, medical care and access to education. Mothers and fathers facing homelessness and poverty experience greater challenges and seek assistance within public systems just to provide these (Paquette & Bassuk, 2009). To ensure their children have food is a priority for mothers/families (Stevens, 2010). Studies have shown that homeless families will go to any lengths, whether legal or not, to acquire sufficient food for their families (Richards & Smith, 2006a). US literature documents a wide range of strategies used by mothers/families living in emergency homeless accommodation; these include:

- skipping meals or going without food in order to feed their children (Deloitte MCS Limited, 2006; Richards & Smith, 2006a; Stevens, 2010; Wiig & Smith, 2009) – also known as 'maternal deprivation (Wiig & Smith, 2009)
- adopting savvy shopping habits (Richards & Smith, 2006a; Wiig & Smith, 2009), including planning ahead by buying food with a long shelf-life (Stevens, 2010)
- trying to budget (Stevens, 2010)
- avoiding waste and using left-overs (Wiig & Smith, 2009)using food banks and external federal sources (Stevens, 2010) including food stamps (Richards & Smith, 2006a)
- using family members to supplement their incomes (Stevens, 2010)
- taking food from the shelter facility (Richards & Smith, 2006a)
- stretching food at the end of the month (Richards & Smith, 2006a)
- eating food in grocery stores (Richards & Smith, 2006a)
- pawning personal items (Richards & Smith, 2006a)
- scavenging in dumpsters (skips/bins) for items, including food (Derrickson & Gans, 1996; Richards & Smith, 2006a)
- acquiring food from families and friends (Derrickson & Gans, 1996).

A number of studies have noted that, in addition to the strategies outlined above, mothers encourage their children to overeat (even eat disliked foods) when food is available because periods of food availability were often followed by periods of food scarcity and hunger (Richards & Smith, 2006a; Smith & Richards, 2008). Young people in US homeless shelters report overeating; eating anything, eating disliked foods and eating at the homes of family and friends as strategies to cope with food insecurity (Smith & Richards, 2008).

Lewinson's qualitative study of families in US extended stay accommodation demonstrates how families cope with their circumstances (Lewinson, 2010). Families adjusted either their emotional responses or the physical characteristics

of the hotel space to accommodate their needs, or adapted their behaviour to fit the environmental context, for example, by 'getting comfortable': they added entertainment, toys, decorations and mementos. They also added functional items and developed solutions such as holding plates (literally holding their plates while sitting on couches/beds); dividing space, either visibly or invisibly, to signify separation of spaces; and getting away from their room, or hotel, to their favourite alternative places. Yet, some residents preferred to remain uncomfortable to ensure that their stay was temporary (ibid).

Policies, interventions and best practice to improve food security among families experiencing homelessness (RO5)

The literature review uncovered few studies that investigated policies, interventions and best practice to improve food security among families who experienced homelessness. All studies extracted were conducted in the US and the findings must be interpreted within that particular context.

Nutrition education programme and interventions

Interventions with families

There is a dearth of evidence on effective nutrition education interventions for homeless mothers and their children (Coufopoulos et al., 2012). In a recent systematic review on this issue, only two studies met the inclusion criteria (Johnson, Myung, McCool, & Champaner, 2009; Yousey, Leake, Wdowik, & Janken, 2007), both of which were deemed to be of low quality. While they showed some improvement in nutrition-related knowledge this did not translate into improved dietary intakes.

A small number of intervention studies have been published. An evaluation of a three-month, delivered, prepared meal programme ('Feastworthy') to a 60-family motel-shelter demonstrated improvements in nutrition behaviours and food security, compared to the control site, but these were not statistically significant (Chatterjee & Brown, 2017). There was high loss to follow-up in the study partly due to families moving out of the shelter prior to study completion. Participating families were satisfied with the programme and many described improved food security.

An evaluation of a short-term nutrition intervention in ethnically diverse, low-income women[12] reported positive increases in nutrition knowledge and behaviours (Rustad & Smith, 2013). It should be noted that almost 40% of the original sample (n=194) did not complete the programmes: reasons included: (1) some had to move, (2) some found employment elsewhere and (3) a few had difficulty procuring childcare.

[12] Aged 23–45 years (n=118); recruited from community centres, homeless shelters and the University of Minnesota in Minneapolis–St Paul.

Rodriguez et al (2013) assessed the feasibility of a 15-week nutrition education, physical activity and media literacy programme for children aged 6–14 years (n=162) living in two urban family homeless shelters in the Bronx, New York (Rodriguez, Applebaum, Stephenson-Hunter, Tinio, & Shapiro, 2013). The programme, 'Cooking, Healthy Eating, Fitness and Fun' (CHEFFS), was well attended, consistently, and qualitative results reflected changes in children's knowledge and attitudes. In many instances, children stated their intention to change health behaviours. The programme was delivered to children with little autonomy in choosing their meals or how meals were prepared. As it was conducted through an after-school programme, parents were not available to attend because of multiple other demands. Many children expressed aversion to unfamiliar foods, but facilitators found that when children engaged in food preparation they were more likely to try and enjoy new foods. Through their experience, facilitators developed healthy snack recipes that could be prepared easily in the shelter setting without kitchen facilities, by incorporating foods that were available in the shelter neighbourhood.

The challenge of developing interventions to improve the nutritional status of homeless children has also been noted by Yousey et al (2007). They suggest that educational strategies may need to be augmented by policies around food provision (Yousey et al., 2007). They implemented an educational program for mothers (n=56) and the cafeteria staff (n=3) at a homeless shelter. Clinic nurses taught four nutrition classes, developed by a registered nutritionist, to mothers and three nutrition classes were taught to the cafeteria staff by the nutritionist. While mothers showed improved nutritional knowledge following the intervention, minimal differences were observed in the nutritional quality of foods served to residents after staff education. The cafeteria staff's ability to demonstrate their learning was impeded by the constraints of food donations.

The role of health and social care professionals

The literature points to a clear role for health and social care professionals – particularly social workers and primary care providers – in addressing issues of food security amongst homeless families. Social workers have a role in ensuring that they address issues related to food security. Biggerstaff et al (2002) argue that while food needs are not central to the concerns of social workers unless there are physical signs of hunger, they should nevertheless investigate food adequacy in client assessments and keep an up-to-date knowledge of sources of food-related supports. A survey of 974 homeless women in Los Angeles County in 1997 found that having a case manager was associated with greater odds of using food stamps and of finding shelter without difficulty in the previous 30 days (Heslin, Andersen, & Gelberg, 2003).

There is also a role for healthcare professionals. In 2015, the American Academy of Pediatrics (AAP) made several recommendations concerning the engagement of paediatricians in efforts to alleviate food insecurity (Council On Community Pediatrics-Committee On Nutrition, 2015). These included: screening for food insecurity at scheduled health visits, familiarising themselves with programmes/resources for those identified as being at-risk of food insecurity (e.g. WIC, SNAP, school nutrition programmes, local food pantries, summer and child care feeding programs) and advocating for programmes/resources to address the issue. The AAP has also issued guidelines on Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity, making recommendations around practice change, partnership with community resources, awareness and advocacy (Briggs, 2013).

Policy

A number of policy responses to improve food security amongst homeless populations in general have been suggested in the literature. In New Zealand, Gorton et al (2010) undertook a review of environmental influences on food security in high income countries to inform actions to enhance food security. They argue that policies to improve food security need to address multiple areas including employment, real incomes, labour market policy, affordable quality housing, education, primary healthcare, accessible and affordable transport, affordable childcare, family support policies, environmental policy, welfare policy, and the needs of ethnic minorities, including obligations to indigenous peoples (Gorton, Bullen, & Mhurchu, 2010).

Various authors highlight the merits of taking a dual approach to address issues relating to food insecurity amongst homeless populations. In their analysis of US data, Gundersen et al (2003) argue that action on both housing and food assistance policies would be mutually beneficial. Policies that improve housing stability (such as rent support programs, housing vouchers, and expansion of low-income housing availability) and food security may improve access to health care and health care outcomes (Kushel, Gupta, Gee, & Haas, 2006). Policies that increase the stability and the supply of affordable housing may be critical to ensure that families can sustain stable housing and avoid homelessness (Hanratty, 2016). In the US Hanratty et al (2016) found that declines in affordable housing may have played a role in increasing shelter use over the 2007–2009 recession. The US Family Options Study followed 2,282 families for 36 months and found providing homeless families with time-limited or permanent rent assistance not only reversed homelessness but also improved food security (Gubits et al., 2015).

Given the links between housing, mental health and food security, it is important to look beyond the costs and benefits of housing programmes solely in terms of improved housing conditions (Gundersen et al., 2003). Bailey et al (2016) developed a US county-level index of availability of subsidised housing needed to meet the demand of low-income households. They estimate that if subsidised units were available to an additional 5% of the eligible population, the odds of overcrowding decrease by 26% and the odds of families making multiple moves decrease by 31% (Bailey et al., 2016). Expanding the levels of subsidised housing may reduce housing insecurity and thereby also improve the health and wellbeing of young children, including their families' food security status.

Policy measures need to be culturally appropriate and acceptable. While certain approaches are taken in some countries, for example food stamps in the US, caution is required in consideration of the extent to which they are applicable, appropriate, desirable, and transferable into different social and cultural contexts.

Conclusion

While much of the literature on family homelessness was published in the 1980s and 1990s, and is largely US-based, the descriptions of the economic and public policy conditions associated with the rise of family homelessness have subsequently continued and are still relevant today (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013).

Housing, diet and health are inextricably linked. There is limited evidence surrounding interventions to ameliorate the food security of homeless families. While interventions to date have demonstrated some impacts on improved nutrition knowledge and certain behaviours, these are limited by the environmental constraints in which families operate. As such, policies need to be introduced which buffer families against these constraints. Such policies should first and foremost address housing provision, be holistic and, where appropriate, integrate food security and mental health.

Chapter 4: Family food practices in emergency homeless accommodation

Introduction

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

The findings presented below arise from in-depth interviews conducted with 10 families resident in Dublin Regional Homeless Executive emergency accommodation. The research aimed to examine food poverty among families in emergency homeless accommodation and the impact this has on the nutrition and health outcomes of parents and their children. Data collection took place between December 2016 and April 2017.

This chapter is organised in two sections:

- **Section one** presents findings from interview one on participant demographic characteristics, pathway to emergency accommodation, and current living circumstances.
- **Section two** illustrates the findings from the second interview of parents that examined their everyday food worlds in emergency homeless accommodation using a photo voice/elicitation technique.

Section 1: Family characteristics, pathway to emergency accommodation and current living circumstances

Demographic overview of sample

Table 4.1 · Participant demographic characteristics (n=10)

Sex	
Female	6
Male	4
Age of parent	
Range	22–45
Mean	34.4
Nationality	
Irish	6
Other nationality	4
Highest Level of education completed	
Primary	2
Secondary/Junior Certificate equivalent	2
Secondary/Leaving Certificate equivalent	6
Household type	
Couple with children	4
Lone parent with child(ren)	6
Main source of income[13]	
Lone parent benefit	5
Job seekers/unemployment benefit	4
Other benefit	1

Table 4.2 · Number of children

Number of children residing with parent in emergency accommodation	
1 child	3
2 children	4
3 children	2
4 children	0
5 children	1
Total number of children in study	20

[13] One participant reported working part-time

Table 4.3 · Children's age range

Age of children	
Range	4 months – 22 yrs
Under 12 months	1
1–2 years	4
3–5	3
6–8	2
9–11	2
12–14	3
15–17	1
18 and above	2

Pathway to emergency accommodation

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

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

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

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

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

Duration of homelessness

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

Table 4.4 · Length of time homeless

Length of time homeless	Number of families
1 to 3 months	3
4–6 months	2
7–12 months	2
1–2 years	1
3 years	1

Current living circumstances

Participants' current living circumstances varied in terms of the main purpose of the accommodation and in terms of the facilities provided. A number of accommodation settings were distinctly geared to the budget travel market but some seemed to have reoriented to serving homeless people only. Other types of accommodation could be described as B&Bs for homeless families and tourists; commercial hotels serving tourists mainly, with homeless families in a minority. Some insight into the different levels of accommodation provided to the families in this sample may be gained from reviews on Tripadvisor for budget hotels where both tourists and homeless families reside:

> ***Horrible horrible place. Staff hateful. Place smells of smoke and cigarette butts lying inside bar. Worst place we have ever stayed in our life. Joke of a place. Noisy and rooms are from the 1970s. We will never ever be back.***

> ***The facilities from the carpeting, flooring and walls are very cheap and dingy. You can feel the soft spots when you walk around. You can feel the springs of the hummocked mattress poking you, so my advice is to take the extra comforter and put it under the sheets. But it was the best deal we could find in expensive Dublin, so if you can tolerate these things and you are not too picky, id say its fine.***

Some families were in hotels rated more positively on Tripadvisor:

> ***Nice hotel, 25 minutes walking from the city center, with clean and spacious room. Quiet area. Breakfast was nice, but could have more fruit. The price was a little bit high considering this is a very Ibis like hotel, so nothing very noticeable about it.***

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

Cooking and dining facilities also varied. Table 4.5 below categorises the accommodation type and the facilities provided

Table 4.5 · Accommodation categories and facilities provided

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

Note: N/A = not applicable

Health issues

Participants were asked to rate their health (very good; good; fair; bad; very bad). Two rated their health as very bad or bad; three as fair; three as good and two as very good. Three reported medical conditions for which they took medication: Type 2 diabetes (1); high blood pressure (1); and depression (1).

Dietary characteristics

A 19-item Food Frequency Questionnaire was used to ask participants about their current diet. This data provides further descriptive context to their interview accounts of food practices, which follow in section two.

Chart 1 below illustrates how often participants consumed each of the 19 food items. The food items most frequently consumed on an everyday basis were as follows: full-fat milk; chips; coke; crisps, low fat milk and sweets. Reported daily fruit and vegetable consumption was low.

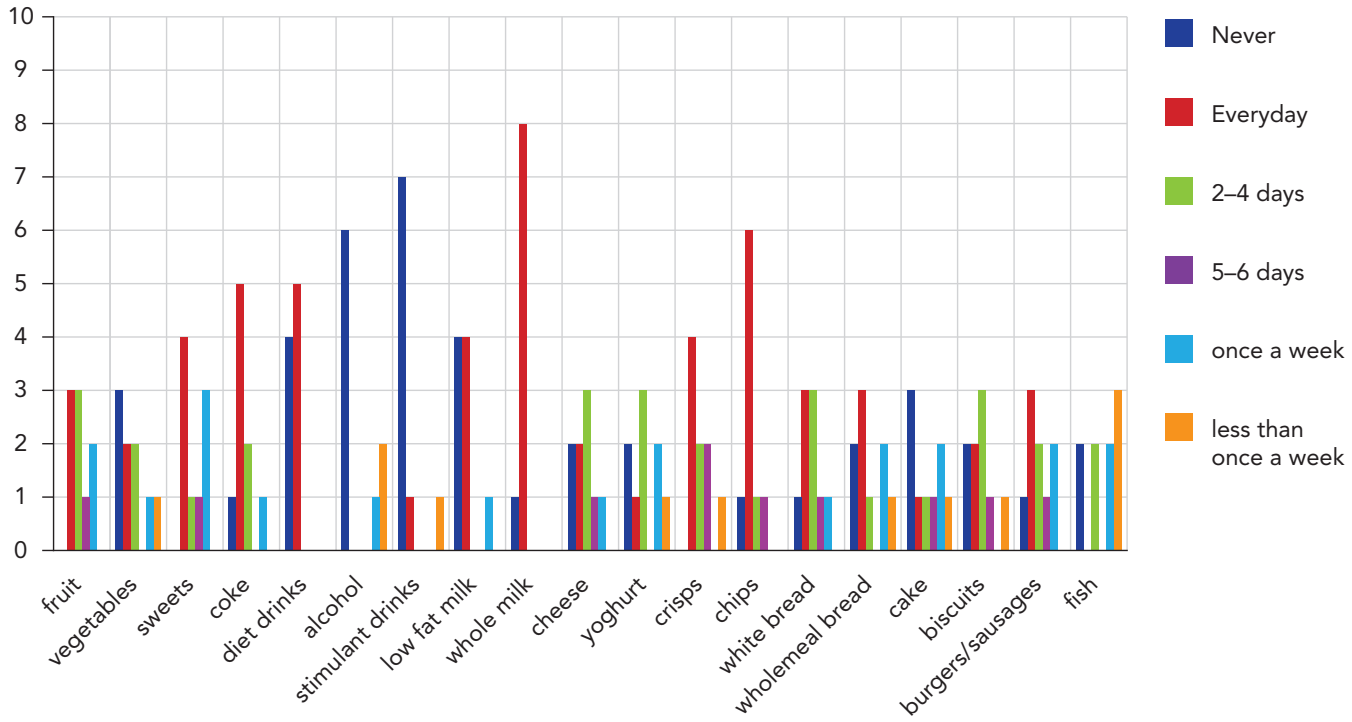

Chart 1 · How often participants consume particular food items

Expenditure on food

Not surprisingly, there was some variation amongst the participants in terms of their weekly expenditure on food ranging from €80 per week for a couple with one toddler in accommodation with kitchen facilities, to €300 per week reported by two families, one with five children without any cooking facilities or refrigeration, and the other a single parent, with minimal access to kitchen facilities, with two teenage children and an infant.

Section 2: The everyday food worlds of families in emergency homeless accommodation

Access to food, storage and cooking facilities in the context of emergency homeless accommodation [RO1]

Food availability and access in emergency homeless accommodation

Availability of food provision services in emergency homeless accommodation varied across the sample of participants. They ranged from accommodation that provided breakfast only, breakfast and an evening meal, to self-catering services.

Breakfast provision

Four families reported that their accommodation provider supplied breakfast. Breakfast consisted of typical hotel fare: toast, juice and cereals, and fried meat products, yoghurt and eggs. Access to breakfast could be problematic for families. For instance, P2, who was in a B&B, pointed out that access to breakfast at 8am made life difficult when trying to prepare five children for school.

Similarly, P4 found it easier to retrieve breakfast from the dining room and take it to their room because of time and space constraints when trying to ready her child for school. Their room had no chair so her daughter stood with her toast and juice in front of the dressing table (Figure 1).

Other parents reported difficulties with availing of the accommodation provider's breakfast because they had to travel across Dublin city to take child(ren) to school. This meant that they purchased breakfast en route. P8, who was in a commercial hotel where the breakfast timetable was not overly restricted, felt that having a breakfast was beneficial but, after two years in residence, this had become boring.

Figure 1 · Stand-up breakfast at dressing table

Dinner provision

P4 had access to her accommodation provider's dinner service. Dinner, available between 4:30 and 5:30pm, consisted of a daily repertoire of four items, and a 'special'. Where possible, P4 and her family availed of the breakfast provided, but after living in the same hotel for 15 months they had grown tired of the food and also questioned its quality. Although P4 admitted that it was good to have a 'special' this was also the option that went quickly. The fixed time of the dinner could also be inconvenient if a family wanted to do something else, such as visit relatives or friends, attend an appointment, or lessen the time spent in

the emergency accommodation bedroom. A dining room was available but P4 and her family tended to take the meal to the room and ate it on the bed (Figure 2) as they disliked the environment, and because the timing did not always suit their toddler's schedule or mood.

Access to cooking facilities

Families had differing experiences with access to cooking facilities, ranging from:

- No access to any cooking facilities
- Shared microwave and fridge
- Shared kitchen with cookers, fridge, and dining area

Parents without access to any cooking facilities described the difficulties of trying to provide food for themselves and their child(ren). Five participants were living with their child(ren) in accommodation without access to any cooking facilities. For P2, who at the time of interview had lived with his wife and five children in emergency accommodation for three months with no access to cooking facilities, this meant that his daily routine was dominated by the need to obtain food for his family. P2 purchased takeaway meals for consumption in the bedroom and also conveyed food from the restaurant where he was employed (Figure 3). This was preferable to a takeaway meal but challenging in terms of transportation and the lack of facilities to clean up the utensils for return to the restaurant. P1 who admitted that 'It hurts me that I can't cook for (name of child)' spent considerable amounts of time travelling from the city centre to an outer suburb to her father's residence to cook simple dinners for herself, her father and her child.

Families with access to a shared microwave and fridge

Whereas P4 was able to access breakfast and dinner at her hotel accommodation, she emphasised that 'It is only two hours a day that food is provided'. This required families in such circumstances to be present at the fixed times to avail of the food on offer. This did not always work out for reasons that included: young child sleeping; being in another part of the city; and having an appointment. Access to a shared microwave was convenient for heating small food items, but P4 did not use these as she had concerns about hygiene, and did not see this as a long-term solution.

Figure 2 · Dining on the bed with hotel-supplied dinner

Figure 3 · In-room dining with food from parent's workplace

Although the families without cooking facilities felt that their situation could be improved with access to a kitchen, the interviews with the four participants that had access to a shared kitchen with cookers, fridge and microwave revealed a plethora of difficulties with their current arrangements. These included: restricted access to kitchen; lack of equipment; queuing to cook and dine; and CCTV surveillance. Storage issues, both in their room and the kitchen, and feelings about the food and eating environment dominated parents' descriptions of their cooking facilities and these will be addressed later in this report.

Kitchen access: restricted

Of the participants with access to kitchen facilities, none had 24-hour access. At P6's accommodation, a room without a private bathroom, shared with her three children, it was only possible to access the kitchen between 7am and 11pm. As she explained, this caused difficulties, and she could not see the sense of this restriction:

> ***It is not normal for a kitchen to close because as a family you can't use the kitchen at anytime and nobody sleeps near the kitchen so you can't disturb anyone (P6)***

The hours of operation meant that her son did not have sufficient time in the morning to get breakfast. Although he attended a school that provided breakfast, he could not reach there in time to get it, and so she gave him €3.00 each day:

> ***He can't get it in the house and he can't get it in the school (P6)***

Figure 4 · Restricted kitchen access

P9 spoke of the pressure to access the kitchen before it closed. She related her experience of returning late to her accommodation after travelling some distance from her previous employment:

> ***One day my daughter left food in the kitchen and the (name] closed the door – she was still cooking – 'tell him the fire is on like' and we have to take the food uncooked out, and it was not well cooked, because he wanted to close the door (P9)***

At the time of interview, P7 had been in the same emergency accommodation for 15 months with her 20-month-old child and partner. Regulations at P7's accommodation stipulated that children could not be left in their room or enter the kitchen. She found physical access to the kitchen challenging. She described this through her pictures of the three flights of stairs that she negotiated three or more times a

day with her toddler, and her cooking ingredients in a backpack. P5 lived at the same accommodation service as P6, albeit with older children. He also found access to the kitchen difficult because of the proprietor's regulations. Like P6, he transported his ingredients down flights of stairs, accompanied by his three children:

> ***I take this picture because the way I live is basically not very good. I have no place to put my stuff I have to put it in a bag (P5) (Figure 5)***

Although P7 and P5 could access a kitchen and cook a meal, the regulations meant that their child(ren) had to sit and wait outside of the kitchen while they prepared food. Parents were not permitted to leave their child(ren) unattended in their room.

P7 and P5 were able to access utensils for cooking and dining, though at times these were not left sufficiently clean by other residents. In contrast P6 and P9's kitchen facilities did not provide cooking utensils, and there was also the challenge of conveying utensils to the kitchen and of having them removed if they left them behind.

While it was beneficial to have access to a fridge and a freezer, access was problematic as P6 described in her picture (Figure 6) of a jammed up freezer of food that was out of date/left behind by previous residents of the emergency accommodation.

Figure 5 · Conveying ingredients to a shared kitchen

Figure 6 · Jammed-up shared freezer with out-of-date food from previous residents

Kitchen access: Queuing to cook and dine

The four participants with access to a kitchen with dining facilities described the need to have a plan when preparing to cook in a shared environment. They could not assume that they would be able to cook when it suited them and often had to queue for a cooker and a table. P9 stated that even if she purchased food to cook a meal for her family on the day that it was purchased, congestion in the kitchen could mean that they resorted to a takeaway.

> ***It is very bad because you can't cook as you want, you can't eat what you want, when you go downstairs you want to cook, you say I am eating this and it is busy you have to wait, and you go so, and no space to cook so I left (P9)***

These circumstances also presented P9 with the further challenge of having to store the food that she was not able to cook.

P7 ensured that she carefully picked her time to cook. She 'staked out' the kitchen to see when it was not in use and marked out the one table for family dining by positioning her plates upon it.

Kitchen access: Dining facilities

All participants with access to a shared kitchen described the challenges of dining as a family. As we have seen, the child(ren) of P5 and P7 had to endure waiting outside the kitchen while their parent cooked a meal. For P5's teenage son this has been particularly difficult as, according to his father, he would rather not have to wait outside the kitchen with his younger siblings. He is not allowed to stay in his room on his own. Yet, even after going to the lengths of preparing food that has been transported from the room, dining as a family group around a table cannot be assured, as just one family dining table was available at the accommodation (of P5; P7; P6 & P9). Through P7's photograph of the dining arrangements we can see the constraints faced by P5 and his family who had to sit in a row to eat (Figure 7).

P7 felt the eating environment to be restricted and negative: 'People say I would rather spend money on takeaways rather than go down there'. P6, who resides in accommodation without access to plates and utensils, also considered it to be a negative environment and depicted her eating environment (Figure 8) as she shows herself eating from a plastic container:

> ***You can't relax there because the place is not nice, the room is not comfortable, how will you eat and smile? It's not nice, the place is not nice, you just eat and go (P6)***

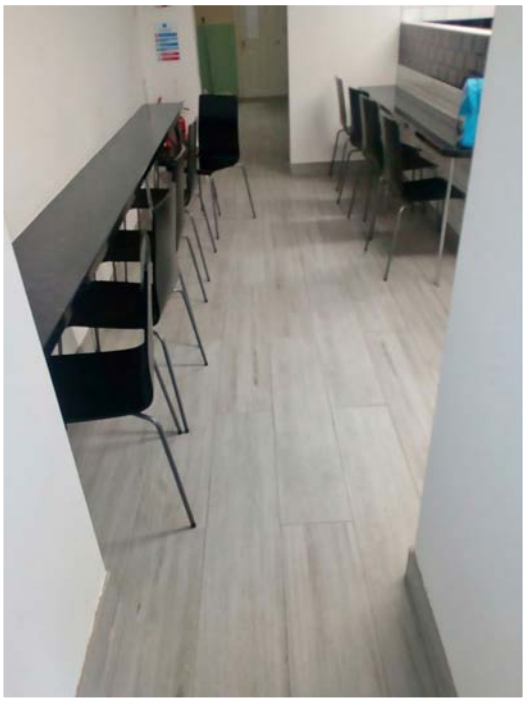

Figure 7 · Family dining in a row

Figure 8 · Eating from a plastic container

Kitchen access: under surveillance

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

P7 described her cooking and eating situation as one of a controlled environment where eating together as a family in a relaxed way was further reduced by being viewed on CCTV (Figure 9)

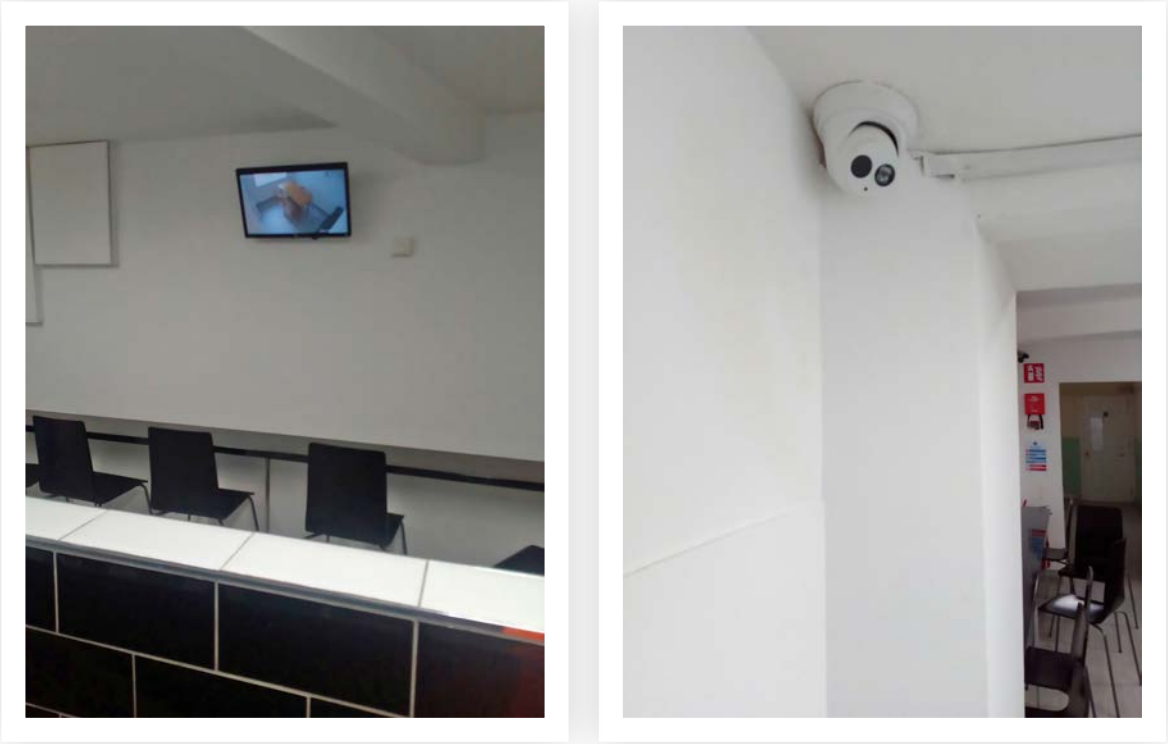

Figure 9 · Under surveillance

Food storage in emergency homeless accommodation

Through photographs of their food environments, we have described how access to food and to facilities for cooking and dining is experienced by a sample of parents in emergency homeless accommodation in the Dublin region. While parents illustrated significant daily challenges with food access for children and themselves, they also faced barriers with storage of food and personal possessions. These issues arose for all parents in this study, regardless of their type of accommodation. For those with access to shared kitchen facilities storage issues appeared to be more complex.

Before outlining parents' descriptions of how they tried to store food in their emergency accommodation it is important to re-consider the contextual conditions associated with availing of emergency homeless accommodation. P3 spoke of

having nowhere to store his child's toys, clothes and buggy and his personal possessions when he had to move into emergency accommodation. Thus, he used his car for storage. P9 spoke of living in a room that was jammed with her possessions 'Everywhere there is nowhere to put the feet' and that she had nowhere to stimulate her four-month-old baby – 'can't put the baby on the floor – where are you going to put her?' (Figure 10).

Figure 10 · Storage constraints

Similarly, P4 described the constraints in their room as they tried to store toys and baby equipment but had no room for a high chair so she fed her child on the bed or in his pram.

Parents also expressed serious challenges with storage of washing and with drying clothes. Although P6 tried to make space in her room by placing a clothes-horse outside her door, this brought her into conflict with the accommodation provider.

In-room food storage

Families with access to kitchen facilities

While all parents in this study experienced significant challenges in storing food in their rooms, there was some variation in their food storage arrangements. The four families with access to kitchen facilities did not have any personal storage space in the shared kitchen and kept their ingredients in their room. Although P5 & P7 could avail of pots, pans and utensils, P6 and P9's accommodation did not provide them with any. They had to use their own pots and carry them to and from the kitchen. P6 related her experience of leaving her pot in the kitchen and never seeing it again. Whereas P5 and P7 had an in-room small fridge, P6 and P9 did not. They shared a fridge-freezer with all of the other residents; but as P6 explained, this was problematic because she had experienced her food being taken.

Although having an in-room fridge to store food was preferable to not having one, the families with access to kitchen facilities still faced constraints in terms of what could be stored in a small fridge. It was not possible to buy larger quantities that required refrigeration, as they simply would not fit in the fridge. This meant that families who wished to cook meals had to shop more frequently. They bought smaller quantities that were more expensive and resorted to ready-made sauces and easy to produce meals that did not require too many fresh/raw ingredients that could not be adequately stored.

As noted above, families experienced difficulties with a lack of space to store food and personal possessions. For P5, who as we saw earlier conveyed his ingredients to the kitchen in a plastic bag, a cardboard box functioned as a store-cupboard for non-perishable items (Figure 11); others used available shelving in the room (Figure 12).

In-room storage: Families without access to cooking facilities

Like the families with access to kitchen facilities, the participants who reported no access to cooking facilities also had differing experiences with food storage, some had fridges in their rooms and others did not. P4 stored food in a bedside locker that was positioned on top of the fridge (this presented issues with child safety to be discussed further) and used the dressing table in the room to prepare small meals and snacks (Figure 13).

Figure 11 · In-room storage of non-perishable items

Figure 12 · In-room storage of food items

Figure 13 · In-room food storage

While P4 had an in-room fridge, this was not the case for P1, P2, and P8. Notwithstanding their lack of access to a kitchen, they faced considerable constraints with storing food. Although P2 depicted how he used the window-sill for perishable items (Figure 14), this had not worked out for P8 who went on to describe how food had fallen off the windowsill onto a flat roof below their room:

> ***It is about stuff that stores without refrigeration – I did try putting stuff on the outside of the window but it kept falling off (P8)***

Figure 14 · Window-sill refrigeration

In-room dining

By necessity, all participants ate food in their room with their families, not just snacks, but dinner, lunch and breakfast. As P4 has described earlier, this was the situation for families in emergency accommodation with meal provision, but it also applied to families with, and without, access to cooking facilities. Similar to their descriptions of the challenges of storing food, parents' accounts of eating in their rooms provided insights into why this was necessary and of the constraints they faced in doing so. Key issues that emerged were the socially unacceptable eating circumstances in communal dining areas, such as queuing for a table, eating in a row and/or eating under surveillance; restricted access to and availability of kitchen and dining facilities; lack of table and chairs in room; and managing hygiene in a confined sleeping, eating and living space.

As shown earlier, families experienced severe space constraints and minimal storage in their one room emergency accommodation. They had limited space to store clothes, food and other possessions but also lacked a suitable place to eat. Again, there were variations across the sample of participants, ranging from having no table or chair in the emergency accommodation room, to having one or two chairs. All but one family described having to eat food on the bed or a combination of some members sitting on the available chairs while others sat on the bed.

Although P7 used the kitchen and dining facilities in her accommodation service she has also portrayed it as an oppressive environment, which meant she would from time to time eat in the room. As she said:

> ***No-one wants to go down there – the people that do go down there are the same people. It's pushing you to get a takeaway (P7)***

Similar observations were made by P5 who resided at the same premises. He commented on the provider's regulations (Figure 15) that allowed takeaway meals to be eaten in the room, but meals cooked in the kitchen were not permitted in their room:

> ***See, if you buy takeaway you are allowed to eat in the room (laughing). Yes it is allowed (laughing). It's the hostel. No make sense (P5)***

For P5, who went to great lengths to ensure that his children ate well, there was little choice other than to eat at the counter-top table under surveillance.

Eating on the bed dominated participants' accounts of eating as a family. As P7 remarked:

> ***There is no chair to sit on, you have to sit on your bed, eat on your bed, do you know what I mean like, your bed is the focal point of your room, it takes up the most space (P7)***

Figure 15 · Regulations

Similarly P8, who had at the time of interview been in a hotel room with her family without access to a kitchen or cooking facilities for almost two years, illustrated their dining situation with the image reproduced as Figure 16. Explaining her reason for taking this picture she reflected:

> ***I just wanted to show that's not a normal family meal at all. It's just like, I suppose it shows the reality of like you have nowhere to eat, you are just eating on a bed but a bed is for sleeping, but in reality you do everything on the bed (P8)***

Figure 16 · Takeaway on the bed

Participants with access to a kitchen described the constraints of queuing, or of arriving too late to prepare a meal. Even though they had the ingredients ready to cook, pressure to feed children and themselves meant that it was often easier to order a takeaway and consume it in the room.

Keeping everything clean

Eating meals in the room and on the bed, particularly with young children and babies, placed great pressure on parents as they tried to keep the area clean. P2 illustrated how he and his family did not eat on the bed and instead ate on the floor making an improvised tablecloth with tin foil (Figure 17).

P3, a father or a two-year, old also found it difficult to keep the bed and his room clean. As he stated: 'My bed gets covered in chocolate and juice every single day because that is where he eats'. P3 further elaborated his anxiety about spillages and staining the carpet in his room. P8 also spoke of the challenges of keeping the 'white snowy sheets' clean and of anxiety about spoiling the room. Similarly P4, who had to feed her toddler on the bed or in his pram, related that food went everywhere as she tried to coax him to eat. Such sentiments were also expressed by other parents, particularly in the context of fear of being asked to move on if they damaged property.

Figure 17 · Dining on the floor

While some families ate directly from takeaway containers others used their own plates. This presented further challenges with hygiene as they tried to wash up after the meal. Through her picture of the bathroom sink (Figure 18) P4 described how she would wash dishes in the sink and place them in the bath before drying them.

P8 faced similar difficulties:

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

Figure 18 · Bathroom sink for washing dishes

How does living in emergency homeless accommodation impact on daily food habits, nutrition, health and well being among parents and children [RO2]

Food habits and nutrition

As we have seen, notwithstanding the constraints on food storage, access to kitchen and dining facilities, and the social context of cooking and dining, families with access to kitchen facilities attempted to prepare meals for themselves and their children. By necessity, their food repertoire was limited to what could be conveniently stored in their room, what they could carry to the kitchen, and what could be cooked quickly. Because of the constraints of having to bring children to wait while a parent cooked, P7 prepared potatoes in her room using a plate and knife, thus reducing the time she needed to spend in the kitchen with her son positioned outside the kitchen. She tended to cook things that were simple and fast, or resort to pasta with grated cheese and sauce that could be quickly heated in a microwave or beans on toast.

P5 also described the necessity to cook meals that did not take too long to produce because his children were waiting and other people were queuing to use the cooker. For both P5 and P7 it was not feasible to attempt to cook foods that required more preparatory work and/or the use of the oven as it just took too long; children were waiting and other people wanted to access the kitchen. P5 lamented the fact that although he had the ability to bake, he could not prepare a cake for his child's upcoming birthday. He further explained that he really could not cook the foods he grew up with, that required more preparation and cooking time.

Prevalence of takeaway meals, convenience foods and snacks

All families spoke of consuming more takeaway meals than they had before they became designated to emergency homeless accommodation. Even those with access to a kitchen found that the constraints on cooking were such that a takeaway meal was easier. For P4 and her family, food was provided at her accommodation for two hours a day, and so they relied upon narrow range of takeaway meals and convenience foods for other times of the day:

> ***I would say on the way home 'what'll we get for dinner?' and then like sometimes I'll make a joke and say 'I'll make Spaghetti Bolognese or something but no it's like either pizza, Chinese or chipper, it's like 'what kind of takeaway, will we get tonight' (P4)***

In discussing their choice of foods it was clear that none of the participants lacked knowledge or awareness about food and nutrition. Moreover, they were constrained in their food choices by the contextual conditions of their living circumstances. As P9, whose family ate chips and chicken from the takeaway

most of the time, remarked: 'I know that the takeaway is not healthy, but I have to eat, I can't do anything'.

Similarly, P8 and her family who had no access to a kitchen had to rely on takeaways, knowing that they were nutritionally inferior but worked at filling them up:

> ***I don't think any of us particularly enjoy eating, especially when it is probably the 200th time that you have had a 3 in 1, or a pizza or its just the same food all the time and very much the same feeling of food, very much stodgy, you never feel nutritionally satisfied it is just sort of filling you up enough so that you are not hungry (P8)***

Families also spoke of consuming convenience meals in their rooms, such as breakfast cereal, noodles and biscuits. For P3 who described his first experience of emergency accommodation in a hotel as:

> ***I am living in a room with a kettle and three fans beating and no cooking facilities (P3)***

In Figure 19 he spoke about the foods he ate in addition to takeaway meals:

Figure 19 · Convenience foods stored in room

> ***If I did not have them there [the tomatoes, ham, bananas etc] we would have to eat in a chipper 3 or 4 times a week (P3)***

Health and wellbeing

Participants were asked to reflect on how living in emergency accommodation impacted their health and wellbeing. In terms of physical health, key issues that arose included complaints of constipation and weight gain. Participants also described that their poor living circumstances challenged their mental wellbeing.

It is not surprising that a diet that is dominated by high fat and low fibre takeaway meals such as that depicted by P4 in Figure 20 below leads to digestive problems.

Figure 20 · Takeaway on bed

Personal digestion issues are not easy to discuss with a stranger, but both P4 and P9 commented that all members of their family suffered from constipation, exacerbated by a lack of physical activity. P4 went on to describe how 'sitting on top of each other, all being all trapped in one room with nowhere to go' made the situation worse. Although families with access to a shared kitchen environment faced the constraints outlined earlier, their diet tended to comprise more vegetable-based meals, that they cooked themselves (Figure 21) and no digestive concerns were reported (P5 and P7).

Figure 21 · Cooking a family meal

Some participants reflected on their weight gain from a diet of energy dense nutrient poor foods. Again this was exacerbated by low levels of exercise and of being confined to a small space. P8 was very unhappy about her weight gain of some 44 kilos since her entry to emergency homeless accommodation. While her diet was dominated by takeaway meals, living in one room with her family without a fridge encouraged grazing. The lack of refrigeration also led to overeating of perishable foods:

> ***If you are in a house with access to fridge you kind of tend to eat breakfast, lunch, or dinner, but if you are sitting beside the food, easy to pick up, you tend to graze and plus as well you tend to eat stodgier foods – you don't want to buy something that you will throw out. It just feels really wasteful. I tend to pick stuff that will fill you up. My mum says 'why don't you have a salad?' but it does not fill you up (P8)***

Although not all participants reported physical health difficulties, mental wellbeing was an issue among all participants. Stress and anxiety was reported from living in cramped one-room accommodation, without any private space. For those with access to a private bathroom this was the only space where they could be alone. The situation was worse for those who shared bathrooms with other residents as they lived in cramped conditions in one room with their children and no private space whatsoever. All lived lives that were permeated by uncertainty about how long they would be in the emergency accommodation.

As P8 remarked, after living in a hotel room for almost two years with her family:

> ***This situation has broken me***
>
> ***It is so stressful and so dehumanising and the fact that there is no end in sight you know there is no in a few months this might happen . . . (P8)***

Many parents were watching their child growing up in one-room accommodation without adequate space to play and to develop. Not surprisingly participants spoke of tension and stress and of the need to get out of the room to save sanity:

If you have a house you can go from room to room, it's just one room, where can you go? You just can't get out of it (P7)

Some tried to break the tension by eating in a restaurant rather than a takeaway, if they could afford it. As P4 explained, unlike the charitable services where you ate what you were given by a volunteer who cooked a meal, at a restaurant it was possible to have choice and to feel like a normal person, even if only for a short while.

For P9 there was a need to not get into conflict at the emergency accommodation as otherwise her life would be worse. She revealed that:

You have to be very strong to be there because it is like driving someone mad, for me it is just like punishment (P9)

As we have seen earlier, P5 made great efforts to prepare a daily dinner for his three children but acknowledged:

Sometimes when I am cooking I feel happy but inside in my heart and my head I feel bad . . . . . because of the way I live (P5)

Child food habits

We asked parents about their children's food habits. All parents had concerns about their children's consumption of food with low nutritional value and the longer-term impact on their health. For those with babies and toddlers, there was evidence of compromised weaning practices, poor quality diets, and poor food socialisation.

Weaning

Every parent experiences concerns about infant feeding, weaning, and their child's food intake. Nevertheless, parents with babies and toddlers in emergency homeless accommodation faced particular challenges with providing appropriate food for their children. For some, their living circumstances constrained their choices to such an extent that they knowingly compromised their child's weaning.

In Figure 22, P6 talked about how her living conditions were so challenging, with no access to a fridge and no access to a kitchen overnight that she resorted to returning her child to infant formula. She explained that she tried to keep fresh milk warm in a flask but this did not work well:

This is my baby going back to Aptamil after leaving Aptamil for almost a year now (P6)

Figure 22 · Reverting to artificial baby food

P9 faced similar challenges with feeding her infant. Although she acknowledged that it was more expensive for her, she regularly resorted to buying ready-made infant formula in bottles.

P4, who had concerns about her toddler not eating the food supplied in the hotel 'other than a sausage', used jars of commercially prepared baby food. She reflected on her photograph (Figure 23) in terms of knowing that it was not appropriate for a two-year-old to be eating readymade food intended for 4–6 month old babies, but felt she had limited choice.

Figure 23 · Baby food for toddlers

Children's food socialisation

All parents expressed concerns about how their child's socialisation in terms of positive food and eating practices was seriously compromised owing to their living conditions in emergency accommodation. P5 was unhappy about making his children wait and not being able to involve them while he cooked their meal. P2 spoke of his children's complaints about eating takeaway meals in the room which had become repetitive. All reflected that they could never socialise in a positive way with food as no visitors were permitted in their accommodation. Thus for children, birthday celebrations with friends and extended family were not possible at their accommodation. For P8, whose youngest child had spent most of their life in a hotel, she observed that her child considered the busy environment of the hotel dining room, with people coming and going, as normal. She also considered that her child had difficulty in sitting for long at a dining table when they had the occasion to do so, and would need to be resocialised when they eventually left emergency accommodation. As might be expected, all parents were unhappy that children's experiences of eating on the bed or floor were inappropriate, as well as their experiences of a limited food repertoire of takeaway meals and convenience microwaveable foods. P8 related her children's experience of a limited food repertoire:

> ***They get really, really sick of eating spaghetti hoops and then they just refuse point blank to eat them so you have to kind of find something else they will eat (P8)***

Children's wellbeing

As we have seen, parents had concerns about their children's dietary practices and food socialisation as they grew up in emergency homeless accommodation. Parents of babies and toddlers reported on concerns about the safety of their living

environment. P9 described the room that accommodated her, an infant and a teenager as an unhealthy environment as her baby shared a bed with her that was located under a vent:

> ***The baby cannot be healthy I worry about my baby's health and you don't know how long it is going to last (P9)***

Parents were keen to point out that hotel rooms were not intended for long-term residence and therefore inadequate for storing food and possessions. Both P7 and P4 spoke of their concerns of children pulling things on top of themselves, particularly kettles, and of their vigilance to ensure that a kettle was emptied after it was used. P6, depicted a perilous situation for her two-year-old child in a room that was jammed with extension cords and where she had nowhere but the floor to prepare her child's food (Figure 24).

Figure 24 · Child safety

Family strategies in negotiating emergency homeless living situations [RO4]

All participants related how they dealt with the limitations of their food and eating environment in emergency accommodation. Strategies ranged from travelling to a family member for food; improvised cooking techniques; use of prohibited cooking equipment; and use of charity food services.

Going to family members for meals

Some families tried to enhance their food and eating circumstances for themselves and their child(ren) by going to family members for meals. In many cases this meant travelling from Dublin city to outer suburbs. If their child attended a school or crèche in the area where they had previously lived, it was often more convenient to eat at a family member's house in the same locality. While P4 was concerned about placing too much pressure on her mother 'who had her own family to feed', through her pictures she showed the sort of food that she had been accustomed to, that sharply contrasted to her current diet. She described the scrambled eggs on toast (Figure 25) as food that was 'more normal like; more healthy' and better also because it was cooked by her mother and demonstrated that someone was caring for her.

Figure 25 · A meal provided by a family member

P1, who travelled across the city daily to bring her child to school spoke of wanting to give her child a normal food experience. She had no cooking facilities in her accommodation. Although she was very much restricted in what she could produce, she explained that buying bags of frozen chips and preparing them herself at her family member's house was a better option than the meal deals purchased from chippers – 2 for €10 – that she stretched across three people. Here she could cook a meal for her child in a home environment, which also supported her need to demonstrate care for her child and reinforced her role as a mother.

Use of prohibited cooking equipment

Participants reported that accommodation regulations did not allow them to have cooking equipment such as microwaves and toasters in their room. Over time, particularly those with no access to kitchen facilities, many families resorted to using toasters, microwaves and/or sandwich makers. Although knowing she was breaking the accommodation provider's regulations, P4 spoke of the fact that it was obvious from the cooking smells that everyone was cooking in their accommodation. Having access to such equipment allowed them to prepare meals/snacks outside of breakfast and dinner time and gave them an alternative to a takeaway meal.

P8 could understand that hotel accommodation providers did not want cooking taking place in the rooms, for fire safety reasons and because it was inappropriate for other guests (tourists) to have cooking smells emanating from rooms. She related that she had recently acquired a microwave with permission from the hotel provider but that the 'microwave put off the fire alarm, (when they used the convection oven) we are not meant to be cooking in the room'. This in turn generated some anxiety about using the equipment, as they were always fearful of losing their accommodation.

Figure 26 · In-room food preparation with prohibited sandwich maker

Improvised cooking methods

Participants described their improvised cooking methods to provide food for themselves and their families. Whereas P8 had tried out using the kettle for heating food and using the microwave to make pasta, she admitted that this was not satisfactory and usually they would resort to a takeaway. For P3, who had not been in emergency accommodation as long as P8, he was still investigating ways of cooking in his room. As his pictures show (Figure 27), the kettle and a plastic bag were used to heat milk and foods such as rice pudding.

Figure 27 · Improvisation – heating food in a kettle

Efforts to enhance children's vitamin intake

Parents of young children took photos that demonstrated they were making efforts 'to get vitamins into their children'. Describing the picture that follows (Figure 28), P2 spoke of concerns about his children not getting enough vitamins and of the fact that they had colds.

Although P4 did not have a fruit bowl or a place to store it she tried to make fruit accessible to her children in the room but found that it would spoil quickly in the plastic bag.

Figure 28 · Vitamins for children

Figure 29 · Ensuring children get fruit

Similarly, P7 showed that she intentionally served her child fruit on his own plate (Figure 30) as she knew how important it was for him to eat properly and in doing so reinforced her child's food socialisation and identity, despite him growing up in emergency accommodation:

> ***I would rather use my own stuff and it's his like – he knows that it is his like so 'this is my food my bowl'***

Figure 30 · Fruit for children: 'My food, my bowl'

Use of charitable services

Few participants availed of charitable food services. Two had attended once and realised that the environment was not right for them and their children. In the case of P5, while he was agreeable to attending, largely because it took pressure off him, his children objected. Charitable services included use of Crosscare; Focus Ireland, soup runs and the Cappuchin Day Centre. For P8, while she did not avail of charitable services regularly, she reflected on the impact this had when she used it for the first time:

> ***It says that you are now on the bottom rung of society there is no lower you can get. At the start it was very difficult. There are the people there who are begging in town – they are all in there and you are walking in. We were in there and a guy OD; they had to bring us out the back way because they didn't want to have the kids see that. Walking past people sleeping in their dinner. But I have to say I have nothing but praise for [Service Provider], it is a service that is very much needed, and very oversubscribed (P8)***

Conclusion

This chapter has described the food environment of a sample of 10 families in emergency homeless accommodation in the Dublin region. Using photo voice/ elicitation techniques, we have gained insight into the daily lives of families designated as homeless and allocated to emergency accommodation in terms of the food they prepare, cook and eat, and how they store food. The findings show that families, regardless of accommodation type, experience severe constraints with access to food and cooking facilities (including storage facilities). These constraints force them to depend on takeaway meals and convenience foods of poor nutritional quality. Their living circumstances position them to eat in socially unacceptable circumstances without dignity. Furthermore, while some families have developed positive strategies to alleviate the constraints in their accommodation, these are not sustainable, and other strategies such as heating food in a kettle and use of charities contribute further to living without dignity. Some families reported health problems of constipation, and weight gain, and all spoke of living with stress and anxiety and of uncertainty about their future. Parents expressed deep concern about how their children were growing up, without appropriate developmental space and of their poor nutrition and compromised safety.

Chapter 5: Perspectives of providers of health and social services to families in emergency homeless accommodation

Introduction

Semi-structured interviews were conducted with six Key Informants (KIs) involved in the provision of a range of health and social services to families in emergency homeless accommodation (Table 5.1). The interviews sought to elicit their perspectives on food and nutrition issues for families living in emergency homeless accommodation; the role of service providers in supporting families, and their perspectives on enhancements that could be made to current service provision.

Table 5.1 · Key Informants

Key Informants (KI)	Role
KI1	Case manager homeless families
KI2	Manager food services for homeless
KI3	Social worker (maternity services)
KI4	Dietician (health inequalities focus)
KI5	Provider of food and social services for homeless people
KI6	Clinical services provider for homeless people (nursing)

Food and nutrition issues amongst families in emergency homeless accommodation

All six Key Informants had a deep insight into the food and nutrition situation of families in emergency accommodation. They articulated the daily food-related challenges of families owing to the inappropriate and inadequate living conditions experienced in emergency accommodation. Their descriptions mirrored the accounts of families in the previous chapter. Key issues were: the lack of adequate cooking and dining facilities; lack of storage for food and personal possessions; a reliance on takeaway meals; dealing with food waste; the challenges of infant and toddler feeding; and concerns about children's food socialisation.

Food storage, equipment and waste

A provider of meal services to homeless families (KI2) spoke of the daily challenges faced by families as they tried to provide food for themselves and their children within the constrained environment of emergency accommodation. Many families struggled in their rooms with food preparation, storage and disposal. Some feared they would lose their accommodation if found attempting to cook in their room. The meal service provider was aware of this situation as he interacted with families who attended the meal service. He reported that he often heard families talking to each other about their fear of being caught breaking regulations as they related 'I was cooking and I was moved to another room so now we will hide waste and smuggle it out of the room'. (KI2)

A social worker (KI3) also highlighted issues of food storage and waste: storage facilities in emergency accommodation meant that some families were faced with having to eat food that was not stored properly 'what do you do with your food waste – what do you do with it – you can't afford to throw it away.' (KI3)

Similarly, a case manager for homeless families (KI1) related how the lack of food storage and equipment in emergency accommodation meant that families had little alternative than eating takeaway meals or of trying to use a kettle for noodles. This, as KI2 pointed out, meant that some families relied upon dry products such as cereal or bread, and this was not a satisfactory solution in the absence of refrigeration as 'bread needs butter, cereal needs milk'. (KI1)

Infant and child feeding

The service providers held serious concerns about the impact of the emergency homeless accommodation on children's dietary practices, particularly in relation to infant feeding. The clinical services provider to homeless families reflected on the acute challenges of feeding infants in B&Bs, for both artificial infant formula fed and breast fed babies. Echoing parents' accounts, the lack of refrigeration, storage and washing facilities, and sterilisation equipment placed children at risk and positioned mothers to recourse to ready-made, more expensive products. She also acknowledged that even when mothers were breastfeeding that they would usually discontinue because their situation was so challenging. Some accommodation settings required mothers to absent their room during the daytime and breastfeeding required appropriate space and a calm environment. For first-time mothers, night-time feeding in emergency accommodation also exacerbated stress-levels. She illustrated these difficulties with the case of a mother who had received complaints about her child crying at night. On the second night of crying because she was not able to settle her baby, and being fearful of being asked to leave her accommodation, the mother took her baby to Temple Street Children's Hospital. This resulted in her being charged €100 for attendance at A&E that was subsequently paid by the service provider. The service provider highlighted that although a baby crying at night is normal event, in the context of emergency

homeless accommodation the situation becomes more stressful and desperate, as in the case above. A parent of a crying baby has nowhere to go; they cannot walk to other rooms, or in a corridor or up and down the stairs, but must remain in the room to which they are confined.

The maternity hospital social worker also illustrated the difficulties for new mothers who were trying to breast or bottle-feed. Although she remarked that breastfeeding was not common, mothers needed to have good nutrition, which was a challenge in emergency accommodation, as few had access to adequate facilities for food preparation. Furthermore, the emergency homeless accommodation situation placed greater obstacles to breastfeeding 'you are in a very dependent relationship with your child in one room' (KI3) and therefore it was easier to bottle feed, particularly if you could leave your child with a family member from time-to-time. However, like the clinical services provider to homeless families, this social worker considered that bottle-feeding was highly problematic in emergency accommodation. Hygiene could be compromised, as emergency homeless accommodation did not provide facilities for parents to sterilise or to appropriately wash and store baby feeding bottles, unless, as the case manager of homeless families advised, key workers made interventions on behalf of mothers. The social worker compared the bottle-fed babies in emergency homeless accommodation with bottle-fed babies in Direct Provision Centres for asylum seekers. Despite the shortcomings of Direct Provision Centres, she felt that babies and mothers in Direct Provision had a safer food environment than those in emergency homeless accommodation.

Toddler feeding: Weaning from milk to solid foods

As well as concerns about infant feeding, KIs had insight into the difficulties parents faced when trying to wean children onto solid foods. They observed that for many families, the constraints of their emergency accommodation, without appropriate access to storage, refrigeration, equipment, and dining space, compromised good weaning practices:

> ***Weaning is complex anyway – so even the amount of equipment that is required makes for reliance on pre-prepared weaning products – you are setting down negative food patterns for life in the crucial toddler years. (KI4)***

The clinical services provider considered that parents were trying to do their best and were forced to offer their toddlers the most convenient, and not necessarily the best, weaning foods:

> ***The jars can be reheated – but lots of sugar-based foods – juices and yogurts – they have not got the facilities to buy well – they can't prepare it for the child, blend it or mash it or whatever. (KI6)***

Similarly, the social worker and case manager also felt that the emergency homeless accommodation created a situation that reinforced children's poor dietary practices. The social worker spoke of parents confined to small rooms with toddlers and of the difficulties in getting their child(ren) to eat and of the need to alleviate food mess in the room. Thus, going to McDonald's could serve a dual purpose: 'She goes to McDonald's because she knows her child will eat it – I know my child will eat it'. (KI3)

Children's food socialisation

The Key Informants were clear that emergency homeless accommodation (in the form of B&Bs, hostels and hotels) were a contradiction in the sense that the 'emergency' of emergency accommodation became a long-term and normalised way of life for many children. The community meals provider considered that 'the family dynamic is disrupted around meal provision' (KI2). This sentiment was reinforced by the social worker who felt that parents had 'little control about what your child can eat' (KI3) and that where their child was fed at school they had one less thing to worry about. Likewise, the dietician spoke of children's 'disrupted food and eating practices' in emergency accommodation as 'that's their normal' and 'that hopefully in a crèche situation they will get to have a normal experience' (KI4).

The family case manager noted that even though hotels and B&Bs provided breakfast, many families could not avail of it because they were travelling out of the city to take their children to school. This situation created a spill over into the school environment such that some schools now provided breakfast. Most interviewees spoke about community food service provision, such as that provided by the Capuchin Day Centre, CrossCare and Focus Ireland. All noted an increase in the number of families availing of meal services. However, as the community meals service provider stated, they now served families who never imagined they would be in these circumstances:

> ***The café is for people who are socially isolated – it was not really intended for families – I have not met a family that I have dealt with who has become homeless other than financial issues. (KI2)***

The case manager for families in emergency homeless accommodation reflected that children's food socialisation was also inhibited by growing up in an environment 'where everything happened on the bed': doing homework on the bed; eating in turn on the bed after waiting for ready meals from a microwave, or of seeing parents 'cooking pasta in your kettle – things you would do if you were camping, things that you shouldn't be doing in your day-to-day living' (KI1), a sentiment reinforced by the social worker and clinical services provider. They considered the emergency accommodation situation negatively impacted on toddlers' meal-time socialisation in terms of learning how to use knives, forks and spoons, and dining at a table. Additionally, as noted by the clinical services provider, parents were seriously challenged with toilet training children in the one room in which all aspects of their lives unfolded.

The inability to have normal celebratory events in emergency accommodation, such as children's birthday parties and celebrations around the time of a birth reduced children's food socialisation. As the social worker remarked:

> ***How does this work with having a new baby? What is it like if you move to a B&B or not know where you are going – losing out on all the cultural norms of life – shapes the people that we become. (KI3)***

In terms of children's food socialisation this promoted the normalisation of social service food and dependency.

While the accounts of KIs illustrated the constraints families faced in providing food for themselves and their children, they also described a system that placed families in B&Bs and hotels, as one of propagating problems that went beyond diet and nutrition. These included: lack of developmental play and recreation for children and parental stress.

Children's opportunities for play and doing homework

Meal service providers considered that children's circumstances in emergency homeless accommodation seriously limited their opportunities for play, and for doing homework. Whereas meal service providers afforded extra space for families, for children's play, and homework spaces, back at their accommodation children were largely confined to the same room as their parent(s) and sibling(s). Regulations in emergency accommodation curtailed children's opportunities to have free play: 'Kids aren't allowed into the corridor, to run up and down' (KI2). Sadly, as the community meal service provider observed of the toddlers using the meal service:

> ***They are more sedate that you would imagine a toddler being. They have adapted into that whole structure – there is no self-directed free play. (KI2)***

Parenting stress

All interviewees spoke of how the designation of emergency homeless accommodation generated considerable stress and anxiety for parents as they tried to contend with providing for their children and the precariousness of their living situation. In terms of the latter, interviewees spoke of parents feeling insecure about being asked to leave their accommodation by the hotel or B&B provider if it was required for sport, music, or other events such as Christmas festivities or weddings. In addition, parents endured anxiety about not knowing how long they would be in this situation. The interviewees emphasised that parents reported how they felt inadequate as parent:

> ***Parents say to us I am not a good mother or a good father because I can't provide this – so much is out of their control, not that they are not a good parent. (KI6)***

Key Informants spoke of parents being 'de-skilled' as a result of their long-term experience in emergency homeless accommodation. They felt anxious about cooking, managing a budget, shopping, or how they would function as a family unit. The social worker, who worked with mothers who had entered emergency accommodation with a new born baby, considered this situation in the context of the idealisation of motherhood 'mothers are meant to keep it together' and of how being placed in emergency accommodation resulted in a diminishing of their position as a mother:

> ***Society has this thing of the 'ideal mother' – what you should be doing, and if you are in homeless services trying to be a good enough mother is very difficult when you don't have the control and choice and the facilities to do your best for your child. (KI3)***

In the context of being able to provide food for their children, parents were further undermined in their parenting ability. As the dietician put it:

> ***There is a fundamental basic human thing about being able to provide food for your family, whatever about all the other stuff that is going on when you have children, providing food for your children that is what you have to do. (KI4)***

Although the clinical services provider related that for some families moving out of situations of domestic violence into emergency accommodation had been an improvement, there was also a clear acknowledgement among all interviewees that living in emergency accommodation was bad for parents and children and contributes to stress:

> ***The whole family atmosphere is missing; if there are two parents there has to be a certain amount of tension if one is out looking for accommodation. (KI5)***

A number of interviewees commented that there were some naïve and simplistic perspectives from some sectors of society about families that benefited from living in hotels and B&Bs. Rather, as noted by all KIs, the current situation was considered to have serious future societal repercussions for children and their families:

> ***It's bad value for society, it's bad value for the government, nobody benefits. I pass by a hotel that puts up homeless people and I know when I see them getting on the bus, and it is generally families I see, and no one looks happy, healthy or smiley, they are generally, they look pale, unhappy and struggling to manage their children and I just don't know how they do it. How would I cope, practically and emotionally. (KI3)***

Improvements to current service provision

All service providers acknowledged, in addition to their own organisations, that there were many agencies working to support families in emergency homeless accommodation. Indeed, some interviewees were keen to point out that some accommodation providers were also doing their best to support families. Nonetheless, there were others where segregation practices existed whereby tourists 'entered one door of the hotel with their wheelie cases and families entered another with their buggies' (KI1). The crisis in family homelessness was perceived by the KIs to be an appalling situation that was blighted by a lack of joined up thinking and a failure of government housing policy, particularly over the last decade. The Key Informants perceived that the current situation illustrated violations in terms of children's rights and human rights in relation to housing and food security. More broadly, responses to family homelessness were marked by interventions that marginalised families who were vulnerable and treated them without dignity and respect.

There was concern among some service providers about the appropriateness of the types of support sometimes being offered. For example, well-meaning charities and individuals wanted to donate meals to accommodation services but this had a wide range of implications, including, amongst other things, food safety and stigma. Some interviewees spoke of leftover food at Christmas, or what might also be described as other well-meaning individuals' food waste, donated for homeless families, such as turkey, ham, Christmas cakes and puddings. Families did not have the capacity to cook/heat these items, and possibly no desire for them.

First and foremost, the Key Informant accounts stressed that it was entirely inappropriate to place families in B&Bs and hotels for long-term accommodation. In many ways, the term 'emergency' has now become a misnomer in the context of emergency homeless accommodation in the Dublin region. The interviewees were forthright that if a family must enter emergency homeless accommodation it needed to have adequate cooking and storage facilities and be for a short-term.

All interviewees could not see how the objective of the Rebuilding Ireland Strategy, in relation to families in emergency homeless accommodation could be achieved, given that the numbers entering family homelessness continued to rise. Rebuilding Ireland intends to:

> ***move the existing group of families out of these hotel arrangements as quickly as possible, and to limit the extent to which such accommodation has to be used for new presentations. Our aim is that by mid-2017 hotels will only be used for emergency accommodation in very limited circumstances (Government of Ireland, 2016).***

Furthermore, in relation to families in emergency accommodation the Rebuilding Ireland Strategy (2016: 87) in its objective to provide supports to homeless families with dependent children describes Action 1.5, as the provision of 'practical supports and advice for good nutrition for those without access to cooking facilities.' In the light of evidence of the limited success of nutrition education interventions with families in homeless accommodation (Johnson et al., 2009; Rustad & Smith, 2013; Yousey et al., 2007) such interventions may be viewed as misguided. The dietician also expressed this sentiment:

> ***I don't see value on giving people in emergency accommodation information on healthy snacks to buy – in the scheme of things they have enough to dealing with without being advised about not buying coco pops etc. They have enough to be dealing with. (KI4)***

In this context, the Key Informants felt that there was an immediate need to provide communal services where families could prepare, cook and eat food together in a dignified way. In addition, the Key Informants stressed that contracts with accommodation providers needed to move beyond 'sticking plaster solutions' and for the DRHE to stipulate minimum standards that allow families to live with dignity in emergency homeless accommodation.

Chapter 6: Conclusion and recommendations

Conclusion

The study aimed to explore food poverty among families living in emergency homeless accommodation in the Dublin region, and the impact this has on the nutrition and health outcomes of parents and their children. While the term food poverty may conjure images of hunger or malnutrition, it is important to consider its multidimensionality in terms of food access, availability, affordability, and social and cultural acceptability. Furthermore, in the context of food poverty among families in emergency homeless accommodation it should also be considered within a social justice framework that recognises the interdependence between the right to food and the right to health (Dowler & O'Connor, 2012), and the right to housing (UN General Assembly, 1948).

While it is not possible to generalise the results of this study to those of other families in emergency homeless accommodation, the evidence suggests that being placed in emergency homeless accommodation such as B&Bs, hostels and hotels causes food poverty. Families are forced to rely on takeaway meals and convenience foods of poor nutritional quality that impacts their health and wellbeing. Children do not have access to appropriate developmental space and experience poor nutrition, and for babies and toddlers weaning may be compromised. Children's positive food socialisation is limited by their living circumstances as they are positioned to eat in socially unacceptable circumstances, (dining on the bed, the floor, in a row and/or under surveillance) without dignity. While some families have developed positive strategies to alleviate the constraints in their accommodation, these are not sustainable. While families do their utmost to meet the basic needs of their children, including providing them with food, they are prohibited from doing so by the constraints of living in emergency accommodation. Such circumstances can contribute to psychological problems including 'toxic stress' (Council On Community Pediatrics-Committee On Nutrition, 2015)

These findings question the extent to which the rights of children under the Convention of the Rights of the Child (Articles 24 and 27) (UN General Assembly, 1989) are being eroded. Indeed, the UN Committee on the Rights of the Child in its most recent review of children's rights in Ireland noted its concerns about the delays experienced by homeless families in accessing social housing and their living in unsuitable or emergency accommodation on a long-term basis (United Nations Committee on the Rights of the Child, 2016). This is particularly important as the numbers of families entering homelessness continues to rise. There is a need to stem the number of families entering into homelessness whilst also ensuring that the

needs of those currently living within emergency accommodation are met, and that their emergency accommodation status is just that, a temporary period, and suitable housing secured for these families. As Edwards (1995) notes, in the context of UK policy that placed London homeless families into accommodation that was leased by the local housing authority from the private sector, a strategy also employed in Ireland through the Homeless Accommodation Payment (HAP):

> ***The homelessness continuum moves from people who are without the 'shelter' of a basic physical structure (such as sleeping in the streets) to those without a 'home', living under a roof that provides no sense of security, belonging or identity (Edwards, 1995).***

Although the current policy response to homeless families appears driven by the need to ensure that families do not reside on the street, and charitable services work to ensure that no-one goes hungry, such forms of 'caring' can result in the social marginalisation of these families and to living a life without dignity:

> ***Caring, thus, can appear benign whilst also being politically charged and morally laden; its performances may be as care-less as care-full. Unearthing not only this slippery nature of care, but also how this slipperiness is produced and mobilised draws our attention to the unseemly politics of food more widely. Illustrating how particular bodies, persons and citizens are marginalized and denigrated by carelessly-careful debates around food . . . . intersects with wider concerns regarding food, social justice and the (bio) politics of everyday inequality (Abbots, Lavis, & Attala, 2015, pp. 14–15).***

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

Standards in emergency accommodation

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

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

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

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

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

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

Emergency accommodation as a temporary measure

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

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

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