

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

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

everyone has a right to a place they can call home



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

A Pilot Research Study

Claire Hickey & Daithí Downey

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Contents

Contents	ii
Foreword	iv
Acknowledgements	v
Executive Summary	vi
Chapter 1: Introduction and Background to the Study	1
Introduction	1
The Origination of this Pilot Study	2
The Objectives of this Study	2
The Structure of this Report	3
Chapter 2: Homelessness and Food Poverty	5
Introduction	5
Homelessness in Ireland	5
Food Poverty	7
Food Poverty and Homelessness	8
Linking Food Poverty, Homelessness and Health Inequalities	8
Linking Food Poverty, Homelessness and Consumer Issues	9
Conclusion	9
Chapter 3: Diet and Nutrition: Investigating differences between the general population and homeless people	13
Introduction	13
The Food Pyramid	14
Recommended Irish Dietary Standards and Dietary Allowances (RDAs)	14
Food Consumption Patterns and Dietary Habits in Ireland	14
Dietary Habits and Food Consumption Patterns among the Homeless	17
Conclusion	19
Chapter 4: Researching Homelessness and Food Poverty: Problems solved and lessons learnt	21
Introduction	21
Selecting the Quantitative Research Tool - issues of methodology and approach	21
Developing the Survey Research Tools	23
Designing the Survey Questionnaire	24
The Survey Sample	25
Accessing the Survey Sample	27
Incentivising Participation	29
The Qualitative Research – Identifying Themes for Examination	29
Applying the Qualitative Method	30
Participants in the qualitative process	32
The Homeless Service Food Providers Questionnaire (FPQ)	33
Conclusion	34
Chapter 5: Research Findings 1: Data on socio-demographics, homelessness and health status	37
Introduction	37
Socio-demographic Profile of Survey Respondents	37
Accommodation Status and History of Homelessness	38
Causes of Homelessness	40
Health Status of Survey Respondents	41



Dieting	44
Body Mass Index	44
Conclusion	45
Chapter 6: Research Findings 2: Data on food consumption, nutrition and quality of diet	47
Introduction	47
Meals and Frequency of Consumption	47
Compliance with the Food Pyramid	48
Quantities of Food Consumed	49
Nutrient Intake among Dublin’s Homeless	51
Conclusion	55
Chapter 7: Research Findings 3: Data on the lived experience of food poverty among people who are homeless	59
Introduction	59
Access to Kitchen Facilities	59
Food Storage	61
Communal Facilities	61
Rough Sleeping	62
Expenditure on Food	63
Shopping for Food	66
Conclusion	68
Chapter 8: Homeless Food Provider’s Services: Issues of access, use and quality	71
Introduction	71
Audit of Dublin Homeless Food Service Providers	71
Food Provision	72
Use of Homeless Food Provider’s Services	73
Satisfaction with Homeless Food Provider’s Services	73
Issues of Choice and Preference in Relation to Food Services	76
Conclusion	76
Chapter 9: Policy Development to Tackle, Prevent and Eliminate Food Poverty, Social Exclusion and Homelessness	79
Introduction	79
The Policy Framework	79
A Policy Framework to Tackle Food Poverty and Homelessness	84
Recommendations for Policy Actions to Tackle Food Poverty and Homelessness	85
Conclusion	89
References	91
Appendix 1	97
Appendix 2	99
Appendix 3	107
Appendix 4	113



Foreword

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

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

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

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

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

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

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

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



Declan Jones
CEO, Focus Ireland



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A number of people offered advice and suggestions on the methodologies for this study and we would like to thank Professor Michael Gibney, Margaret O'Neill and Maureen McGowan who offered support and advice in the early planning phase of the study.

Particular thanks to Dr Sharon Friel of the Centre for Health Promotion Studies, NUI Galway, who not only advised on methodology but together with her colleagues at the Centre converted the nutritional data, advised on its analysis and read and commented on the drafts of the report.

Thanks to the Health Promotion Unit and the Community Dietician Managers who provided information and advice on the formulation of some of the policy recommendations regarding healthy eating programmes and the development of diet and nutrition strategies for people who are experiencing homelessness.

Finally, thanks to all members of Focus Ireland's Research Advisory Group, who provided helpful comments and support during the research process. Particular thanks go to Ciaran McCullagh, who worked closely with the authors to bring the report to completion.

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Executive Summary

Introduction

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

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

Why Focus Ireland carried out this study

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

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

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

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

The objectives of the research study were:

1. To establish the extent to which individuals out-of-home are vulnerable to poor diets and inadequate nutrition.
2. To explore the difficulties that homeless households face in sourcing, funding, storing and preparing nourishing food for themselves and/or their families.
3. To explore issues of service use and service access by individuals experiencing homelessness and to explore the coping mechanisms employed by homeless adults when food services are restricted, closed or inaccessible to them.
4. To set out policy options for homeless service providers to tackle food poverty in a co-ordinated way, as well as input into national strategies to tackle food poverty among socially excluded groups in Ireland.

Research methodologies

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

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

The Sample

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

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

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

Summary of the Main Findings

Socio-demographics, homelessness and health

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

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

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

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

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

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

The mean Body Mass Index¹ among the full survey group was 23.31, which falls within the normal range. Eight per cent of respondents were underweight, 83 per cent of all those who were reported to be underweight were female.

Food consumption, nutrition and quality of diet

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

i) The food pyramid

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

ii) Quantities of food consumed

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

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

iii) Nutrient intakes

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

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

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

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

The lived experience of food poverty among people who are homeless

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

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

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

Recommendations for Policy Actions to Tackle Food Poverty and Homelessness

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

1. *Homelessness – An Integrated Strategy*: national government strategy for addressing the accommodation and welfare needs of people out-of-home.
2. *Shaping the Future*: the Dublin homeless action plan contains a range of commitments with regard to the provision of services and accommodation to adults and families out-of-home.



3. *National policy on social inclusion and anti-poverty*: At the heart of this national policy framework is the National Anti-Poverty Strategy (NAPS) "*Building an Inclusive Society*". NAPS contains very important targets on reducing overall levels of consistent and relative income poverty, reducing health inequalities and child poverty as well as setting income adequacy targets and targets to ensure improved access to quality public services.
4. *Social welfare policy and provision*: elements of social welfare policy and provision that impact on food poverty include the free school meals scheme, breakfast clubs targeted to children in high-risk schools in disadvantaged areas and elements of the Supplementary Welfare Allowance System.
5. *National policy on health and health promotion*: key policy and strategy areas include the national health strategy *Quality and Fairness – A Health System For You* (2001) and the *National Health Promotion Strategy* (2000).
6. *Planning and development policy*: the *Retail Planning Guidelines for Planning Authorities* seeks to establish local, efficient, equitable and sustainable retail provision, which is readily accessible, particularly to marginalised groups.

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

National policy Homelessness – An Integrated Strategy

- i) As part of an independent review of *Homelessness – An Integrated Strategy*, Focus Ireland recommends policy formulation to address issues of food poverty, health, and diet and nutrition among homeless persons.
- ii) This review should consult with voluntary sector homeless service providers when setting the terms of reference and monitoring progress and outcomes, and it should be published for consideration by homeless service providers and by the Cabinet Committee on Social Inclusion, the Cross-Departmental Team on Homelessness, the National Office for Social Inclusion, and the Oireachtas Committee on Environment and Local Government as well as social partners.
- iii) Policy development should be undertaken to detail, agree, resource, deliver, monitor and report on a dedicated community nutrition programme for homeless persons to tackle the issue of food poverty and improve the health related impacts of poor diet and nutrition. Such a programme requires the co-ordination of policy at national and local levels.
- iv) The role of the established Cross-Departmental Team on Homelessness in facilitating the development of policy in this area needs examination and resource commitments as required. Local homeless actions plans offer a vehicle for the identification of development and implementation strategies on food poverty and offer a basis to identify and resource the local delivery mechanisms for a dedicated community nutrition programme targeted on homeless persons.

Recommendations for Homeless Service Provision

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

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

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

- i) Consider increasing the range of low-fat and low-sugar foods available through food centres. In particular, this study's findings support the need to increase the provision of sun flower oil or olive oil spreads for cooking and use on bread and sandwiches and the use of fortified milk for cooking, drinking and adding to drinks and cereals etc.
- ii) Consider how foods and refined cereals with low-fibre can be replaced with those of high fibre. For example, the use of brown rice and pasta instead of white rice and pasta and the provision of breakfast cereals such as porridge and bran or wheat based products rather than sugar coated cereals.
- iii) Consider how to increase the range and frequency of fish and fish products on food centre menus.
- iv) Consider offering the choice of decaffeinated tea and coffee as a standard not an exception of food service provision
- v) Consider reducing the provision of confectionery and savoury snacks in favour of more healthy options such as fresh fruit and yoghurts and include organic fruit and vegetables on menus.
- vi) Consider ensuring a diversity in menu development for food centres that avoids reliance on high-fat, low-fibre foods, provides in season fruits and vegetables and presents menu choices as part of an identifiable cuisine (e.g. Irish, French, Italian etc)
- vii) Consider promoting a healthy eating week in homeless food centres as part of a national health promotion policy and in anticipation of the establishment of a dedicated community nutrition programme for homeless persons. An emphasis could be placed on the provision of food that supports healthy and balanced diets as well as the delivery of nutritional advice and supports to parents and a healthy food promotion programme for homeless children using childcare facilities.

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

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

Recommendations for national policy to tackle food poverty

Poverty and income inadequacy

- i) The Government should meet the commitment set out in NAPS to achieve a rate of €150 per week (in 2002 terms) for the lowest rates of social welfare to be met by 2007 and the appropriate equivalence level of basic child income support (i.e. Child Benefit and Child Dependent Allowances combined) to be set at 33-35% of the minimum adult social welfare payment rate.
- ii) Focus Ireland recommends that an investigation into what foods should be included in an average basket of goods for a healthy and balanced diet be conducted. A policy objective of this study should be to examine the role of price controls for staple foods such that minimum social welfare payments are sufficient to cover the costs of this basket of goods.

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

Access to Public Services

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

- i) Detailed standards in relation to access to public services for socially excluded groups are to be set out as part of government commitments under the NAPS. To bring this forward, formal expressions of entitlements across the full range of public services for all persons socially excluded and in poverty need to be established as a matter of priority.
- ii) Outstanding quality standards and guidelines regarding the standard of service delivery that can be expected should be established as soon as possible.

Health and health promotion

School Meals Scheme

- i) Deepen the impact of the reform of the Free School Meals Programme by investigating and developing innovative food promotion and food delivery projects at primary and secondary levels.
- ii) More resources are required to deepen the impact of the Free School Meals Programme and the implementation of innovative projects to improve the diet, nutrition and overall health of children at primary and secondary levels is essential.

Diet Supplement Scheme

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

Institutional arrangements

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

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

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

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

Conclusion

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

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

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

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



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Chapter 1

Introduction and Background to the Study

Introduction

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

This study was undertaken during 2002 and 2003 and occurs within the context of recent socio-economic changes in Ireland that herald the end of the so-called *Celtic Tiger* era of economic growth and wealth creation².

Today, public concern with the post-boom increase in the cost of living pivots on the axis of housing costs, traffic congestion and high prices for goods and services. For example, while interest rates in Ireland are at an historic low in 2003, inflation has been moving in the opposite direction³.

Low interest rates remain a dominant influence on rates of investment in housing that continue to push prices upwards, while high inflation has been the result of recent budgetary changes in fiscal policy and lack of competition in the non-traded sectors of the Irish economy. Both impacted significantly on the Irish cost of living in 2003⁴.

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

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

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

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

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

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

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- 2 The economic slowdown apparent since 2000 has affected the rate of employment growth with average employment increasing by 1.4 per cent (23,600 persons) in 2002 compared with average growth rates of 2.9 per cent in 2001 and 6.9 per cent in 1999
 - 3 CSO figures show that the rate of inflation was 5.1% in February, up from 4.8% in January. Excluding mortgage interest rates, the underlying CPI was 5.3%. The CPI excluding tobacco was 4.7%. As measured by the EU Harmonised Index of Consumer Prices (HICP), Ireland's year on year inflation rate was 5.1% in February 2003, up from 4.7% in January. The early estimate suggests that euro area inflation in January 2003 was 2.1 %, down from 2.3% in December 2002. The Consumer Price Index is the official measure of inflation in Ireland. It is an important social indicator as its value impinges on the measurement of economic growth and economic wellbeing. However, there are a number of problems associated with the standard measure. The index is designed to measure changes in the cost of purchasing a basket of goods of a 'representative' household or 'typical' Irish household. It would be surprising if such an index were appropriate for everybody. Recent research has found that for the urban poor in Ireland in the late 1990s and up to 2001 a price index based on a basket of goods purchased by the urban poor has risen substantially faster than the CPI for a 'typical' household. For more details see Garvey, E. and Murphy, E. (forthcoming) *The Cost of Living Changes for Low Income Households*, Dept. of Economics, NUIG, Combat Poverty Agency Poverty Research Initiative.
 - 4 Since 2000, eurozone monetary policy attempts to soften the rate of economic deceleration and to improve the climate for investment has meant interest rates moving downwards to a current rate of 2.5 per cent

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

The Origination of this Pilot Study

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

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

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

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

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

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

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

The Objectives of this Study

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

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

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

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

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

The Structure of this Report

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

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

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

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

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

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

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

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

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

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

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

Chapter 2

Homelessness and Food Poverty

Introduction

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

Homelessness in Ireland

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

- a) there is no accommodation available, which in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of, or
- b) he is living in a hospital, county home, night shelter or other such institution and is so living because he has no accommodation of the kind referred to in paragraph (a) and he is, in the opinion of the Authority, unable to provide accommodation from his own resources.

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

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

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

The extent of homelessness in Dublin

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

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

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

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

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

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

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

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

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

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

Food Poverty

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

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

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

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

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

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

Food Poverty and Homelessness

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

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

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

Linking Food Poverty, Homelessness and Health Inequalities

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

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

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

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

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

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

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

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

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

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

Linking Food Poverty, Homelessness and Consumer Issues

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

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

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

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

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

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

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

Conclusion

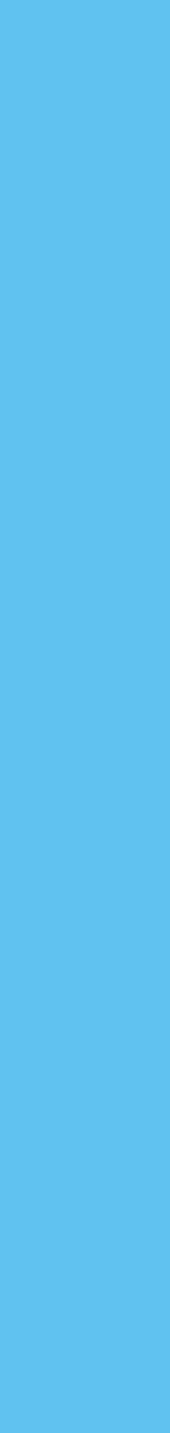
The number of people experiencing homelessness in Ireland has increased by 6 per cent between 1999 and 2002. Research from Dublin indicates an increase of less than 1 per cent in the capital's total homeless population. It is interesting to note that in Dublin the number of single adults who are homeless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

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

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

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

The following chapters attempt to address these key questions.



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

Chapter 3

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

Introduction

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

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

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

The Food Pyramid

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

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

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

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

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

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

Figure 3.1 The Irish Food Pyramid

Recommended Irish Dietary Standards and Dietary Allowances (RDAs)

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

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

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

Food Consumption Patterns and Dietary Habits in Ireland

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

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

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

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

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

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

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

The Slán survey, 1999

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

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

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

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

The North/South Ireland Food Consumption Survey, 2001

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

Key findings from the NSIFCS were that:

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

Age and gender

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

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

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

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

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

Social class

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

The Slán survey found:

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

Findings from the Slán survey indicated that adults from social class 5 and 6⁵ consumed less fruit and vegetables and dairy products than adults from higher social classes. For example, 57.3 per cent of adults in social class 5 and 6 complied with the food pyramid recommended targets for fruits and vegetables compared with 73.2 per cent from social class 1 and 2.

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

Dietary Habits and Food Consumption Patterns among the Homeless

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

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

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

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

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

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

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

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

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

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

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

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

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

Darnton-Hill & Ash's study⁶ (1988) also found evidence of micronutrient deficiencies among hostel dwellers. Thiamine, magnesium and folate were all below Australian RDAs and participants in the study had marginal vitamin C intakes. Energy intakes were also below recommended dietary intakes.

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

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

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

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

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

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

⁶ Cited in Evans & Dowler, 1999

Conclusion

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

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

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

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

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

Chapter 4

Researching Homelessness and Food Poverty: Problems solved and lessons learnt

Introduction

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

Selecting the Quantitative Research Tool - issues of methodology and approach

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

The food diary method

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

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

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

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

The 24-hour recall method

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

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

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

The semi-quantitative food frequency questionnaire (FFQ) method

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

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

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

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

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

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

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

⁷ Referred to in the remainder of this report as FFQ

Developing the Survey Research Tools

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

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

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

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

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

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

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

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

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

Designing the Survey Questionnaire

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

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

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

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

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

ii) The food frequency questionnaire (FFQ)

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

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

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

iii) Socio-demographic data

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

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

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

iv) Food purchase, expenditure and preparation

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

v) General health

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

vi) Comments and insights

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

The Survey Sample

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

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

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

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

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

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

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

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

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

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

Accessing the Survey Sample

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 4.1 Source of Interview Participants

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

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

Incentivising Participation

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

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

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

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

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

The Qualitative Research - Identifying Themes for Examination

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

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

i) Access to cooking, preparation and storage facilities

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

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

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

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

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

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

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

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

iv) Expectations, cultures, values and choice concerning eating

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

Applying the Qualitative Method

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Participants in the Qualitative Process

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

The Focus Group Discussion

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

Interview 1

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

Interview 2

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

Interview 3

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

Interview 4

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

Interview 5

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

Interview 6

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

Interview 7

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

Homeless Service Food Providers Questionnaire (FPQ)

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

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

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

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

Conclusion

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

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

In conducting the fieldwork two key issues emerged:

- i) The problem of reliably identifying and ensuring access to persons who were experiencing homelessness but were not necessarily in contact with homeless service providers. This was particularly problematic for young people aged 18-25 and women with children.
- ii) Finding and subsequently organising follow-up qualitative interviews with a sub-set of the original sample.

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

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

