

IT SLIGO

Around the table: Food work in children's residential services in Ireland.

A dissertation submitted to the School of
Business and Social Sciences Institute of
Technology Sligo

PhD

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Declaration

This material submitted for assessment of the programme of study leading to the award of PhD is entirely my own work and, except where appropriately acknowledged and cited, does not include the work of any other party.

Signed:

Date:

Deirdre Byrne.

Dedication

To Martha and Seamus

...again, the scone rising to the tick of two clocks

(Seamus Heaney *Sunlight* 1975)

Acknowledgements

I would first and foremost like to thank the participants, the young people from the five centres who allowed me to share their mealtimes. I appreciate the time they spent with me and I hope that I have done justice to the trust they invested in participating in this research. I would also like to thank the workers from the five centres who facilitated my visits and those who took the time to complete the questionnaires.

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Abstract

This study uses food and eating practices around the table to explore the complexities of daily life in residential care settings for young people principally from the workers' perspective. The overall aim is to elicit the significance of food and eating practices in children's residential care settings in Ireland. How food is used in residential care - what is eaten, how, when and where it is eaten - increases the sociological understanding of institutional eating practices in residential care for young people - an under researched area in Ireland.

The table, both physical and metaphorical, is the focus for this research. Using a four legged table as a conceptual metaphor the four themes or legs that support the central focus of this thesis are; commensality, hierarchy, discipline and government. The approach taken is an exploratory sequential mixed methods design of: focused ethnography in five residential care centres, a survey of ninety two social care practitioners and photo- elicitation with a further forty two social care professionals. Thematic analysis of the collected data sets was connected during interpretation. This study puts forward a conceptual framework that enhances the knowledge of aspects of everyday life in residential care. In addition it makes a practical and theoretical contribution to the literature on residential care for young people.

The findings are situated in the broader literatures of the sociology of food, the new sociology of childhood and the sociology of home. The key findings suggest the significance of food in residential care settings need to be considered within the everyday realities of lives lived in the centres – the young people's 'home'. Food can be used as a symbolic instrument to demonstrate care. Furthermore, food can also be used symbolically to reject the care on offer. In addition, food and eating practices can be seen as an expression of governmentality that contributes to the normalisation of 'proper meals' in a 'homely home'. The research has highlighted the value of using the metaphorical table as the key focus to examine the theoretical concepts to enhance the understanding of the significance of food and eating practices in residential care for young people in Ireland.

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List of Abbreviations

| | |
|----------|---|
| BMI | Body Mass Index |
| CAAB | Children Acts Advisory Board |
| CASA | The National Centre on Addiction and Substance Abuse at Columbia University |
| CFA | Child and Family Agency (Tusla) |
| CICA | Commission to Inquire into Child Abuse |
| CRC | Children's Rights Commission |
| CRiSP | Centre for Research in Social Professions |
| CSO | Central Statistics Office |
| CWT | Caroline Walker Trust |
| DAFM | Department of Agriculture, Marine and Fisheries |
| DCYA | Department of Children and Youth Affairs |
| DFSA | Department of Family and Social Affairs |
| DOH | Department of Health |
| DoHC | Department of Health and Children |
| DSP | Department of Social Protection |
| EPIC | Empowering People in Care |
| FSA | Food Safety Authority |
| HACCP | Hazard Analysis Critical Control Point |
| HBSC | Health Behaviour of School-Aged Children |
| HIQA | Health Information and Quality Authority |
| HSE | Health Service Executive |
| IBM SPSS | International Business Machines Statistical Package for Social Sciences |
| LHSC | Life Histories and Social Change in Twentieth Century Ireland |
| NHS | National Health Service |
| NNS | National Nutrition Survey |
| SAI | Sociological Association of Ireland |
| SCI | Social Care Ireland |
| SSI | Social Services Inspectorate |
| UNCRC | United Nations Convention on the Rights of the Child |
| WHO | World Health Organization |

Preamble

This thesis presents a view of the food and eating practices around the table in residential care for young people. Residential care for young people was an unknown quantity to me before embarking on this project. This preamble is an account of my first experience of a residential care centre on the day I conducted a pilot study.

Originally I had planned to conduct the twenty-four hour observation in this centre. On the day of the pilot there were two young women in residence. One was at school and the other, Martina, who was 16, was there as she was not attending school. I arrived at lunchtime and was shown into the office. I was told that Martina would be moving elsewhere that day for her own safety (she was threatening to abscond) but they did not know where and she had not yet been told.

I was shown into the kitchen/dining room where a worker was making lunch - a toasted cheese and ham sandwich, for Martina and herself. The worker answered two telephone calls while eating her lunch and in the end threw her sandwich out because it had gone cold.

The workers told me that they had planned to do the weekly shop that day and that I was welcome to join them. They were hoping that Martina might also join them and then she would help prepare the evening meal. I was concerned at this point that they were performing food and eating practices for me and I was not going to get a true representation of everyday life in the centre.

When Martina was told later that she was going to spend the evening at another location, she refused to go. She went into the kitchen and began to prepare vegetables for the evening meal without any discussion with the staff. She was using a table knife to peel the potatoes. I asked if there was not a paring knife and she told me that they kept the knives in the office. I asked why she had not asked for the knife and she said she couldn't be bothered. I asked if she wanted me to ask and she said ok. I went into the office and asked the workers if I could have a knife for Martina and was told not to let it out of

my sight. Martina peeled some potatoes and cut up some scallions to make champ. I commented on her kitchen skills and she told me that she had worked part-time in a hotel kitchen. When she was finished I returned the knife to the office.

While we were in the kitchen Martina's mother and her social worker arrived. They had come to try and persuade her to go and stay elsewhere for the night. In the meantime another worker had gone to collect the other resident from school and was going to keep her out (she was taken to a fast food restaurant and then to a youth centre) until things had been resolved with Martina. The manager suggested that perhaps my spending that night there would not be appropriate as there would just be one young person and three adults and it would be intense for the remaining young person.

Martina was getting more distressed as the afternoon progressed. Her social worker left and her mother said that she would take her home rather than leave her there for the night. If she agreed to go with her parents, the workers could not prevent her as Martina was in voluntary care. In the end she did go home with her parents, there was no shopping done and the evening meal did not get cooked. Instead, the worker and the manager made tea and toast for themselves (Fieldnotes Glenview Pilot).

After spending the day in this centre I realised that the ebb and flow of everyday life in residential care had the potential to be unpredictable and turbulent. While this experience went some way to allaying my concerns that the workers and young people in the centres would be performing food and eating practices for me, it also showed me that everyday life in residential care is not easily stage-managed. I did not meet the second resident, there was no evening meal cooked and I did not stay in the centre for the planned 24 hours. After the pilot study I realised that I would need to have a flexible approach and be prepared to adapt my plans to situations in the centres that could change from one moment to the next. It became apparent that I would not be able to conduct a traditional ethnography such as Emond (2000), to become orientated with residential care centres, so I decided to implement a focused ethnography approach.

Introduction

Food is central to all our everyday lives because without it we do not survive. However, it is ordinary and commonplace and its significance can often be overlooked. Food, according to Bell and Valentine (1997: 3), 'is packed with social, cultural and symbolic meaning'. It is central to 'our sense of self' and our 'experience of how we live in and through our bodies' (Lupton 1996: 1). The overall aim of this study is to elicit the significance of food and eating practices in Irish children's residential care settings. Focusing on the food and eating practices around the table, this study explores aspects of everyday life in residential care centres. From the workers' perspective I examine the key issues and challenges of food within the centres. This research will significantly increase the sociological understanding of institutional eating practices in children's residential care. It is the first comprehensive study conducted on the matter in Ireland.

Food is recognised as important in the healing process for traumatised children and young people in public care settings (see Bettelheim 1950; Hancock et al. 1990; Tomlinson 2004; Barton et al. 2012; Snellgrove 2013). According to Bettelheim:

Food represents one of a child's earliest contacts with the outside world. It is the activity around which personal relationships first develop and around which they may first break down (Bettelheim 1950: 165).

Bettelheim's research was based in a school for emotionally disturbed children in the 1940s in America. He refers to the relationship between infant and carer, but the same quote could equally be applied to a young person's first contact with the workers in residential care today. Food is used as a welcome in residential care as it is in many social settings. It is used symbolically and practically to demonstrate care:

Food and eating practices are of aid in restoring security in all moments of stress. They are a convenient distraction, they provide outlets for tensions, and most of all they are symbols of security (Bettelheim 1950: 182).

This research shows food continues to be used in residential care, as Bettelheim suggests. It is used symbolically to demonstrate care and control (Punch et al. 2009; McIntosh et al. 2010; Emond et al. 2013). The significance of food and eating practices in residential care for young people is a neglected area of study in Ireland. In the UK, however, food and eating practices in residential care for young people have been researched more extensively (Caroline Walker Trust 2001; Emond et al. 2013a; 2013b; Punch et al. 2009a; 2009b; 2011a; 2011b; 2013; McIntosh et al. 2010; Dorrer et al. 2011). That body of work has been a valuable source of data and has helped to frame the context of my research. The primary aim of this study is to advance the understanding of care in residential settings for young people in Ireland in a way that has not been done before.

Situated in the broader literatures of the sociology of food, the new sociology of childhood, the sociology of home and drawing on the theoretical concepts of commensality, hierarchy, discipline and government, it will identify how food plays a central role for the young people and the workers in residential care centres. To ascertain how food and eating practices should be conducted in care settings I turned to the National Standards for Children's Residential Centres (DoHC). Standard 6.11 states: 'staff and young people eat meals together and these are regarded as a positive social event' (DoHC 2001:22). From deep reflection on that standard I decided to use the table in residential care as a focal point of this research.

The research uses an exploratory sequential mixed methods design consisting of: focused ethnography (short-term field visits with focus on a preconceived research question, see Wall 2015; Kühn 2013; Higgenbottom et al. 2013; Knoblauch 2005), a quantitative survey of workers to examine the central role of food in residential care and a photo-elicitation. Using a mixed methods design enabled me to take advantage of different but complementary data to address the research problem and explore the complexity of food and eating

practices in daily life in children's residential services from the workers' perspective.

Exploring the significance of food and eating practices in Irish children's residential care settings will highlight the complexities of daily life for the young people and the workers. It considers how, and if, the practices of food and eating in the centres reflect similar practices in the general public. Is commensality regularly practised? It examines if hierarchy and discipline are evident at the table? It contemplates who or what governs those food practices?

It develops the theory that food is a powerful symbolic instrument to demonstrate care and control within institutional settings (Punch et al. 2009 and Emond et al. 2013). It evaluates how institutional regulations may conflict with the State regulated aim to provide a 'homely' home. It considers how the food and eating practices of the workers in residential care impact on how food practices are structured in the centres.

The research was conducted over a four year period between 2010 and 2014. The original desk study commenced in 2010 and the first stage of qualitative fieldwork took place over a six month period in 2011. The second stage quantitative fieldwork data collection was completed in 2012. Finally, the photo-elicitation was carried out at the beginning of 2014.

Researchers, according to Finlay (2002: 531) and, in particular qualitative researchers, influence the 'collection, selection and interpretation of data'. Therefore reflexivity needs to be considered at all stages of the research process (Reed-Danahay 2007; Spence 2007; Bryman 2008; Walker et al. 2013; Hesse-Biber and Johnson 2015). Reflexivity involves positioning the researcher in all stages of the research (Hesse-Biber and Johnson 2015) because the researchers' identity, perspectives, experiences and values influence the research process. Therefore I should at this stage clarify my own social location. I am both qualified as a chef and a social care practitioner. My journey through education, culminating in this PhD, has been unconventional. I left primary school with a failed Eleven Plus and secondary school in 1980

with two O-Levels. I returned to education and qualified as a chef in 1987. I was awarded a 1st Class Honours BA in Applied Social Care in 2010.

I was considering continuing into postgraduate study when this preconceived research project came onto my radar. Finlay (2002) suggests reflecting on the research process should ideally begin from the moment the research idea is conceived. Despite my lack of input during conception, I believe that the project was designed for me. I was selected for this project and commenced it as a funded Masters in September 2010. One year later I secured additional funding for a further three years from the Irish Research Council to complete the exploration of food and residential care as a PhD.

I am interested in food and people. I am a chef with a deep interest in the sociology of food and a social care practitioner with an awareness of some of the issues and challenges of working in residential care. Hanrahan (2003) suggests that there is an expectation that academic writing should be impersonal and authoritative. The writer is meant to act as though learning happened without being contaminated by personal experience. Reflecting on how my biographical position impacts on the research process, this thesis is written from the view of someone who inhabits a world somewhere between sociological theory and a practical knowledge of food.

The overview of this PhD thesis is as follows: in chapter one I present my decision to use the table as the metaphorical focus. The physical table is central to the food and eating practices in residential care as it is in most western domestic settings. To structure the literature review I construct a metaphorical table standing on the legs of commensality, hierarchy, discipline and government.

Chapter two explores where children feature in the sociology of food. Children and food are high on the political agenda in many countries with concern about childhood obesity and exposure to marketing of particular foods. Children are therefore perceived as either being a problem or having a problem. The chapter investigates where children fit into the theories of family

food practices, how they are enculturated into the foodways of the family and how children's food and eating practices have become a problem.

In chapter three food and residential care for children and young people are placed in a historical context. A history of statutory care for children in Ireland is presented with a focus on food and eating. Smith (2009) suggests that knowledge of the historical, cultural, political and professional contexts of residential child care over the past 300 years is essential to understanding how it is practised today. The history of residential care for children in Ireland began with the foundling hospitals, then moved to the workhouses, the industrial and reformatory schools and continues with residential care centres today. The Kennedy Report (1970) was a crucial turning point for children in residential care resulting in their being cared for in more domestic environments. Services for children in state care at present strive to be child-centred, child-focused and child-orientated. There is an absence of literature on daily life within the centres today in Ireland not least in terms of food and eating practices.

Chapter four draws on selected theoretical literature to support the chosen methodological approach. This study uses an exploratory sequential mixed methods design to address the research problem. This decision was made from a pragmatic stance as the most appropriate process and method to employ. Mixed methods is a relatively new addition to the research paradigms so a review of its progression, some of the debates within the mixed methods community and some strengths and weaknesses are discussed. Finally I present my rationale for using a mixed methods approach.

In chapter five the implementation of the method is discussed. The exploratory sequential mixed methods design consists of: focused ethnography in five residential care centres, a survey of social care practitioners working in the field and photo-elicitation. Using a mixed methods approach benefits the construction of contrasts and similarities across the centres I visited and centres that completed the questionnaires. In addition the final phase of the research design is a form of photo-elicitation conducted with social care professionals. Interpretation of this visual data brought into focus various

layers of social meaning. This chapter also considers the ethical issues associated with conducting research in residential care for young people and finally some limitations of the study are identified.

In chapter six I present the results from the data collected situated at the dining table in five residential care centres. This chapter provides a systematic description of the young people and the workers in their social environment. The centres varied in purpose and included one short stay/respite, three long stay and one high support. During this first phase of data collection I meet 15 young people and 63 workers. The qualitative data collected during the fieldwork in the centres is presented and analysed. Links are drawn with the everyday food and eating practices in residential care and the broader theories that were identified in the literature review. These include: is commensality regularly practised? Is hierarchy and discipline evident at the table? It considers the government of those food practices. This chapter illustrates how food and eating practices have the potential to elicit the complexities and multi-faceted nature of residential care for young people.

Chapter seven presents analysis of the second stage of this study. Fieldwork data was collected through postal questionnaires with 92 social care practitioners. The questionnaire was designed to further develop and clarify questions and issues that were identified during the first stage. The design also incorporated the four main themes that structured the literature review and aimed to determine if: commensality was regularly practised; the dining table was a hierarchical space; how discipline was manifested in where, when and what young people eat; and who or what governs food and eating practices in children's residential care.

In the final chapter the original purpose of the study is restated and the research findings are presented. Some limitations that were identified during the research process that may be relevant to future research in the area are discussed. This research makes a significant contribution to the knowledge of food work in residential care from the workers' perspective and, as anticipated, has found there is considerably more going on at the table in residential care than sharing food.

Chapter One: The Table

The aim of this study is to elicit the significance of food and eating practices in Irish children's residential care settings. Focusing on the table it explores this aspect of everyday life in residential care centres and examines the key issues and challenges of food within the centres. This chapter provides an introduction to some of the theories concerned with food and eating. To ascertain how food and eating practices should, according to official regulatory discourse, be conducted, I turned to the National Standards for Children's Residential Centres (DoHC 2001) and found that they had very little to say about food. One thing they do say in standard 6.11 is: the young people living in residential centres and the workers employed there, 'should eat together and that meals should be positive social events'. The decision to use the dining table as a focal point of this research originates from deep reflection on that standard.

Why, when, where, what and how we eat is intrinsically connected to a physical and metaphorical table. Analysis of what is eaten, how, when and where it is eaten will be deployed to provide a picture of everyday life in residential care for young people. The sociology of food and the sociology of children are recent additions to the field. The available literature is extensive so to bring more clarity to a complex situation I will use a four legged table as a metaphor, the four themes or legs used to support the table are: commensality, hierarchy, discipline and government. However, table legs cannot stand on their own. They are usually held together by the table top. For the purpose of this study the table top will represent the question – who or what governs the table in residential care?

1.1 Getting my feet under the metaphorical table

Metaphors are pervasive in everyday life: in language, thought and action (Lakoff and Johnson 1980) and a prime example for this study being - *food for thought*. The metaphorical table introduced in this chapter conceptualises food in residential care as a table in order to better understand the complexity of

food in care settings. The metaphorical table is supported by four legs or themes that are developed throughout the thesis: commensality, hierarchy, discipline and government. The theories underpinning the selection of these four themes are as follows:

- Commensality - stems from reflection on standard 6.11 that requires workers and young people to eat together. Commensality means sharing food together and, as Simmel (1910); Douglas (1972); Lupton (1996); Murcott (1997); Jackson et al. (2009); Wilk (2010); Fischler (2011); Ralph (2013) suggest, the ideal place to do so is at the table.
- Hierarchy - Emond et al. (2013: 6) suggest food practices at the table in residential care may contribute to the creation or reinforcement of hierarchies. The literatures on the sociologies of food and children show that children's position in society has changed over the past few decades but they remain in a subordinate position to adults (Corsaro 2005; Mayall 2000; Beardsworth and Keil 1997; Qvortrup 1994). Children's position at the table reflects their position in society.
- Discipline - children in residential care are perceived as children who are in need of both protection and control (McIntosh et al. 2010) and Emond et al. (2013: 2) suggest that food practices in the centres 'may be used to show we care or to exercise control'. The literatures on the sociologies of food and children suggest the table is a prime site for disciplining children into the foodways of their families and their cultures (Beardsworth and Keil 1997; Mennell 1996; Lupton 1996; Caplan 1997; Germov and Williams 2008; Coveney 2008).
- Government - what and where we eat, according to Coveney (2014: 63), 'is a matter of culture, governed by social mores, customs and traditions' or 'the government of the table'. He maintains there are personal and political 'forces at play to shape and control our appetites'. This theme was also selected because children's residential services are governed by a multiplicity of rules and regulations at both internal and external levels (O'Sullivan 2009; Smith 2009; McIntosh et al. 2010).

Metaphor, according to Lakoff (1993: 240), 'is the main mechanism through which we comprehend abstract concepts and perform abstract reasoning'. Central to Lakoff and Johnson's (1980) theory is that a metaphor comes from one source domain and gives meaning to a target domain. Korthals (2008) contends that food is often used as both the source and the target of metaphors. Yob (2003: 134) suggests that a metaphor is not the thing being referred to but a symbol of it and is employed 'to explore and understand something esoteric, abstract, novel or highly speculative'. To force simplification and rationalisation of the complex and multifaceted issues I am using a metaphorical four legged table as the focus for inquiry into food and eating practices in residential settings for young people.

The idealized image of the proper family eating proper food in Westernised countries is strongly associated with the table. The archetypal table, according to Dubuission (2005: 10), is uncomplicated: it 'may be read as infinite variations on a very simple theme'. That is: a flat surface varying in shape and size supported by a leg or legs to raise it approximately 75cm from the ground.

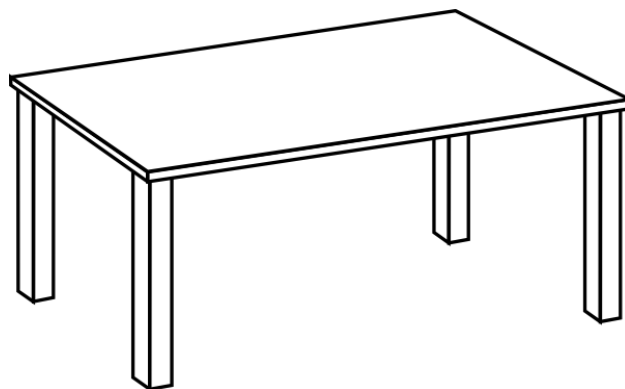


Figure 1 Table
Source: ClipArt (2014)

Tables, like other furniture items, are interesting from a sociological point of view. According to Hemachandra (2009: 7) furniture can serve as 'a narrative of our lives in profound and surprising ways'. Byars (2005:7) discussing the innovations and invention of domestic design products, notes that tables were

included in his study with trepidation, as they may be considered uninteresting when placed in contrast with the iconic status of chairs in furniture design. Byars suggests the tables he profiles serve to shift the reputation of the table as utilitarian objects into fascinating, but still very functional tools.

Early texts on the history of table etiquette, according to Romagnoli (2013), show that in medieval times houses did not devote a particular space for dining. There was little room for a fixed dining table and the moveable table was constructed of boards on trestles. Romagnoli (2013) suggests that the expression ‘to set the table’ comes from constructing the table as opposed to laying cutlery on it. Over time there was a transition from the moveable table, found in the halls of the manors and castles, to a fixed table in the bourgeois dining rooms of Victorian England.

Images of Victorian domestic life, including how they used the dining table, still influence idealised visions of family life today (Nelson 2007). The design of many domestic homes in the 1960s and 1970s were open-plan in nature and the separate dining room went out of vogue. The kitchen/diner became the space to cook, eat and socialise in middle class homes from the 1980s onwards. The table, often large and wooden, has become a regular furniture item in contemporary homes and is often situated in the kitchen/diner or in general living areas, as Figure 2 shows. The table is considered the heart of the home. In the poem *Perhaps the World Ends Here*, by Joy Harjo (1994), she maintains ‘the world begins and ends at the kitchen table’.

The table is not just a site where meals are consumed. Prior to fitted kitchens it was often the only work surface available for food preparation. The kitchen table has been a multi-purpose furniture item throughout its history. According to Arnold et al. (2012: 89) the kitchen table is ‘central to maintaining family cohesion and to coordinating everyday activities’. The image below (Figure 2) (illustrated by Arnold et al.) is the ground floor plan of a family home in California. Each red dot represents an adult or a child’s position in the house over two weekday afternoons and evenings.

As you can see the kitchen table is the most intensively used space in the house. The dining table, on the other hand, was not used at all.

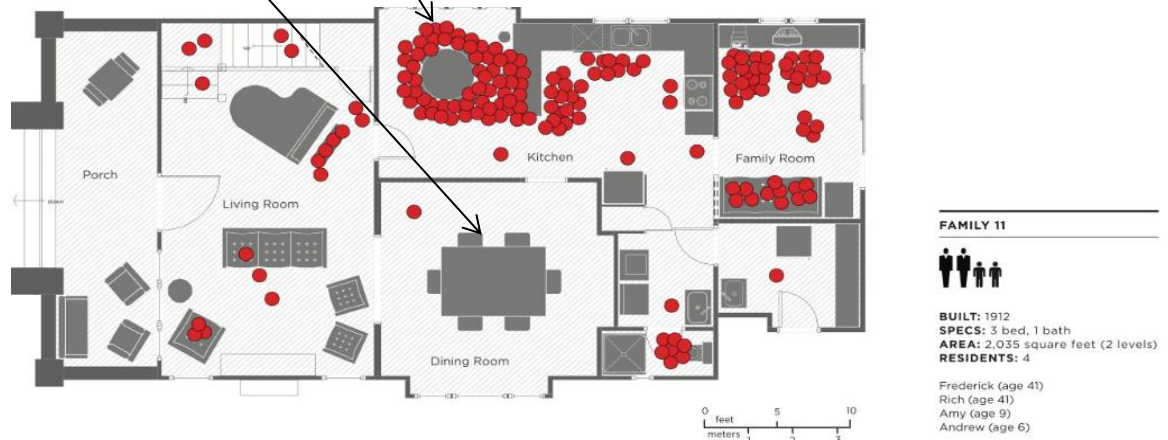


FIGURE 2 FAMILY MEMBERS' LOCATION
 Source: Arnold, Graesch, Ragazzini and Ochs (2012)

The decision to use the table as the focal point of this thesis stems from the Department of Health and Children (DoHC 2001) standard 6.11 that requires that the young people living in residential centres and the workers employed there should eat meals together and that mealtimes should be sociable events. By concentrating on food practices at the table, the research was confined to the most public area of the centre - the kitchen/dining room. Positioning myself at the table and the research in a fixed and public space helped address some of the ethical issues of research with this vulnerable group.

The table is referred to as: the table, the kitchen table and the dining table throughout this study. To aid clarification the table in this chapter refers to the metaphorical table. When a kitchen table is referred to it is a table situated in a kitchen and a dining table refers to a table in a dining room or an open-plan dining room/kitchen/living room.

In this chapter the table is considered as a cultural site drawing from theoretical frames found within anthropology, sociology and cultural geography. The anthropologists Ochs and Shohet (2006: 35) conceptualize a cultural site as socially controlled and controlling, constant yet changeable, a certain space in a particular time that is rich in symbolic meaning and mediated by material artefacts. They view mealtimes at the table as: 'pregnant arenas for the production of sociality, morality and local understanding of the

world'. The geographers Warf and Arias (2009: 1) suggest cultural geography influences the social sciences and recent work within the disciplines 'have become increasingly spatial in orientation'. Space matters because where things happen is critical to knowing how and why they happen. The sociologists Punch et al. (2011), discussing children's food practices in families and institutions, suggest that spaces are created in everyday activities 'through active positioning and being positioned by the action of others' (Punch et al. 2011: 2). The position in this study is the table in residential care centres for young people who, themselves, have been positioned there by the actions of others.

I argue that by employing the metaphorical table as the key focus to explore the theoretical concepts of commensality, hierarchy, discipline and government this research will enhance the understanding of the significance of food and eating practices in children's residential care centres in Ireland.

1.2 Commensality

Eating with others is a social event worthy of the sociological gaze. Simmel (1997 [1910]), discussing the *Sociology of the Meal*, suggests that eating is an entirely individual, even 'egotistical', act because 'what one individual eats can under no circumstances be eaten by another' (Simmel 1997: 130). For Simmel, the time when people began to share meals was when the regulations around food and drink emerged and this was the first victory over the primitive physiological act of eating:

Persons who in no way share any special interest can gather together at the common meal – in this possibility, associated with the primitiveness and hence universal nature of material interest, there lies the immeasurable sociological significance of the meal (Simmel 1997 [1910]: 130).

Dining becomes a social act only when it rises above the egotistic and functional act of eating. Commensality is eating with other people. According to Fischler (2011: 2), for whom commensality has been a main area of research, it literally means 'eating at the same table (*mensa*)' and it 'provides a script or a template for many or most of human eating occurrences' (Fischler

2011: 8). Fischler's position on commensality might reflect his French origins and his conclusions may differ if he were, for example, American. According to Kerner and Chou (2015: 2) early discourse on commensality focused mainly 'on issues pertaining to obligatory or prohibited commensalism' or as a social function that unites or separates people. Discussing the politics of commensality, Fischler suggests that there is a gradient in the manifestations of commensality from intimate familiar to formal occasions. That gradient can also be interpreted as private to public. Douglas (1972) analysed the food events in her own home and concluded that the gradient ranged from intimate to distant. A stranger may be offered a drink but only family and honoured guests are welcome at the table for meals.

Commensality is 'institutionalised in many cultures starting with the family meals eaten together' (Tierney and Ohnuki-Tierney 2012: 121). Tierney and Ohnuki-Tierney suggest, similarly to Martin (2004), that commensality can take different forms, for instance, students eating together either in college cafeterias or in their shared accommodation. Sobal and Nelson (2003) suggest commensal units include workers eating lunch together. In the work setting even if the food is being consumed 'al desko', it is considered a social aspect of the day. 'Fika', having coffee and cake with friends or work colleagues is another example of sharing food with others that is not a formal sit down meal but, according to Henderson (2005), is an important custom in Sweden.

Inverse commensality according to Tierney and Ohnuki-Tierney (2012: 121) is found in institutionalised religions in the form of fasting or commensality without food: Lent, Ramadan and Yom Kippur are examples of this. Therefore commensality exists even when food is not eaten. Fischler (2011a: 19) maintains that solitary eating cannot be considered commensal and eating alone is perceived negatively because it is not social. Again Fischler is reflecting the French 'cultural attachment to mealtime and commensality' (Fischler 2011b: 218). Solitary eaters are viewed with suspicion for excluding themselves from communal eating and for not sharing. This highlights the social tension between eating alone and eating with others. I argue that solitary dining is also a social act inasmuch as a person may choose or has no option but to eat alone.

Eating with others or eating food prepared by someone else requires trust (Milne 2013). Lupton (1996) and Fischler (1988) suggest there is always a degree of ambivalence regarding food because what we eat crosses our bodily boundaries and we can become contaminated by it. We must trust both the people we eat with and how the food has been prepared because the food we ingest is potentially dangerous. This is one reason why sharing food is central to kinship in most societies.

Sharing a meal with other humans raises us from the animalistic need to satisfy the individual appetite. Eating with your fingers, according to Simmel (1997: 132), 'is the expression of unreserved desire' and therefore linked to the primitive physiological act of eating. Using cutlery civilises that desire because a distance is created between the food and the individual. However eating with your fingers is socially acceptable in many countries in Asia, the Middle East and Africa. In addition not all societies use tables and chairs. Nevertheless, 'a proper meal' in western countries, and in particular middle-class London, was first deciphered by Mary Douglas in 1972 and has influenced many food scholars:

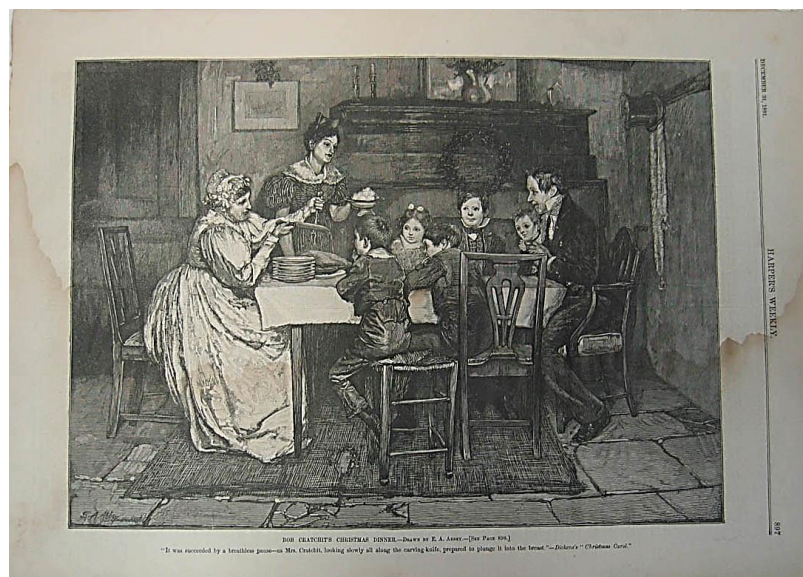
Meals properly require the use of at least one mouth entering utensil per head. [...] Meals require a table, a seating order, restriction on movement and on alternative occupations (Douglas 1972: 66).

Participation in the ritual, rhythm and routine of meals is considered a key way of displaying and experiencing family (Fiese et al. 2006). A 'proper' family meal in westernised societies conjures up the image of all the family gathered around the table enjoying the same food and having convivial conversations. That image remains a constant symbol of ideal family life. Lupton (1996) suggests that it is not only the food served at the table but also the ritual of sitting down together that is considered important because 'the family meal and the dinner table are potent symbols, even metonyms of the family itself' (Lupton 1996: 39). The idealised image of the family meal at the dining table, according to Ralph (2013: 424), 'reached its apex during the mid-twentieth century', in particular the two decades after the Second World War. However,

the image of the family gathered around the table has a much longer history and, according to Murcott (1997), so has the concern for its alleged decline:

Even if we have only a little time at home together, we want to make the most of that little. In our family we always try to have Sunday breakfast and dinner together at least... I ate only seven meals at home all last week and three of those were on Sunday' said one father (Lynd and Lynd 1929: 153-4 cited by Murcott 1997: 32).

Murcott (1997: 43) asked 'do people actually eat like this and if so how often?' Jackson et al. (2009) and Murcott (1983; 2012) argue that the family meal taken at the dining table is a 'venerated social institution' according to 'society's moral guardians' (Jackson et al. 2009: 131) but in reality the family dinner has always been variable in practice. The image (Figure 3) of Dickens' (1843) *A Christmas Carol* is an early example of that idealised image.



on the table, presumably impatient for the food. They look barely held in check suggesting that children's behaviour at the table was then, as it is today, in need of control.

Throughout academic literature and popular media there is continued concern that families sitting at the table to eat together is in decline. On the one hand families may eat together but not at a table, sitting instead on the sofa in front of the television, so reducing the opportunity for social interaction or the need for table manners. On the other hand families do not share meals because they are time poor, due to both parents working outside of the home and children having extracurricular activities resulting in solitary snacking and grazing. That ideal of the 'proper' meal taken at the table, with other people not engaged in any other activity, suggests the table is a morally superior space.

Wilk (2010: 430) argues that to assume an ideal family meal around the table is the norm renders other eating arrangements as 'deviance or evidence of social decay'. This alleged decline in the family meal has been linked to increases in childhood obesity, eating disorders, drug and alcohol abuse, early and promiscuous sexual activity and behavioural problems at school for young people (Jackson et al. 2009; Ralph 2013).

The National Centre on Addiction and Substance Abuse at Columbia University (CASA 2012) has been conducting surveys with young people and their parents for the past two decades. They have consistently found that young people who eat five or more meals with their parents per week are less likely to smoke, use drugs or drink alcohol. The CASA surveys are not published in full but in short briefing papers and therefore not open to peer review. Wilk (2010) suggests this enables CASA to imply that the family eating together leads to less antisocial behaviour while not providing us with all the variables such as: income, household size, marital status or location of the families in their survey.

Wilk (2010) and Murcott and Chaumont (2012) argue that the CASA correlation between the frequency of young people's presence at the family dinner table and anti-social behaviour may have no causal implications. Correlation and causality should not be confused. According to Pallant (2013:

124) ‘correlation provides an indication that there is a relationship between two variables; it does not, however, indicate that one variable causes the other’. The CASA findings could be interpreted as follows: A, eating with the family leads to young people being less anti-social; B, less anti-social young people are more likely to eat with their families or, C - as Pallant suggests, a third variable causes both A and B. That third variable, in this case, could be the socio-economic status of the families surveyed.

Food surveys are a widely used method in food studies and, according to Miller and Deutsch (2009: 120), ‘a particularly useful tool’. By contrast, Wilk (2010: 432) argues that ‘the daily experience of family mealtimes cannot be elicited on survey forms’ because when people are asked questions such as – when it comes to dinner, where do you and your family usually sit? – they are likely to respond with an aspirational view of where the family eat. If that is the case then *What Ireland Ate Last Night* (Bord Bia 2011) should be read with reservation. This online survey, with 1003 respondents, found that 36% of families always eat together and a further 48% have family meals as often as possible. The majority (60%) of respondents ate their meals in the kitchen and a further 21% ate in the dining room. In addition, 88% reported everyone eating the same meal. Therefore a large amount of Irish people appear to be having, or aspire to have, ‘proper’ family meals gathered around the table enjoying the same food. Bord Bia did not enquire about the convivial conversations.

Wilk (2010) maintains that ethnographic methods provide richer examples of the complexities of family food practices, though the dynamic of family meals can be changed by having a researcher observe them eating. Research into people’s private eating habits is complicated and to address this problem I will use both a survey and focused ethnography to elicit a fuller and more rounded view of how food works in residential care.

Jackson et al. (2009) and Murcott (1997; 2012) suggest the ideal of the family meal may always have been more of an aspiration than an actuality. Analysis within the *Life Histories and Social Change in Twentieth Century Ireland* (LHSC 2011) project, conducted by Ralph (2013), focused on the

interviewees' responses about family mealtimes and food practices. The LHSC project collected life histories from 113 respondents who participated in the 'Living in Ireland Survey' that formed part of the European Community Household Panel study, conducted between 1994 and 2001. Respondents were drawn from three birth cohorts: those born before 1935, between 1945 and 1954, and between 1965 and 1974. Ralph found that patterns of family food practices in Ireland in the twentieth century responded to changes in the economy, changing work roles and innovations in technology as well as changes in family size and structures. He found within the three cohorts that families did eat together at the table and overall there was no evidence to suggest that there has been a linear decline in Irish families eating together.

According to Ralph (2013), Jackson (2009) and Murcott (1983) the contemporary concerns for the decline of the family meal are based on a misreading of the past. Ralph (2013) identifies two trends that give rise to more rather than less opportunities for the traditional nuclear family to share mealtimes in 1970s and 1980s Ireland: one, this cohort were unlikely to have had live-in domestic workers or farm labourers, and two, they were less likely to have extended family living in their homes, as was the case for the earlier cohorts.

The other trend is that while family tensions endured, a more democratic, open attitude to parenting was becoming apparent in the 1970s and 1980s. The authoritarian nature of social relations between adults and children from the two earlier cohorts show that mealtimes were often oppressive occasions where children's behaviour was strictly controlled. This oppressive image of the family meal contrasts with the image of the ideal mealtime shared exclusively with immediate family that protects against social anomie:

The strict hierarchy governing adult-child relations at mealtimes served in many instances to alienate children from adult family members, especially authoritarian fathers (Ralph 2013: 433).

To recap thus far: eating with other people is referred to as commensality and, according to Fischler (2011), this means eating at the same table. The literature highlights some tensions in this social pattern for consuming food. Eating with

other people is not always an option for people who live alone and is sometimes a preferred choice for those who live with others. Commensality can be difficult to research due to normative beliefs. Commensality is both inclusive and exclusive, as Ralph's statement above illustrates, the table is not always a welcoming and democratic space for children or adults.

Commensality can demonstrate on the one hand *equality* - who is invited to the table or on the other *hierarchy* - who sits where at the table. Idealised images of the family dinner table (as Figure 3 shows) often depict that hierarchical relation: a man sitting at the top of the table, children at the long sides and a woman serving.

1.3 Hierarchy

Hierarchy is the next theme that supports the table metaphor. The meal table is a setting where the inequities of power based on gender and age can be played out within the family. Wilk (2010) suggests that the enactment and enforcement of hierarchical behaviour can be very subtle, such as what direction the serving dish is passed or a disapproving glance for slurping your food. According to Visser (1991: 130) in the Western world the dining table is 'usually oblong, to fit into our oblong rooms'. The oblong table gives rise to the people seated at the short sides having a distinguished position. A round or a square table may remove that hierarchical distinction. According to Lacy et al. (2013: 62) in Arthurian legend the round table was the symbol of chivalric equality because no knight could sit in a favoured position. Yet in China, where a round table is often used, there is a strict hierarchy of seating. The most important person (honoured guest or eldest family member) is seated in the favoured position facing the entrance (Zinzius 2004). These conflicting views on table design suggest that all tables used for eating have the potential to have hierarchical prized positions.

Not all meals are eaten at a table and not all houses have one. Hemachandra (2009:7) suggests 'the quality of one's furniture has always indicated socioeconomic status'. Tables take up quite a lot of space and not all households can accommodate one in the kitchen, have a separate dining room or afford one. The housing conditions for the urban working-class in Ireland

one hundred years ago, according to McManus (2003: 39), were appalling. 'Families lived in single rooms of tenement houses, sharing a single water supply and a toilet in the backyard'. It is unlikely they would have had space or the finances for a table large enough to accommodate all the family at one sitting (Jackson 2009; Murcott 1997). Figure 4 below is a photograph of a typical Dublin tenement room. The table, as you can see, is not very large. It appears to be a multi-purpose furniture item used for personal washing, food preparation and eating.



FIGURE 4 DUBLIN TENEMENT ROOM 1913
Photograph: National Archives

Using a table and chairs both unites and separate the diners in hierarchical formations. People sitting on individual chairs are divided as opposed to those who sit on communal benches. People sitting on individual chairs are more easily observed by those in hierarchical positions. The dining table in affluent homes was situated in its own room away from the smells and noise of the kitchen. Murcott (1997) reminds us that in those affluent homes of the upper class, children did not eat with the family at the dining table but in the nursery. Young children were, and still are, often fed earlier than adults and when they are allowed to join the table they are restrained in high chairs with individual tables. The restraints may prevent the child from falling out of the chair but they also keep the child at the table. The child learns even before he/she can

speak that they have to request permission from an adult to get down from the table.

Stapleton and Kennan (2009) suggest that families are historically, socially and culturally complex phenomena. In Ireland, as elsewhere, the family is recognised as the 'primary socialising agent for young people' (Lalor et al. 2007: 57). The sociological analysis of the family, according to Beardsworth and Keil (1997), is permeated by two opposing themes. One - the family is an intimate, positive, supportive institution. Two - families are the site of conflict and oppression. The family meal table is a site where these two opposing themes can be played out.

The ideal of the family meal table, that is adults and children eating together, is a place of harmony and solidarity (Wilk 2010). However encounters between adults and the children are shaped within the framework of unequal power relations. The socialisation of children at the table can result in the table becoming a setting for the exercise of power and authority where conflict and oppression prevail. Adults can exercise their hierarchical position at the table by: controlling what and how much food is available; making children eat what they may not want to eat, using food as a reward or withhold certain food and using food as emotional power to represent care, love and nurturance (Counihan 1992).

The hierarchy of the table is multifaceted. Where you sit can determine your position within the family and the quality and position of the table in the home can determine your socioeconomic position in society. The table can be the scene where the inequities of the power differential between adults and children are played out. Despite this the table is considered the ideal site to discipline young people in table manners and how to behave in company.

1.4 Discipline

The dining table is a controlled and controlling space (Visser 1991; Ochs and Shohet 2006). Children are disciplined at the table by adults who train them in appropriate behaviour when eating. Rules such as: eat with your mouth closed,

no raw joints (elbows) on the table, do not play with your food or you must ask to be excused from the table, do not come naturally to young children.



FIGURE 5 SPAGHETTI TWIRLING WORKSHOP
Photograph: Deirdre Byrne (2013)

Figure 5 above shows my four year old grandniece learning how to twirl spaghetti onto her fork. A few minutes before the photo was taken she had abandoned both fork and fingers and was eating straight from the bowl. Visser (1991) describes a similar scene, where a fifteen year old boy ate spaghetti with his hands in public. The boy's father was so aggrieved that he sent the son away to boarding school. The son did learn how to roll spaghetti tight onto a fork and put the fork into in his mouth because eating: neatly, cleanly and noiselessly are the three basic rules of the table in western societies:

Because these three general principles are so warmly encouraged in our culture, having been arrived at, as ideals to be striven for, after centuries of struggle and constraint, we simply never doubt that everyone who is right-minded will find a spaghetti-eating companion disgusting and impossible to eat with were even one of them lacking (Visser 1991: 17).

Michael Pollan (cited in Johnson 2013) states that sitting around the table is important as it is where children are not only taught the manners that they need to get along in society, such as sharing, taking turns or participating in adult conversation but he goes so far as to suggest the family meal is the nursery of democracy. However the table is also a site where power and resistance occurs

at mealtimes between adults and children (Coveney 2008; Wills et al. 2008; Bell and Valentine 1997; Grieshaber 1997). The family dinner table is not just a significant site for ‘the construction and reproduction of ‘family’ in contemporary Western society’ but it is also the arena where ‘emotional relationships and power relations’ are played out (Lupton 1996: 38). According to Visser (1991: 54) the dining table is ‘a constraining and controlling device, a place where children eat under the surveillance of adults’. McIntosh et al. (2010: 290) found that ‘relations of power and resistance are routinely played out through food’ within residential care centres for young people.

Grieshaber (1997), in her work on parent-child power relationships at the dining table, uses Foucault’s (1977) idea of disciplinary power to explore contestation and negotiation. According to Balan (2010) Foucault’s analysis of power moves beyond the oppression of the powerless by the powerful. He views power as ubiquitous. It is found in all relationships and it only exists when there is resistance. Grieshaber (1997: 652) demonstrates that power is multi-relational in her investigation into how young children actively resist parental authority during mealtimes:

Discourse-embedded parental power, authority and associated social practices are constantly challenged by young children who respond through resistance in a variety of ways including argument, disagreement, conflict and opposition.

Foucault’s concept of disciplinary power is that of an accumulation of power techniques that operate through people and institutions, expressed on diverse levels of power-knowledge-resistance. Children learn to eat at the table through routine order. Meals are consumed in a specific location, at a specific time, certain food is served and a particular amount eaten. According to Grieshaber (1997: 653) adult supervision during meals is: ‘constant so that children eventually learn to consume food in a regulated and disciplined manner, within a particular timeframe and in a limited space’. Disciplinary power is internalised by the children who in turn learn to discipline themselves. Grieshaber suggests that it is through disciplinary power rather than socialisation that children learn to eat ‘properly’.

Through discipline behaviour is regulated - in this case the regulation of space - *table and chairs*, time - *breakfast, lunch and dinner* and behaviour - *posture and movement at the table*. However, where do the regulations come from? The rules and regulations of table manners are, in general, personal standards of behaviour and may differ from one household to another, but patterns are evident. The manners instilled by the adults in my home were largely based around noiseless eating, mouth closed and no slurping. We were reminded of them by both parents and older siblings when a breach occurred. I find myself adhering to those standards and have passed them on to children and even adults eating in my company. I assume that my parents ate by the same rules in their homes so manners were passed down from one generation to the next.

As discussed, learning how to behave at the table is vital to proper public behaviour. Mennell (1987) discusses ‘civilising of the appetite’ and, building on Elias (1978), presents a history of the development of self-control in Western Society with reference to food conduct that originated in the late sixteenth and early seventeenth centuries. Mennell (1987: 384) demonstrates that the state attempted to curb excess in Europe during medieval times, with the introduction of the sumptuary laws. One such law in France in 1563 ‘forbade private families to have meals consisting of more than three courses’. Coveney (2006: 39) recognises that no single powerful force appeared to police the uncivilised appetite ‘instead there was an increased organisation of society which regulated the minutiae of everyday life’. This new form of power was identified by Foucault (1995 [1977]) as the theoretical perspective of governmentality that is considered in the subsequent section.

1.5 Government

I now turn to the final theme, completing the four legged table, where government is presented. First, to provide some clarity, three terms that are used in this section are defined: government, governance and governmentality.

Government in western societies can be classified as the democratically elected body that exercises sovereign authority over state and society.

Governments are responsible for making and enforcing laws, managing state finances and protecting the population. Governments express power through

the regulation of people's lives through state laws. The definition of government goes further than political rule and administration of the modern state. According to Dean (2009: 18) government expressly attempts to shape aspects of our behaviour to fit 'particular sets of norms and for a variety of ends'.

Foucault (1982) argued that thoughts on government needed to be returned to its older and more expansive meaning. Government does not only refer to political structures and the management of states but also how the conduct of individuals or groups might be directed such as 'the government of children, of souls, of communities, of families, of the sick' (Foucault 1982: 790). This study looks at the *government* of children's residential services in and around the table and how they affect food and eating practices for the young people and the workers. The table in the centres are governed on multiple levels by external and internal authority and regulation.

Governance, in a general sense, signifies: a strategy, process, procedure or programme that controls, regulates or manages problems on a global, national, local or organisational level (Lemke 2007). Rose (1999) suggests the term governance gained popularity in political science in the 1980s when sociologists and political scientists attempted to find an alternative way of thinking about political power. Governance, according to Lemke (2007: 53), indicates a movement in the 'analytical and theoretical focus from "institutions" to "processes" of rule and announces the eclipse or erosion of state authority'. Kondakov and Barbero (2010) suggest that governance differs from government in how subjects are organised. Through governance subjects are given more freedom of choice provided their actions are guided by those promoted by the state. Rose (1999: i) argues: 'freedom is not the opposite of government', instead it is 'one of its key inventions and most significant resources'.

Governmentality focuses attention on the diverse ways in which we may govern the conduct of ourselves and others. According to Coveney (2006: 12) through governmentality a variety of methods emerged for knowing populations and managing them through that knowledge. This power was

associated with a new form of control that is ‘internalised and exercised through surveillance rather than force’ (Gadde 2008: 9). Foucault offers a body of thought on governance that works outside the conventional divisions between: state and society, public and private, government constraints and individual freedom. Unlike government but similar to governance, according to Joseph (2012), by governmentality the power to influence the actions of others is administered from a distance. The aim of governmentality is to produce ethically responsible and ‘normal’ citizens. McNay (2009: 60) suggests that governmentality has emerged as the embodiment of ‘the most definitive historical instantiation of disciplinary social control’.

Miller and Rose (2008: 14) argue - if to govern implies the conduct of conduct then there must be a problem with individual or collective conduct that needs conducting. They suggest that it makes sense to begin with questioning ‘how this rendering of things as problematic occurred’ and demonstrate that problems are not pre-given ‘they are constructed’ through knowledge ‘and made visible’. I draw on the work of Coveney (2006) who demonstrates that when the problematisation of population’s health and welfare became visible the disciplines and techniques concerned with knowing the population and managing it through that knowledge grew. In the current discourse on food and health the words ‘panic’ and ‘epidemic’ are often used.

The everydayness of eating is a problem, not just for the individual but for society as a whole. The problems of eating today include the need for self-control over our natural appetites and the apparent unlimited choice of foodstuffs available. Coveney (2006) examines the development of our current ways of thinking about food, pleasure and our bodies. He shows ‘anxieties about our appetite for food have given and continue to give rise to concerns about the very moral fabric of society’ (ibid: xii). Those anxieties have existed in Western societies and can be traced back to the ancient Greeks. Coveney applies Foucault to our current concern and anxiety about what we should and should not be eating:

Warnings and admonitions constantly alert us to the fact we could be digging our own graves with our knives and forks. These concerns are usually couched in terms of our health, especially in terms of the scientific, calculated understanding of food we recognise as the field of nutrition. However, nutritional knowledge does not merely consist of facts, figures and recommendations from scientific experts. As a knowledge about what, when and how much to eat, nutrition provides a guide for individuals to assess their eating habits in terms of what is 'good' (Coveney 2006: xii).

From a governmentality perspective knowledge is not objective because experts in the human sciences, such as sociology, psychology or medicine, prioritise already-formed subjects to be managed through the art of government (Foucault 1995; Coveney 2006). Experts develop strategies and techniques to manage individuals who can freely choose to act on their advice. A distinctive feature of governmentality is that it operates on self-regulation rather than passive submission. According to Foucault (1982: 790) 'power is exercised only over free subjects' because subjects are faced with a field of possibilities to which they can react in several ways. Therefore power only works if subjects are able to react to it, indicating, as Nettleton (1997: 217) suggests, individuals are not passive and/or 'docile' subjects who are shaped by the processes of governmentality.

Power is not simply oppression of the powerless by the powerful. Grieshaber (1997) offers a view where children are not always subordinates who passively respond to their environments. The young children in Grieshaber's study actively contested and negotiated the power relationships played out through food and eating practices within their families. In agreement Gallagher (2008) argues that adults do not have complete control over children: if they did children would always do as they were told. Social attitudes to children have changed over the past sixty years, due partly to the relatively recent recognition of children's rights, they have been provided with freedom of choice. That choice includes what they eat. As a result children are expected to be self-reflecting and self-regulating individuals on the one hand but on the other there is growing concern about what children choose to eat. This highlights a discursive tension between children's agency to act independently

and adults' duty and responsibility for the socialisation and protection of children in their care.

Ristovski-Slijepcevic et al. (2010: 468) identify dietary governmentality as a technique of government because eating behaviour is linked to ethical or moral conduct. The key role of governmentality, according to the authors, is to provide 'social standards for people's behaviour'. For Foucault (1995) governmentality comprises a range of techniques and organised practices deployed to shape the conduct of individuals and populations. Rationalities are developed based on expert knowledge that are spread through a network-like system that guides conduct by 'processes of surveillance, normalisation and responsabilisation whereby individuals and collectives such as families rather than the State, become responsible for social risks' (Ristovski-Slijepcevic et al. 2010: 468).

Governmentality focuses attention on the diverse ways in which we may govern the conduct of others, but of equal import is how we govern ourselves. This is accomplished through the 'technologies of the self' by which we come to know ourselves through discipline and training. This new form of control is 'internalised and exercised through surveillance rather than force' (Gadde 2008: 9). Consider how often people refer to themselves as *good* or *bad* in relation to their food choices. Coveney (2006) suggests that it is through our knowledge of nutrition that we can make moral judgements about ourselves and others:

It is this moral imperative which is encoded in nutrition that makes it so compelling, so engaging, so judgemental, and so strangely popular (Coveney 2006: xiii).

The Statutory Regulations for Children's Residential Care requires that children living in residential care are provided with a 'healthy and nutritious diet' (DoHC 2001). Healthy eating habits, where and with whom to eat could be described as – 'the government of the table' (Coveney 2008: 224). Using the perspective of governmentality Coveney examines nutritional expertise and the social organisation of family food habits. The knowledge of nutrition permeates many aspects of our everyday lives. An obvious one at present is the government campaign to eat five portions of fruit or vegetables a day.

Through governmentality, we use self-surveillance to ensure that the recommended daily amount is consumed or we feel guilty. I am contending that the government in the traditional sense of the word not only offers advice on what and where the young people in residential care should eat but also has ultimate control over their being at the table.

Through governmentality food spaces are also regulated. Expert advice on why we should eat at the table tells us that it is good for the body and the soul. Information such as: eating upright in a chair aids digestion, eating in company prevents over consumption and encourages children to eat more nutritious food. As for the soul, gathering at the table to eat creates a happy household. While we might know that not all family mealtimes live up to these claims, ethically we feel guilt, at least some of the time, for not being able to achieve the ideal of the normal happy family gathered together daily to eat at the table.

1.6 Conclusion

In this chapter I have constructed a metaphorical table standing on the four legs of commensality, hierarchy, discipline and government to better understand the complexity of food in care settings. I have set this table with various themes that will be developed in the following chapters. Explored further: Is the sharing of meals at the table, *commensality*, an aspiration or reality in residential care? Is enactment and enforcement of *hierarchical* behaviour and *discipline* embedded in the rituals, rhythms and routines of the table? And, finally, how does the *government* of children's residential services in and around the table affect food and eating practices?

The physical table in this study is situated in residential care centres for young people. In chapter three a fuller understanding is developed of the history of statutory care for young people in Ireland with particular reference to food from the founding hospitals to the present day. The next chapter will begin by looking at the broader sociology of food and will focus on where children and young people feature within this literature.

Chapter Two: A Place for Children in the Sociology of Food



FIGURE 6 BAKING LESSON

Photograph: Zoe Bowyer (2012)

2.0 Introduction

In this chapter I will discuss selected themes in the literature surrounding the sociology of food and children. The image above (Figure 6) illustrates a current idealised image of a child's place in the kitchen. It harks back to a, perhaps romanticised, era when a daughter learned to cook at her mother's side. In this picture, however, both the bakers are children and both are learning to cook. The taller one is reading the recipe.

The sociology of food and food studies are growing fields of study but the inclusion of children and young people is relatively recent within the literature as is the inclusion of children in sociologies in general. An influential article published by Thorne (1987) suggested that the general perception of children

from an adult's perspective, is that they are: victims of adults, learners of adult culture or a threat to adult society. Qvortrup (2009) stresses that Thorne's 1987 article has been significant because it demanded the visibility of childhood and giving children a voice.

Many scholars in the fields of childhood studies and the sociology of children have highlighted children's perspectives (see for example Jenks 2005; Corsaro 2005; James et al. 2009; Qvortrup et al. 2009; Smith 2014). While our understanding of childhood may be growing, children continue to be viewed as not completely 'fully fledged citizens' (Olk 2009: 191). Devlin (2009) argues that young people continue to be viewed as *having* a problem or *being* a problem.

According to James et al. (2009: 4) when the relationship between children and food has been studied 'it has almost exclusively been within the private sphere of the family'. The studies have relied on adult informants rather than children themselves. James et al. (2009) suggest that this is at odds with the current situation where children consume much of their food outside of the family home. They also identify that there is a gap in the knowledge in that hardly any work explores children's own experiences and perspectives of food.

The relationship between children and food is currently high on the political agenda in Ireland, as it is in many countries. Two areas causing particular concern are: children's exposure to marketing and childhood obesity. Concern for young people and their relationship with food and their bodies is not new and, according to Coveney (2006: 10), can be traced back to the *dietetics* in ancient Greece. According to Wright et al. (2012: 673) current campaigns and policy are designed and directed towards young people 'who are a risk to themselves and the state because of their ungoverned/unruly behaviour and bodies'.

What follows is a discussion of children and young people as they feature in the sociology of food today. The three areas that I have selected to explore where children feature in the disciplines and drawing from Thorne (1987) are: children's subordinate position to adults - *victims*, how children are socialised

into the foodways of their culture - *learners* and food and eating is a health problem for children - *threats*.

2.1 Victims: *children's place - on the margins*

To begin the discussion Corsaro (2005) suggests that the inclusion of children within the field of sociology is relatively recent because, as Qvortrup (1994) indicates, children are marginalised by the power imbalance between children and adults. If children in general are marginalised, it can therefore be assumed that, children in the care of the state are further marginalised. The sociology of children and childhood studies has developed since the 1990s and has started to modify adult perceptions of children and childhood and how they differ across time and societies. The recent publication by Smith and Greene (2014) presents some of the contrasting perspectives from twenty two of the most influential figures in the field over the past thirty years. The sociology of childhood, according to Mayall (2000: 248), has advanced a greater respect for children but it has also led to a fuller understanding of the wrongs suffered by children. To develop a broader understanding of the power relations played out between adults and children this section explores the generational power imbalance within children and adults' food and eating practices:

Sociologists seek to analyse and understand class, gender, age and ethnicity; it is clear that food can and frequently does play a crucial role in symbolizing and demonstrating social distinctions. [...] The diet of the poor reflects the economic disadvantages with which they have to cope; the diet of children reflects (to some extent) their subordinate position vis-a-vis the adults who wield power over them (Beardsworth and Keil 1997: 53).

2.1.1 Eat what you're given

Taste is idiosyncratic. Lupton (1996: 95) defines taste as 'the totally private and individualised disposition of a person according to their specific likes and dislikes'. Taste is the sensation felt when food or drink enters your mouth. Stevenson et al. (2007) suggest, on an individual level, the appearance, smell, texture or taste of a particular food item can be powerful reinforcers of food choice. Cook (2009: 115) suggests that taste, pleasure and hunger are

experienced bodily on the palate and in the stomach. A parent or care giver may be able to tell when a child *should* feel hungry, because a sufficient amount of time has passed since their last meal, but they cannot tell *if* they feel hungry or, perhaps more specifically, if they enjoy the food they are presented with. Therefore children are the authority on what and when they would like to eat.

Children in the early twentieth century, Coveney (2006) suggests, were strongly encouraged, and in some instances forced, to eat what they were given and to clear their plates. According to Lupton (1996: 54) children feel powerless when they are forced to eat food they dislike and the negative emotions aroused may carry into adulthood. An example she gives is George Bush (sr), based on his childhood experiences, banning broccoli from the White House after he became president of the USA. In recent years the philosophy of forcing children to eat foods they dislike has changed. Children today can refuse or reject certain food or dishes that are not to their liking. In the past few decades the expert advice (Stewart-Turner 1986, Baker and Henry 1987, Thompson 1995) given to parents is that children should be given choice and participate in the decision making about their diet.

Half a century ago parenting advice such as Ginott (1965: 76) maintained that problem eaters ‘were created by mothers’. His advice, just as Leach in 1977, was for mothers not to express strong feelings about food but to offer good quality tasty food and trust that the children will eat as much or as little as their appetite needed. Children’s choice about their food fifty years ago was, or should be according to Ginott (1965: 75), – would you like half a glass or a whole glass of milk? Advice for parents of fussy/picky eaters today is to rename, redesign or be deceptive. One school of thought is to feed children vegetables by stealth (Caton et al. 2011). Websites such as *thesneakychef.com* inform parents how to hide healthy food in children’s favourite dishes. Satter (1987) maintains that ‘the parent is responsible for what is presented to eat, the child is responsible for how much is eaten and even whether he eats’ (cited by Coveney 2008: 230). In the current climate we believe, on the one hand, that children will be self-reflecting and self-regulating individuals and on

the other, they have to be tricked or conned by their parents due to growing concern about what children choose to eat.

Grieshaber (1997: 652) offers a view of the child/adult conflict at the table where children 'are not passive recipients and respondents to their environments' - that is they are not always subordinates. The young children in Grieshaber's study were actively involved in 'contestation and negotiation of power relationships within their families'. As discussed in chapter one Grieshaber used Foucault's (1977) idea of disciplinary power to explore the ritual and routine of family mealtimes. Grieshaber found child/adult conflict was an integral part of daily interaction and practice within the families. Children used a variety of ways including: argument, disagreement, conflict and opposition to resist adult authority at the table. Lupton (1996: 55) also found the eating practices in families are characterised by power struggles. In addition she found that the power differential between children and adults around food practices 'are experienced in an embodied way...the child's body constructs resistance through emotional reactions or physical actions'. These include: leaving the table without permission, having a temper tantrum, retching or vomiting.

Children's most effective form of resistance to their subordinate position is refusing to eat. According to Visser (1991) children learn from an early age that food refusal is a guaranteed way of getting adult attention. Food refusal highlights the power dynamic between children and adults. It can trigger emotional responses that range from concern for the child's health to feeling rejected. Children refusing to eat may provoke a battle of wills where the child will not eat and the adult repeatedly serves the food until it is eaten. The Commission to Inquire into Child Abuse (2009) reports such battles in the industrial and reformatory schools. In the past it was common to deprive children of food, for example being sent to bed with no supper for bad behaviour. Mennell (1996) suggests that children's food being apart from adult's food was not the result of indulgent parenting, it was a matter of:

Making them eat what was good for them, whether they liked it or not. At worst, making them eat food to which they actually felt an aversion was seen as a necessary part of breaking the child's peevish will' (1996: 296).

Today it is more likely that children displaying resistance at the meal table will be offered an alternative meal or snack. Coveney (2008) argues that social attitudes in relation to children have changed over the past sixty years.

Children have been seen to have rights under the United Nations Convention on the Rights of the Child (UNCRC). They can make choices, be autonomous and their opinions should be respected. At the same time, though, children are disciplined and trained to become civilised adults. The table may no longer be the site to break children's will, but it remains an essential tool in that civilising process.

2.1.2 Children's food

There are certain foods that are deemed as unsuitable for children. For example, in Ireland, strongly flavoured or highly spiced foods. Other foods, because of the association with children are seen as unsuitable for adults, an example being Farley's Rusks. Mennell (1996: 296) suggests that the anxiety and concern in feeding children 'plain, simply cooked, weakly flavoured food' is easily communicated to children and may lead to them remaining anxious about food into adulthood. James et al. (2009) suggest that 'children's food' is not just a descriptive term it is far more complex than just being distinct from 'grown up food'. For them:

Children's food becomes a cultural classification that is continually shored up, disaggregated, reconstituted and fragmented in and across the shared histories and biographies of adults and children in different societies (James et al. 2009: 6).

Adults purchase the majority of the food brought into the home. Children have limited purchasing power, dependent on age they may have control over their school lunch and their own pocket money. Children are not in the financial position to shop for the household food. This could result in children having little impact on what is eaten in the home. However, Coveney (2014) found that in his study of family food practices children were the most important

factor influencing the shopping, cooking, managing meals and juggling food preferences in the families and suggests that ‘children now sit at the top of the table’ (Coveney 2014: 33). This would suggest that the adult’s food in Coveney’s sample has been infantilised.

When children do get the opportunity to display consumption through the purchase of foodstuffs, according to James (1982), younger children often purchase confectionery. Older children who have greater access to money purchase a greater variety of foodstuffs and with their increased independence have more occasions to do so. Lupton (1996) suggests that for some children buying and eating sweets or fast food is not just for the pleasurable taste but because such foodstuffs are viewed as ‘junk’ by adults and therefore rationed or prohibited. In her study of children’s confectionery James (1982) suggests that lollipops, space dust, gob stoppers and bubble gum, for example, are designed to spend as much time out of the mouth as in it. James found that children could challenge adult rules on civilised eating behaviour in the way these sweets are consumed. Another area where it is assumed children have power is through pester power

2.1.3 Pester Power

Children’s food preferences are influenced by their parents but they are also influenced by persuasive advertising and the opinions of their peers.

Advertisers are said to encourage children to pester their parents to purchase particular products (Burridge 2009). The products in these campaigns are often processed, high in fats, sugar and salts. One tactic used by marketers is to adorn food packaging with cartoon characters or celebrities. The parents in Turner et al. (2006) reported that they found it difficult to deny their children food products that contained their favourite cartoon character or celebrity. According to Marshall et al. (2007: 166) ‘children develop increasingly nuanced persuasive strategies over time’. Those strategies begin with pointing at the desired item or taking it off the shelf in the supermarket. When they get a little older the item is asked for and denial may result in a tantrum. The next stage is to bargain with the adult – if I help with the washing up can I have ...?

Pester power can lead to adult-child conflict (McDermott et al. 2006). There is an alternative argument that the interaction between children and parents around food purchases is a normal part of growing up in a family unit (Lawlor and Prothero 2011). As already discussed, parents today are encouraged to involve children in family decision making and the expert advice is for children to be given choices and participate in decision making about their diet. I have witnessed very young children in supermarkets being asked which yoghurt they would prefer. Children's yoghurt has a department of its own in supermarkets and Tesco for example has over 60 different children's yoghurts on display. It could be argued that advertising could help children to make that decision. From the marketing perspective Lawlor and Prothero (2011) suggest that children learn consumer skills through interactions in the context of purchase decisions. Marshall et al. (2007) found that children believe that they are more influential in the decision making process than their parents think they are. There are also areas where children's influence is greater, for example the choice of breakfast cereal, snacks or takeaway foods. This suggests that parents still have control over the bulk of food purchases.

Marshall et al. (2007) also suggest that at a policy level parents are positioned as rational agents who wish to enhance their parenting skills by seeking and following expert advice. In reality feeding a family can be an emotional issue when parents are torn between providing children with a healthy diet and giving way to their preferences. Take, for example, *Jamie's School Dinners* (Channel 4 2005) and the highly publicised battle between the parents and celebrity chef Jamie Oliver when he attempted to introduce a healthy diet in schools (BBC 2006). Mikulak (2013: 73) suggests that the 'now infamous incident of parents sneaking chips' through the school railings, that was shown repeatedly throughout the show, may have been exaggerated but this image helped to drive home the message that not all parents rationally wish to enhance their parenting skills by following the advice of experts. The show did result in the British government admitting that more time and money needed to be spent on school meals. In 2006 cheap highly processed meat products were banned from British schools in favour of fresh meat and vegetables.

Hupkens et al. (1998) maintain that social inequality is embedded in food consumption. The diet of the middle classes is generally more in keeping with dietary recommendations than the working classes (e.g. Charles and Kerr 1988; Mennell et al. 1992; Hupkens et al. 1998; Jackson 2009; Backett-Milburn et al. 2010). The parents who ‘sneaked the chips’ through the school railings, Julie Critchshaw, Sam Walker and Marie Hamshaw, were vilified in the British press and were depicted as ‘sinner ladies’ and ‘junk food mums’ (Jackson 2009: 2). Fox and Smith (2011: 403-411) suggest that the media commentators blamed social inequality and lack of education for the parents not knowing what was best to feed their children. The parents, on the other hand, ‘framed themselves as campaigners protesting their right to free choice in an age of food fascism’. This ‘media event’ reflects some of the social, cultural, economic, class and place-based factors within which food and eating practices are embedded.

Children have moved from the position where they were seen and not heard and forced to eat what they were given to sitting, according to Coveney (2014), at the top of the table directing what the family will eat. Coveney suggests that an understanding of the social and political processes is required to explain how children’s positions in families have changed. Families are less likely to be working along the traditional patriarchal lines where the father was the bread winner, the mother did not work outside of the home and children had little or no choice in food matters. According to Coveney how the children (mainly middle class) in his study arrived at making decisions about the family’s food is not clear and he suggests that it is driven by children being a target market for food manufacturers’ advertising. As their parents become more affluent, the children in turn have become ‘a viable, consuming sub-population with its own wants and needs’ resulting in ‘parents provide the child decides’ (Coveney 2014: 35-36).

Our perception of children and childhood has changed through sociology. Children are recognised as members of the social group with the right ‘to participate in constructing social order, social policies and practices’ (Mayall 2000: 256). However sociology also identifies the subordination of children as a group to adults as a group – subordination that, Mayall maintains, the

children themselves accept. Children have gained some ground with their rights being recognised and their views being heard but there remains a generational power imbalance between children and adults in families and society in general.

2.2 Learners: *children get to know their place*

Mead suggested in 1943 that one approach to arrive at a dynamic description of the total food pattern of a culture was to study how ‘good food habits are inculcated in the growing child’ (Counihan and Van Esterik 2008: 19).

Worldwide, children are socialised into the particular foodways of the particular culture they are born into. Beardsworth and Keil (1997) suggest that the socializing of children into the foodways of their culture begins at weaning. Levi-Strauss (1965, 1968), Douglas (1972), Barthes (1957) and Bourdieu (1978), are, according to Mennell (1996: 6), the most influential writers on food habits, and are influenced by the structuralist approach, recognising that ‘taste is culturally shaped and socially controlled’ and not personal or innate.

2.2.1 Civilising the child’s appetite

Meal tables are the training grounds of a family, a community and a civilisation (Fraser 1994 cited by Lupton 1996: 38).

Children *learn* how, what and where to eat in ways that are acceptable within their own particular culture at a specific point in time (Beardsworth and Keil 1997; Mennell 1996; Lupton 1996; Caplan 1997; Germov and Williams 2008; Coveney 2008). According to Beardsworth and Keil (1997: 55) ‘a central part of being human involves learning what humans as opposed to non-humans eat’. Mennell (1996) discusses ‘civilising the appetite’- how children learn what and how to eat in a way that is acceptable human behaviour. Lupton (1996: 22) suggests that the development of civilized behaviour when eating or good table manners ‘represents a desire to avoid the animalistic nature of humanity’. Children are encouraged to eat with their mouths closed, to use their cutlery, to sit up straight, to keep their elbows off the table and to ask to be excused from the table:

The family meal is an important site for the construction and reproduction of the contemporary 'family' in western societies and the emotional relationships and power relationships within the family (Lupton 1996: 38).

As Lupton's quote suggests family food practices can not only illustrate the normative social behaviour but also how relationships are created and sustained within the group. The family meal is an iconic symbol for what family is or should be. A 'proper' meal eaten at the table, according to James et al. (2009: 39), 'constitutes the cement of family life' (see also: Murcott 1982; Charles and Kerr 1988; DeVault 1994). Getting children and young people to eat that 'proper meal' can be a challenge and cause anxiety for the parents. Marshall and O'Donohoe (2010) suggest concern about children's food goes beyond what they eat. There is also concern about how and where they eat. The table is the prime site for the socialisation of children into the foodways of their family and their culture.

2.2.2 The family who eats together...

Participation in the ritual, rhythm and routine of meals is considered a key way of displaying and experiencing family. James et al. (2009: 35) suggest that cooking and eating a proper family meal together 'reproduces the generational and gendered orders through which family life is constituted on an everyday basis'. The family gathered around the table enjoying the same food and having interesting conversations remains a steadfast symbol of ideal family life.

The idealised image of the family meal at the dining table as discussed in chapter one did not reach its peak until the 1950s and 1960s (Ralph 2013). Critical perceptions of the current trend in the decline of the family meal are linked to: the frequent use of take-away food, eating in front of the television, microwave dinners, the family eating at different times due to mothers working outside of the home and snacking/grazing.

According to Ryan (2006) the decline of the family meal is seen by some as an indication of the breakdown of family life and even the cause of anti-social behaviour. A recent advertisement for Bisto Instant Gravy is a good representation of this concern. It begins with children making promises to be good, for example cleaning their bedrooms if their parents will cook them a 'proper meal' accompanied by Bisto gravy. The 'proper meal' is the same as in Murcott's (1982) and Douglas (1972): meat, potatoes, at least one other vegetable and gravy. Murcott (1997) suggests that the decline of the family meal should be followed by a question mark because the ideal image of the family sitting at the dining table having interesting conversations may be a myth. Short (2006: 3) questions if the family meal 'in its 'traditional', democratic, communicative and social form - has ever really existed'. Jackson (2009: 131) reviews the current evidence on the decline of the family meal and suggests that 'we are experiencing a moral panic'. However, the proper family meal cooked from scratch remains an important symbol of family life and is a widely shared (mainly middle-class) aspiration.

2.2.3 Cooking, a dead duck?

A further concern focuses on the decline of everyday cooking skills in the home, often attributed not only to the development of convenience foods and kitchen technologies but also to the increased participation of women in the labour market. Notwithstanding this, the interest in cooking has mushroomed since the 1980s with critical academic interest but also a proliferation of cookery books and television cookery shows (Short 2006). Cookery programmes attract large audiences and the chefs who host these programmes have become household names with their books topping the bestseller's lists. Rousseau (2012) suggests some celebrity chefs have moved from superstar status to self-styled revolutionaries tackling issues such as obesity or sustainable food choices. A recent campaign in Britain has resulted in cookery lessons becoming a compulsory part of the school curriculum 'due to pressure from leading chefs and health campaigners' (Ensor 2013). The internet has added significantly to food and cooking information.

Despite the vast amount of culinary knowledge available there is anxiety, within the popular media and health promotion about the general lack of basic cooking skills. Short (2006: 51) suggests that worries for the decline in domestic cooking are not a recent phenomenon. She cites a Scottish public health report from 1932 that lamented ‘too many housewives arm themselves with the frying pan, the teapot and the tin opener’ as the new technologies and convenience foods of that time. Coveney et al. (2012: 637) also argue that the problematisation of cooking skills is not a new development but the recent concerns are accompanied by new forms of government. They looked at discourses on cooking skills through a governmentality lens which resulted in the identification of another layer of subjectivity where ‘subjects are expected to be food literate in every sense’. Coveney et al. (2012) suggest that nutritional knowledge filters through governmentality resulting in our need to know what food is nutritionally ‘good’ for us but also how to cook it, preferably ‘from scratch’, using raw ingredients.

According to Short (2006) and Coveney et al. (2012) there is an assumption that cooking skills were transferred from mother to daughters in the domestic kitchen. Coveney et al. (2012) maintain the idea that cooking skills being handed down supports a belief that particular social and cultural structures are central to domestic life. Responsibility for feeding the family remains a highly gendered activity (Lupton 2013; Daniels et al. 2012; Short 2006; De Vault 1994) with women in households doing the majority of everyday food work. Results from a Bord Bia (2011) survey, *What Ireland ate last night*, suggests that in Ireland cooking from scratch, with fresh ingredients and using no pre-prepared ingredients, is on the increase. This survey showed that half of the adult meals were prepared from scratch but only a quarter of the children’s. The survey did not report as to who was doing the cooking. Harkins (2010) found that women were largely responsible for family food routines in her study of eating practices in Irish families.

Mac Con Iomaire and Lydon (2011), in a discussion on the state of Irish cooking, cite the market research group Mintel (2006) who report that young people aged 15-24 have grown up primarily on a diet of convenience foods. Mac Con Iomaire and Lydon maintain that the reheating or assembly of these

meals is not cooking. On the other hand, Short (2006) argues that there is a different set of skills required by the cook who uses convenience food and new kitchen technologies. I believe it also depends on what is meant by 'convenience food'.

For the purpose of this argument, take for example lasagne - a fairly complicated dish consisting of sheets of pasta layered with two sauces. There are degrees of convenience available for this dish. The first and perhaps most convenient is a chilled ready meal version. Unpack and place in the oven - note not the microwave oven – no need to defrost or wash the baking dish. The next level of convenience is a Dolmio lasagne kit consisting of two jars of sauce, one red and the other white and sheets of lasagne. This version requires mince to be cooked and the red sauce added then the dish assembled in a suitably sized baking dish layering the mince sauce, lasagne, white sauce, topped with grated cheese and baked in the oven. Lasagne in my home consists of homemade bolognese sauce using tinned tomatoes and dried herbs, a béchamel sauce and I use precooked lasagne. Then there is cooking from scratch - you could make your own pasta sheets, but where do you draw the line as to what is convenience food? It could be argued that any food you can buy is a convenience.

2.2.4 Fast food

It is rarely asserted within sociology that a bodily process, for example a craving for a certain food, is purely biological (Lupton 1996: 3). From the nutritional or sociobiological perspective humans choose certain foodstuffs to eat because they are programmed to 'know' that the foods are physiologically good for them (ibid: 6). According to Mintz (1997) Western diets have changed since the industrial revolution mainly because of the increase in the availability of refined sugars and fat, both animal and plant. Falk (1994) suggests that food may also be consumed for the cultural values that surround it. A recent study showed that immigrants to the United States choose to eat fast food as a way to 'fit in' (Guendelman et al. 2011). A study into the popularity of McDonalds in Beijing, (Yan 1999 in Counihan and Van Esterik 2013: 456), found that in some circumstances customers of Western fast-food

restaurants ‘cared less about the food and more about the cultural messages it delivers’.

Children’s social worlds are increasingly constructed around consuming not just food but what they wear or what mobile phone they own. Schor (2005) and Piacentini (2010) suggest that wearing a particular brand can determine if children fit in or not. Wills et al. (2008: 53) suggest that ‘consumption practices involving the purchase and display of commodities or ‘props’ are an important aspect of identity-making work’. Stead et al. (2011) found that the contents of a school packed lunch could also be particularly significant for young people concerned with image and peer opinion. For children and young people being *seen* to consume certain foods can be a way of ‘fitting in’ with a peer group.

According to Wills et al. (2011) the family is the key site for the transmission of cultural capital. Kincheloe (2011: 29), on the other hand, argues that ‘exposure to market produced popular culture has profound effects on children’s consciousness’. Children and young people know things that their parents don’t. Kincheloe suggests that this knowledge increases children’s cultural capital. Returning to the idea of the bodily process of craving, Stevenson et al. (2007: 422) in their study into adolescents’ views of food and the barriers to healthy eating, found that ‘taste, texture, appearance and smell’ were frequently reported as ‘one of the most powerful physical reinforcers of food choice’.

In addition, it is not just the food that attracts children to fast food chains. According to Schlosser (2012) fast food chains spend approximately \$3 billion annually on television advertising but the marketing focussed towards children goes far beyond those adverts. In the United States, 90% of children aged between three and nine visit a McDonalds every month and the child friendly play areas are an ‘effective lure’ (Schlosser 2012: 47). He suggests that most effective are the toys given free with *Happy Meals* as key to attracting children into their restaurants. The fast food chains offer different versions of a toy to encourage repeat visits by children and adult collectors. The most successful campaign in American advertising history, according to Schlosser (2012), was

the *Teenie Beanie Baby* give-away in 1997. Over a course of ten days 100 million *Happy Meals* were sold in America.

To recap, children want to go to fast food restaurants because they are designed to attract children, they get free toys with their *Happy Meals* and as Kincheloe (2011) suggests, fast food restaurants, and in particular McDonald's, play an 'increasingly important role' in children's lives and 'the company wants children to feel that they will be ridiculed or laughed at if they don't go to McDonald's' (Kincheloe 2011: 25).

2.2.5 Picky eaters

People are fussy about what we put in our mouths. Fischler (1980) has described the omnivore's paradox - neophobia versus neophilia or fear of the new versus love of the new. According to Mills (2004) during Freud's oral stage (0-2) young children experience the world through their mouths and all manner of things are tried and tasted. Visser (1991) suggests that as small children we are encouraged to be neophobic - that is not to be too adventurous with what we put in our mouths. Once this has been mastered, suddenly children are being encouraged to be neophilic and to develop a varied palate. Harkins (2010: 157) found in her study of eating practices in Irish families that 'many parents were determined to train their children to eat a wide variety of foods' – to develop their children's palates.

The exact nature of neophobia has yet to be resolved, according to Dovey et al. (2008), but it is generally recognised that this behaviour reaches its peak between 2 and 6 years of age, decreasing as children get older. Blissett (2014) suggests that babies willingly accept new tastes but when they become toddlers and therefore mobile there is a rise in neophobia. This makes evolutionary sense, according to Blissett (2014: 1), the child is no longer under the watchful eye of the caregiver and therefore: 'they need a mechanism that discourages them from ingesting potentially poisonous foods'. Blissett suggests the foods likely to contain the highest toxins are plant and meat which goes some way to explaining why vegetables and meat are often refused at this stage.

Fast-food companies and food producers ‘love and encourage the neophobia in us’ (Visser 1991: 45). If you go into a McDonalds anywhere in the world you are guaranteed to get something familiar to eat. The use of tomato ketchup for some would also provide the same security. How many of us have spent time cooking a meal for someone who then covers it in tomato ketchup? But for them it may be ‘the constant comforting presence on the table of the same brand-name sauce to lend a predictable taste to everything’ (ibid: 43). Children, being social actors who participate in the social world, can affect change or at least challenge the rule of law. Parents and carers can compete with what a child or young person wishes to eat and their own belief of what is nutritionally appropriate. Parents and carers also have to compete with what children like and do not like to eat. Cook (2009) suggests that pleasure and displeasure with regard to food can only be ascertained at a personal level on the palate:

Taste, pleasure and hunger – when encountered at the level of the palate – position children’s subjectivities as authoritative (Cook 2009: 115).

The struggles between parents or caretakers and children about food and eating practices are far reaching. Some parents, for example Michael Pollan, give way to a child who will only eat white food as it is preferable to seeing the child go hungry (Johnson 2013). Food neophobia or reluctance to eat or try new foods has been shown to decrease with age (Dovey et al. 2008). Children have an innate preference for sweet and salty flavours which declines during adolescence, leading to adults having a lower preference for sweet and salt than children. Lafner et al. (2013) affirm the physiological change in the development of taste and show that age is related to food preferences.

Another way older children can challenge the eating practices within the family is by refusing to eat certain foods for ethical reasons. Young people may express independence or even rebellion by choosing to become vegetarian. Vegetarianism symbolises ‘a mixture of socially desirable goals about concerns for the environment and animal welfare’ (Trew et al. 2006: 256). By becoming vegetarian a young person may be able to distinguish him or, more commonly, herself, from the family.

Children get to know their place from an early age through the foodways of their culture. They learn how, what, when and where to eat in ways that are acceptable within their own particular culture at a specific point in time. Cooking and eating a family meal together represents the order through which everyday family life is, or ideally should be, constituted. Concern for the alleged decline in the family meal and cooking skills assumes a loss in commensality and shared family time to the detriment of society as a whole. Children and young people's food choices can help them to fit in or opt out of social groups. However, as already stated, there is growing concern that what children choose to eat is leading to ill health.

2.3 Threats: *children's health - a problem*

As discussed earlier, children in recent years have become a target market for food manufacturers. As adults have become more affluent, their children, in turn, have become consumers with their own wants and desires. Parents provide the food, but the child decides whether or not they will eat it.

According to Burrige (2009) there is a questionable assumption that adults will prioritise healthy nutritious food while children 'are assumed to prioritise enjoyment over health if left to their own devices' (ibid: 195). This suggests that children are hedonistic and lack self-governance when it comes to food choice. Much of the public concern for children's health is focused on what they choose to eat and the wider anxieties and debates about the 'so-called obesity epidemic' (ibid: 193). This section explores some of the concerns relating to children's health and the problematisation of food.

2.3.1 Nutritional advice

The human body is dependent on food for health. Hanekamp and Bast (2007) suggest that nutritional knowledge is a relatively recent development. The nutritional importance of many food components were not recognised until the beginning of the twentieth century. The World Health Organisation defines nutrition as follows:

Nutrition is the intake of food, considered in relation to the body's dietary needs. Good nutrition – an adequate, well balanced diet combined with regular physical activity – is a cornerstone of good health. Poor nutrition can lead to reduced immunity, increased susceptibility to disease, impaired physical and mental development, and reduced productivity (WHO 2013).

Historically, nutritional advice concentrated on malnutrition. The first example, according to Hanekamp and Bast (2007), was the discovery in the eighteenth century that the lack of vitamin C intake on long sea voyages caused scurvy resulting in sailors being forced to take citrus juice as part of their daily ration. Hughes (2008: 177), also on Captain Cook and the vitamin-C deficiency, suggests 'enforcing the consumption of lime juice and sauerkraut with the threat of fifty lashes for malingerers is a strategy rarely available to contemporary health promoters'. Food policies were initially designed to ensure that food was distributed in an economic way to prevent deficiencies. In recent decades, in Westernised countries, access to food is assumed to be more than adequate. Food and nutrition policies have shifted from the prevention of diseases of deficiency to those caused by excess. In 1937 the Ministry of Health in the UK was already seeing an improvement in the health of the population. Diseases such as rickets were on the decline and there was a steady improvement in the physique of school children. However, the following recommendations from 1937 illustrate that some nutritional advice has changed little over the intervening years. As you can see, then as now, they advised eating more fruit, vegetables, oily fish and less sugary processed foods:

The Committee recommend an increased consumption not only of fruit and green vegetables but also of potatoes-the latter in substitution for some of the sugar and highly milled cereals in ordinary diets. They also draw attention to the particular value of sea fish, as a source of protein and iodine and other mineral constituents; herring and mackerel are especially recommended as rich in vitamins *A* and *D* (Ministry of Health 1937).

Looking at the current trends in government dietary advice, Falbe and Nestle (2008) suggest that food industries have influenced the advice offered by the World Health Organisation and the USA and Canadian governments. Falbe

and Nestle present an argument that the food companies use their political and financial weight to challenge or have themselves excluded from government health promotion campaigns that suggest eating less of their products.

Healthy eating guidelines were developed in Ireland in the late 1980s and early 1990s. The recommendations for a Food and Nutrition Policy were published in 1995 (FSA 1995). The most recent dietary guidelines for Ireland use a modified version of the American food pyramid model. However the wording has changed in recent years. Food and drinks high in fat and sugar are positioned at the top of the diagram and the advice given by the Health Promotion Unit (2005) is that they should be consumed in small amounts. The most recent advice is ‘there are NO recommended servings for this group because they are not essential to health. These foods should be avoided’ (Safefood 2014: 17).

The problematisation of food through nutrition can be seen through both the medical and social models that aim for the same outcome - ‘the formation of a self-reflective, self-governing individual or collective subject’ (Coveney 2006: 23). In other words, a ‘good citizen’ eats the correct food to maintain a healthy productive body of a particular size. Coveney (2006) argues that nutrition combines both science and moral conduct and is an obvious illustration of governmentality. The current concern and anxiety about what we choose to eat is constant, yet ever-changing. Expert advice on food regularly makes headline news. At present, sugar is a food to be avoided and kale is the new superfood. The Department of Agriculture, Food and Marine (DAFM) outlines the research needs for industry, academia, consumers and the regulatory authorities. Under food and health, they suggest what drives the consumer’s needs:

As modern lifestyles create new health challenges, maintaining or improving health and wellness has become a well-established priority in many people’s lives. As health infrastructures feel the strain of rising demand and falling support, the responsibility for people to find their own path to good health has become more important (DAFM 2011: 33).

Crotty (1995) views nutrition as a form of social control and argues the scientific rules that underpin many public health nutrition policies ‘are

symptomatic of the dominant medical culture, which as well as being moralistic, sexist and class prejudiced, is highly fallible to boot' (cited by Coveney 2006: 15). Crotty suggests that theories for the reduction of fat in Western diets are based on studies on middle-aged men that exclude women, children and older people.

Since the 1970s, nutritional advice has shifted from concerns of malnutrition and deficiency to 'the diseases of affluence' (Keane 1997: 173), such as heart disease and diabetes linked to low-fibre, energy-dense diets. In particular, childhood obesity is a significant concern and the Taskforce on Obesity states:

Most worrying of all is the fact that childhood obesity has reached epidemic proportions in Europe, with body weight now the most prevalent childhood disease. While currently there are no agreed criteria or standards for assessing Irish children for obesity some studies are indicating that the numbers of children who are significantly overweight have trebled over the past decade. Extrapolation from authoritative UK data suggests that these numbers could now amount to more than 300,000 overweight and obese children on the island of Ireland and they are probably rising at a rate of over 10,000 per year (DoHC 2005: 6 [emphasis added]).

It should be noted that in the absence of data, the above statement, is pure speculation. Five years on from this report the Irish Heart Foundation criticised the absence of any significant progress in tackling obesity. They called on the Government to act on food-labelling, the physical environment and food marketing directed at children (RTE News 2010). Safefood conducted an island of Ireland survey of 5,000 young people between the ages of twelve and seventeen. Their aim was to establish an understanding of 'young people's knowledge of healthy eating behaviour and their perceptions of the risks associated with food and dieting' (Trew et al. 2006: 4). The survey found that young women reported eating a healthier diet than young men, and that young people, just like older people, while aware of expert dietary advice, do not necessarily translate this into their own dietary practice. Trew et al., found the young people's reason for choosing a particular food was

determined by taste. They were of the opinion that food that tasted good (sweet/energy-dense) was inherently bad for them and that healthy food did not taste good. For respondents who identified themselves as being overweight food was selected on the basis of weight control rather than nutritional motivation. The majority of the young people in this study did not view healthy eating positively. For some it was 'a temporary necessity to avoid the negative consequences of obesity' (Trew et al. 2006: 4).

2.3.2 Childhood obesity, a moral panic?

Children and adults being (described as) over-weight and obese has been termed the 'obesity epidemic'. The World Health Organisation (WHO) is concerned that childhood obesity is rising in developed and developing countries. The (non-communicative) disease has, according to the WHO, become a pandemic. Ireland has a government campaign called *Little Steps* to get children active and to help tackle obesity. Many European countries have similar campaigns. The campaign literature from 2005 suggested that 22% of Irish children were overweight, half of whom were obese (Little Steps 2008 citing Irish Universities Nutrition Alliance 2005). In the Growing up in Ireland (2012) survey that figure has risen to 25%. Newspaper headlines on the subject include 'Irish children the fattest in Europe' (O'Regan 2010) and 'Surge in obesity as Irish teens pile on the pounds' (O'Regan 2009) and would concur with Robb's (2007: 183) image of 'the unfit and overweight teenager [who] has become a staple of anxious media coverage and of popular cultural representation'. Recent television programmes on the topic have included: *Honey We're Killing the Kids* (BBC) in the UK and here in Ireland *Operation Transformation* (RTE) and may be feeding on the anxiety of worried parents. Another consideration is that television programmes showing children and families who appear to have lost control can lull those watching into a false sense of security, that maybe they are doing okay.

The media coverage on the state of young people's health and in particular concerns about the rise in obesity is having a negative impact on young people's 'sense of the ideal body weight' (Robb 2007: 184). Robb cites a Guardian article from 2005 that reported 'girls as young as five were fretting

(unnecessarily) about their weight' (Robb 2007: 184). In the article, Moorhead (2005) discusses research with 81 girls aged five to eight, of whom 47% said they wanted to be thinner despite only 14% actually being overweight.

Bodywhys (2011), the Eating Disorder Association of Ireland, reports that eating disorders are becoming more prevalent in the six-to-thirteen age group and that it has become normal for children under ten to express dissatisfaction with their body shape. This article includes reference to a study into young children's attitudes to body shape that found 'from a very young age children are associating positive qualities with being underweight - and at the same time connecting negative qualities with being overweight' (bodywhys.ie 2011). The *Growing up in Ireland* (2012) report of the 13-year-old cohort shows that 39% of girls and 30% of boys in their study were trying to lose weight. The report does not say if those children were overweight or obese.

The Body Mass Index (BMI) is the most common test to assess obesity. It has been used by the World Health Organisation (WHO) since the early 1980s. Children and young people undergo many physiological changes as they grow therefore a more complex BMI is used including their age and gender.

Ernsberger (2012) criticises the use of BMI to judge if children are obese. Using age related BMI charts means that taller children have a higher BMI therefore the significant increase in children identified as overweight could be related to an increase in height not fatness. However, Perry et al. (2009) disagree and suggest that the increase in weight of the children in their study was disproportionate to the increase in height. WHO (2013) maintain that the BMI is the most useful population-level measure of overweight and obesity. However, it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals.

According to Lupton (2013: 37) inflation in the numbers of people being classified as overweight has resulted from the lowering of the cut-off point, in 1998, for over-weight on the BMI scale. Lupton argues that the BMI is a 'major factor in making the obesity epidemic possible' and that the BMI is in fact 'an arbitrary figure'. Since WHO started collecting the data in 1980 worldwide obesity, as measured by BMI, has doubled. In 2008, 2 billion adults were defined as overweight, of whom 500 million were obese (WHO 2011).

2.3.3 Fat children

Fat studies is a relatively recent field of study ‘that critically examines societal attitudes about body weight and appearance and that advocate’s equality for all people with respect to body size’ (Rothblum 2012: 3). ‘In Western societies the fat body has become the focus of stigmatizing discourses and practices aimed at disciplining, normalising and containing it’ (Lupton 2013: 3). When the fat body belongs to a child, the anti-obesity discourse directs responsibility to the parents, and in particular the mother, to regulate and monitor their children's weight (Gard and Wright 2005; Gard 2011; Lupton 2013). Children and young people who are overweight or obese are more likely to suffer discrimination and to be bullied (WHO 2011). This discrimination and bullying will most often come from their own peer group in the institution where they spend most of their time – school.

2.3.4 School

Schools are an area of children’s lives where their food practices have been studied (Daniel and Gustafsson 2011; Roberts and Weaver-Hightower 2011; Pike 2011; McIntosh et al. 2011; Forero et al. 2009). What children eat during school time has also received much media attention in the UK over the past few years. This was highlighted by celebrity chef Jamie Oliver who headed a campaign to increase the nutritional quality of the food served to school children in England. Schools are responsible for the intellectual development of children but they are also considered to have responsibility for the social and physical wellbeing of children. McIntosh et al. (2011) suggest that throughout history schools have been central to policy interventions concerning food. Here in Ireland those interventions range from the ragged schools in the mid-1800s to the School Meals Programme or Breakfast Clubs of today. However food policies in schools, as the illustration below (Figure 7) suggests, go far beyond actually providing food for hungry children.



FIGURE 7 FOUCAULT AND BENTHAM WALK INTO A SCHOOL CANTEEN
Source: www.shutupfoodies.com (2011)

Schools provide a site for the nutritional education of children and there is an expectation that the information will spread throughout the community (DoHC; Morgan 2009). This idea has been prevalent since the domestic economy movement of the late 1800s that applied scientific principles to the management of the home that included teaching cooking skills and nutrition. This new scientific knowledge was principally aimed at girls who, according to Coveney (2006), would take the recipes home and cook for their families.

In Ireland there is a statutory obligation to supply food for children attending pre-school. The Food and Nutrition Guidelines for Pre-School Services (DoHC 2004) recognise that introducing a varied and healthy diet to early years' (0-5) children can lay the foundation for a healthy life. The guidelines are premised on the Child Care Regulations 1996 that states:

A person carrying on a pre-school service shall ensure that suitable, sufficient, nutritious and varied food is available for a pre-school child attending the service on a full-time basis.
(Article 26 (1) of the Child Care Regulations 1996)

In early childhood settings children not only learn what to eat, they also learn how to eat. They are schooled in the social norms of eating. They learn to eat sitting at the table, acceptable table manners and how to share. It is when we move outside the early years' education in Ireland that food in schools becomes less controlled. In Ireland there is no statutory regulation for the

provision of primary and post-primary school meals. There is not the same history of cooked school dinners as there is in for example Britain, France, Japan or the USA. The majority of schools in Ireland do not have cooking facilities so lunch is either brought from home, purchased from a tuck shop or vending machine on site or purchased from a local shop or cafe.

There are two school meals programmes in Ireland. One is the Urban School Meals Scheme for primary schools that is operated by the Local Authorities and part-funded by the Department of Social Protection (DSP). The Local Authorities do not have a legal obligation to provide this service but many do. The other programme is the School Meals Local Project that is funded directly by the DSP and operated by voluntary groups and organisations. Funding for the schemes has increased significantly in recent years. According to Morgan (2009) it was €4.2m in 2004 and Humphreys (2014) stated in the Dail that it was set to increase to €37m in 2015. The schemes aim to provide nutritious food for children from disadvantaged backgrounds to enable them to take full advantage of the education provided for them. The rationale for providing food for children is that inadequate nutrition has a negative impact on children's ability to concentrate in class. Proper nutrition can improve children's ability to concentrate, reduce disruptive behaviour and encourage school attendance (DSP 2012).

The most recent review of the School Meals Programme (DSFA 2002) found that the basic food provided by the scheme consisted of 'milk and a sandwich or a bun'. However, some Local Authorities provided other food items such as: soup, yoghurt and fruit with a small number providing full meals. The DSFA also report in response to what facilities were available for providing lunch - only 9% of schools had kitchen facilities thus making the provision of a hot cooked meal impractical. The majority of schools did not have dining rooms. So here in Ireland it would appear that the training and discipline of school children in the rules of the table is not taking place in the schools. There is a contradiction between practice and policy - because the schools do not provide food they cannot control the healthfulness of what school children eat. Despite this schools are encouraged to develop food policies that will enhance the nutritional health of the next generation:

The primary school setting provides an excellent health promotion arena for reaching large sections of the population - children, teachers, families and the surrounding communities in an effective and efficient way (DoHC 2003).

In Britain, schools monitor children's growth and children are subject to a School Entry Health Check between 4-5 years (NHS 2014). The National Nutrition Surveillance Centre (2009) and HSE (2012) have recommended that all children should have their growth monitored between 0-12 years. However there is at present no universal growth monitoring system in Ireland. A pilot study in the primary schools of five counties is due to start in 2014 (Anderson and Furlong 2014). The HSE decision to adopt the WHO Child Growth Standards is due to normal growth being seen as a good indicator of well-being and detecting abnormal growth patterns early means that appropriate nutritional or social interventions can be put in place. The training manual for health care professionals (HSE 2012) responsible for the growth monitoring contains four references to children being underweight and over sixty to obesity. It may be assumed that the purpose of the screening is to identify children who are over rather than under normal growth standards.

Robb (2007) examines some of the popular misconceptions of childhood, one being the assumption that children today are healthier than the children of the past and that they have a better chance of living a healthy life than their parents or grandparents. An RTE documentary *What's Ireland Eating* (Boucher-Hayes 2011) suggested that the life expectancy of today's children may be shorter than recent generations because of what they are choosing to eat. Gard (2011) and Lupton (2013: 19) put forward the argument that from the critical biomedical perspective life expectancy in Western countries continues to rise and 'there is no statistical evidence that being fat necessarily equates to a greater risk of ill health or disease'. Statistics do show that people at the extreme end of the overweight scale do experience negative health outcomes. However, there is a small beneficial impact in being overweight, particularly for older women (Oliver 2006; Rail et al. 2010; Lupton 2013).

Children's health is viewed as problematic not just for themselves but for society as a whole. This generation of children being viewed as unhealthy

leads to our future being uncertain and them being seen as a threat to adult society. As shown, much of the medical, public health promotion and popular media concern for children's health is focused on what they choose to eat and the wider anxieties and discourses about the 'obesity epidemic'. The Organisation for Economic Co-operation and Development (OECD 2012: 2) report that child obesity figures have remained stable for the past 10 years in England, France, Korea and the United States. They did not have statistics on children in Ireland because as discussed and stated in the Taskforce on Obesity 'there are no agreed criteria or standards for assessing Irish children for obesity' (DoHC 2005: 6). Childhood obesity statistics in Ireland are based on UK data where levels have stabilised. It may, therefore, be assumed that the levels also remain stable in Ireland.

In conclusion, schools' responsibility goes beyond the education of children. They are also regarded as responsible for 'their social and physical wellbeing' (McIntosh et al. 2011: 63). Schools are considered a site for the dissemination of nutritional training for children, their families and the wider community. The problematisation of food through nutrition can be seen through both the medical and social models that aim for the same outcome - 'good citizens' who eat the correct food to maintain a healthy productive body of a particular size. Nutrition combines both science and moral conduct and is a form of governmentality.

2.4 A place for food in the sociology of children

The sociology of food and food studies are growing fields of study as is the sociology of children and childhood studies. This chapter has explored where children and young people feature in the sociology of food. Finding a place for food in the sociology of children has been less fruitful. When considering children and their relationship with food, childhood obesity holds a dominant position and is high on the agenda. According to James et al. (2009: 1) 'ideas of risk predominate as the main way in which children's relationship with food is constructed'. Within the literature children's food is a problem and there are few references to the pleasures that food can hold. Another concern is the

commercialisation of childhood through exposure to the market via television and the internet (see for e.g. Marshall 2010; Cook 2009). James (1982: 307) argues that children, because they are positioned as a group apart from adult society, 'have sought out an alternative system of meanings'. James illustrates this through her study of 'Kets', a food over which children have maximum control and that they use to alienate adults. The interest in children and what, where and when they eat continues unabated but further contributions from the sociology of children and childhood studies combined with food are required as James et al. suggests:

Children's identities are variously and complexly mediated through food, whether in the context of the home, the family, the media or other institutional settings. Children's food practices are therefore a key research arena for childhood studies (James et al. 2009: 10).

2.5 Conclusion

This chapter has discussed selected themes on the sociology of food and where children feature within that literature. The sociology of food is a growing field of academic study as is the interest in food and cooking in general. Since the 1980s the focus of childhood and children in sociology has moved from children being the objects of socialisation to a more dynamic, conceptual and theoretical philosophy of children and childhood leading to a '*new paradigm*' of childhood studies that emerged in the 1990s (Smith and Greene 2014: 241). Today, as recognised in the UNCRC, children have a right to be heard and as a result they are encouraged to be self-reflecting and self-regulating individuals. Nevertheless there is concern about the choices that children make particularly when it comes to food. This chapter has explored three areas where children feature within the sociology of food: their subordinate position to adults, how they are inculcated into the foodways of their culture and concerns about children's health.

Children appear to have moved from the position where they were seen and not heard and forced to eat what they were given to sitting at the top of the table directing what the family will eat. However, while children have gained some ground with their rights being recognised, they remain in a subordinate

position to adults within families and society in general. In relation to food children must learn how, what, when and where to eat in ways that are acceptable within their own particular culture at a specific point in time. Grieshaber (1997) found that disciplinary power is useful in exploring the construction and operation of family mealtimes where the power relationships between adults and children are negotiated and contested through food.

The family gathered together to share a meal at the table is the epitome of family life - but there is doubt of its universality in practice. Concern for the alleged decline in the family meal and cooking skills assumes a loss in commensality and shared family time to the detriment of society as a whole. There is growing concern that what children choose to eat is leading to ill health. Nutrition combines both scientific knowledge and moral conduct and, for Coveney (2006), is an obvious illustration of governmentality. Through governmentality attention is drawn to the diverse ways in which we may govern the conduct of others and ourselves. By means of discipline and training new forms of control are internalised and exercised through surveillance rather than force (Gadda 2008). It is through our knowledge of nutrition that we can make moral judgements about ourselves and others in relation to *good* or *bad* food practices and choices.

This chapter explored where children feature in the sociology of food. Children are perceived as either being a problem or having a problem. Overall the chapter investigated where children fit into the theories of family food practices, how they are enculturated into the foodways of the family and how children's food and eating practices have become a problem.

In the following chapter food and residential care for children and young people in Ireland are placed in a historical context concentrating on food and eating practices within statutory care institutions.

Chapter Three: A history of statutory care for children in Ireland with a focus on food and eating

3.1 Introduction

To place food and residential care for children and young people in context one should have an understanding of its history. According to Smith (2009: 33) we should be careful not to view history from the moral high ground as some of our 'best practice' today could be viewed as barbaric in the future. History according to Lerner (1997, cited by Hendrick 2005: 11) 'is not a recipe book ... historical events are infinitely variable and their interpretations are a constantly shifting process'. Hendrick (2005: 11) counters LP Hartley's ([1953] 2002: 17) famous dictum and reminds us 'the past' is neither 'a foreign country', nor do they always 'do things differently there'.

Smith (2009) suggests that having knowledge of the historical, cultural, political and professional contexts of residential child care is essential to understanding how it is practised today. This chapter aims to provide a history of statutory care for children in Ireland from 1703, when the founding hospitals were introduced, to the present day. A critical review is presented of selected literature concentrating on references to food and eating practices within the institutions and contrasted with the food and eating practices of children in the general public at similar times.

The last three centuries have seen dramatic changes in our perceptions and attitudes to children in general. According to Jenks (2005: 58), from the eighteenth century 'the child has moved through time from obscurity to the centre stage'. The literature shows a similar journey for children in state care for whom services have become child-centred, child-focused and child-orientated. The large institutional buildings have closed and residential care centres have become smaller and more specialised while foster care has become the preferred option for children and young people in need of alternative care today.

Food and eating practices in residential care for young people is a neglected area of study in Ireland and there are no contemporary academic materials available addressing the subject. However food and eating practices in residential care for young people have been researched in the UK (Caroline Walker Trust 2001; Emond et al. 2013a; 2013b; Punch et al. 2009a; 2009b; 2011a; 2011b; 2013; McIntosh et al. 2010, Dorrer et al. 2011) and that work provides a point of departure for this study. The primary aim of this chapter is to advance the understanding of residential care settings for young people in Ireland in a way that has not been done before that is with a focus on food and eating.

3.2 Foundling hospitals

According to Robins (1980), prior to the 1850s, Irish children in need of care did not always receive charity and their situation did not prick the conscience of society. He describes Ireland in the early eighteenth century as:

A callous age and one not noted for its humanitarianism. Women were burned publicly for capital offences; boys were hanged for stealing. In such an atmosphere the plight of starving homeless children aroused little sympathy (Robins 1980: 10).

Before the *Poor Relief (Ireland) Act* 1838 was introduced, statutory social care for children was minimal. According to Powell (1981) up until 1838 there were three foundling hospitals and nine workhouses or houses of industry in Ireland. Unaccompanied children under five could not be admitted to the workhouses so they were accommodated in the foundling hospitals. The first foundling hospital was established in Dublin in 1703 in an attempt to curb the increasing incidents of infanticide and to decrease the amount of begging children on the streets.

Robins (1980) and Powell (1981) suggest that the high mortality rate of abandoned children placed in the foundling hospitals was the subject of many enquiries. High mortality rates were also recorded in the foundling hospitals in London and Paris at the time. Thomas Malthus, suggested controversially, that the high mortality rates in the foundling hospitals was one way to limit the rapidly growing population at that time:

If a person wished to check the population and were not solicitous about the means he could not propose a more effective measure than the establishment of a sufficient number of foundling hospitals (Malthus 1803: 202 cited by Powell 1981: 163).

According to Robins (1980), in the period 1756-1771, out of the 14,311 children admitted to the foundling hospitals at least 10,000 had died. The children, deposited in the hospitals, most often babies, may have been already undernourished and in ill health. In the 1700s the safest way to feed an infant was to use a wet nurse. Stevens et al. (2009) discussing the history of infant feeding identify that the alternative feeding methods, at that time, included animal milk, pap or panada. Pap is bread soaked in milk or water and panada is cereal soaked in broth. The glass feeding bottle had yet to be invented and the devices used to feed infants were difficult to clean. Therefore 'the build-up of bacteria made the feeding devices detrimental to the infants' health' (Stevens et al. 2009: 35). According to Stevens et al. (2009: 35) until the early nineteenth century the use of unhygienic feeding devices, improper milk storage and lack of sterilization 'led to the death of one third of all artificially fed infants during their first year of life' (emphasis added). For the period the foundling hospitals were in operation (1703 until 1831, when they stopped admitting children) feeding undernourished and sick infants was difficult both in and outside of the hospitals.

Robins (1980) and Powell (1981) suggest that the children who survived experienced a general climate of neglect. Food in the foundling hospitals was insufficient and Robins gives the following example: in 1758 a number of boys complained about their diet to the board of governors, this resulted in them being put into stocks and given twenty lashes each. The boy's complaint was that the bone they were given to eat was infested with maggots. In truth the maggots would have contained more nutritional value than the bone. In 1758 the lack of sanitation, overcrowding and the absence of hygiene would have created the ideal conditions for the production of maggots in the majority of rudimentary kitchens.

The foundling hospitals were subject to scandals and enquiries into child neglect and abuse throughout their history. They were closed in the 1850s. The responsibility for children needing care had moved to the workhouses.

3.3 The workhouse

Under the Poor Relief (Ireland) Act, 1838, in an attempt to address the growing numbers of homeless poor, 130 additional workhouses were established throughout Ireland. The famine (1845-1849) according to O'Sullivan (2009), 'made a bad situation immeasurably worse' (CICA Vol. 1, 2009: 35). In 1853 the number of children under the age of fifteen living in workhouses was 82,434 (Nicholls 1856).

According to Powell (1965) the ethos of the workhouses was to provide conditions within them that were not equal to the living conditions of a subsistence labourer from the area. The reason for this ethos was to discourage people from becoming dependent on the workhouse: if conditions were unfavourable then only people in dire need would use them. This proved quite a challenge for Nicholls, the Poor Commissioner for Ireland at the time, as the living conditions for a subsistence labourer were very poor. According to Powell (1965) Nicholls found it difficult, 'to draw up a diet that would be less than that of an Irish labourer and yet support life' (Powell 1965: 10). The assistant Poor Commissioners conducted investigations on the diets in their districts 'to establish a dietary for the workhouse that would be worse than anything found outside' (Clarkson and Crawford 2001: 70).

Knowledge of nutrition, according to Miller (2012: 446), was in a nascent state in the 1830s and 40% of the population of Ireland subsisted principally on potatoes at that time. Miller (2012: 447) suggests the Irish dietary customs were unique so it was not surprising to find the Irish labourers 'falling under the gaze of digestive analysis'. Burke (1987) suggests that one survey conducted by the assistant commissioner, W.H.T. Hawley, in 1839 was particularly detailed. The survey recorded that the average Irish labourer within his district ate 4-5 pounds of potatoes washed down with a pint of skimmed milk or buttermilk for breakfast, dinner and supper. Supper was not always eaten especially in the shorter days. According to Burke (1987) and

Clarkson and Crawford (2001) this was a nutritionally adequate diet but a monotonous one. The resulting workhouse diet consisted of two meals a day for adults and three for children between nine and fourteen years consisting of:

- Breakfast: three and a half ounces of oatmeal and a half pint of new milk
- Dinner: two pounds of potatoes and a half pint of new milk
- Supper: six ounces of bread (Robins 1980: 177).

That is less than a cup of porridge, two or three potatoes (depending on the size) and, if it was today's white sliced, six slices of bread but in reality the bread would have been wholegrain and would weigh more and therefore be a much smaller quantity of slices. Also Smith et al. (2008) suggest that a common practice at the time was to adulterate flour with inedible substances such as sawdust to increase its bulk and reduce the cost for the workhouse managers and increase the profit for the retailers.



FIGURE 8 WORKHOUSE BOYS (1909)
Original source: www.workhouse.org.uk

The photograph in Figure 8 shows residents eating in the chapel in this Wilkinson designed workhouse. The workhouses were segregated therefore men, women, girls and boys did not eat together as the photograph shows. Wilkinson was commissioned to design the workhouses in Ireland and the National Inventory of Architectural Heritage (Department of Arts, Heritage

and the Gaeltacht 2014) shows that a dining room and a chapel were in separate spaces. However, overcrowding may have led to both spaces being used for eating. In Sligo town the workhouse was designed to accommodate 1,200 people so mealtimes were likely to have been unceremonious affairs. In 1844 J. G. Kohl, a German traveller, published an account of how people were fed in a North Dublin workhouse. He described a potato kettle that could boil 120 stone of potatoes. The potatoes were weighed into individual nets and when boiled the inmates were marched in military fashion to receive their net and marched away with it (Higginbotham 2014). This workhouse was designed to hold 2000 inmates so the potato kettle boiling and the lines of marching poor must have been continuous.

Charitable organisations, religious orders and individual philanthropists also worked with the growing problem of abandoned and destitute children at this time. The measures included orphanages and ‘ragged’ schools. The ‘ragged’ schools provided free education and a meal for street children. Robins (1980), Kennedy (1996) and O’Sullivan (2009) are in agreement that the involvement of religious and lay organisations in the care of destitute children reflected a growing public concern for child welfare.

In the early part of the nineteenth century concern began to grow that workhouses or adult prisons were not suitable environments for children. This concern was for their moral wellbeing as they were coming into contact with ‘all types of adult paupers and vagrants, giving rise to the real possibility of abuse’ (CICA Vol. 1 2009: 35) in the workhouse and by hardened criminals in the prisons. This attitude to children was not confined to Ireland.

Aries (1960) argued that childhood did not exist up to and including the Middle Ages. Children over seven years were not recognised as a specific group and they were not treated differently from adults. Aries’ theory suggests that childhood as we know it today was invented sometime between the sixteenth and twentieth centuries (Clarke 2003: 3). Authors, such as Pollock (1983), counter that childhood and adolescence did exist in previous centuries but children were not necessarily viewed in the same way as they are at present. Robins (1980) maintains that the change in attitude towards children

came about when the infant mortality rates began to decrease. Critics, according to Clarke (2003), reject that view and argue that parents throughout the centuries felt deeply for the loss of a child. The image of the child began to change in the eighteenth and nineteenth centuries and, according to Parton (2006), attitudes towards children have kept pace with social change.

3.4 Industrial and reformatory schools 1850s - 1970s

In an attempt to address the problem of children being sent to prison the Reformatory Schools (Ireland) Act, 1858 was introduced, followed ten years later by the Industrial Schools (Ireland) Act, 1868, to provide an institution, to care for children, other than the workhouses. The model for the reformatory and industrial schools came from Continental Europe and originated in Germany, Switzerland and Scandinavia. According to O'Sullivan (2009) the education provided was centred on practical training, 'the approach fitted well with the Victorian idea of utilitarian progress and also helped to provide skills to fuel the Industrial Revolution' (CICA Vol.1 2009: 36). Another motivation was to control this element of society (children) who were viewed as a threat to the existing order.

Gilligan (2009) suggests that the 1800s was a time of institutionalization and seclusion. Children were accommodated in large institutional buildings that were geographically isolated. He argues that this reflected the wider social policy 'to hide society's 'outsiders' or to 'bury' social problems' (Gilligan 2009: 4). Others, for example O'Donnell et al. (2011), counter that whilst some of these institutions may have been isolated many were in the middle of towns and cities. The buildings were not hidden, they are easily recognisable, and can still be seen throughout Ireland. The very presence of these institutions was a reminder to the rest of society to behave or they may get to see the inside of these formidable buildings.

The Commission to Inquire into Child Abuse report (CICA) states the reformatories were for children who had been convicted of offences and the industrial schools were for children who were 'neglected, orphaned or abandoned, not for criminal children, but those potentially exposed to crime' (CICA Vol.1 2009: 36). The existing religious and voluntary schools and

homes applied to be certified as reformatory or industrial schools and the following three decades saw the building of many new institutions. By 1898 there were 71 such schools across Ireland, the vast majority managed by the Catholic Congregations.

The day-to-day finance for the schools depended on a capitation grant per child that covered recurring expenditure for food, clothing, equipment, staff, etc., but capital expenditure lay with the owners of the school. Raftery and O'Sullivan (1999) suggest that state funding was not provided to build the schools, as it had been in England, because Catholic Congregations owned the majority of them. The Government could not be seen to be favouring Catholics over Protestants. According to Kennedy (1996), because religious orders and voluntary organisations controlled these schools, the State was relieved of its responsibilities for children in need of care.

The population of the schools peaked in 1898 with 7,998 residents but, as O'Sullivan (2009) points out, there were also 6,000 children still living in workhouses in that year. The history of the schools (CICA Vol 1 2009) shows that one of the driving issues for the owners was to increase their certification for higher numbers of children as the funding was per capita. The CICA report shows that this increased funding did not enhance the living conditions for the children in the schools.

The industrial schools, according to Raftery and O'Sullivan (1999: 11), were surrounded by myths, amongst them: that they were orphanages - the majority of the children had one or both of their parents alive; that the children were there because they had committed a criminal offence - the majority were there due to their parents' poverty or questionable morality or for school non-attendance; and that the schools were for boys over the age of ten - more girls than boys were placed in industrial schools over the one hundred years they existed until the 1970s. Raftery and O'Sullivan dispel the most pervasive myth that the children were the objects of charity and argue that the State was entirely responsible for the schools. They suggest:

In the absence of anyone to contradict this, the children themselves accepted it, as did the general population.

3.5 Food in the industrial and reformatory schools

The CICA Report (2009) heard evidence from 1090 witnesses who had been admitted to the institutions between 1914 and 2000, interviewed the staff and studied existing reports. I have studied the CICA Report with particular reference to food. Under the Children Act, 1908 the Department of Education had legal responsibility for the schools. The Rules and Regulations for Certified Industrial Schools in Saorstát Éireann, 1933, under section 6 Dietary state:

The children shall be supplied with plain wholesome food, according to a Scale of Dietary to be drawn up by the Medical Officer of the school and approved by the Inspector. Such food shall be suitable in every respect for growing children actively employed and supplemented in the case of delicate or physically under-developed children with special food as individual needs require. No substantial alterations in the Dietary shall be made without previous notice to the Inspector. A copy of the Dietary shall be given to the Cook and a further copy kept in the Manager's Office ([Saorstát Éireann 1933] source CICA Vol.1 2009: 59).

This dietary indicates an improvement in the quality and quantity of food when compared to the dietary in the workhouse that had been kept to the bare minimum. Food was served in large refectories. The one pictured below (Figure 9) is a particularly large example from St Joseph's Industrial School Artane that was certified to accommodate 825 boys. Imagine the logistics of serving that many children with food all at once. It would have been like a military manoeuvre three times a day. The noise would have been deafening from the cutlery on plates alone because it is unlikely that the boys would have been allowed to talk at the meal table.

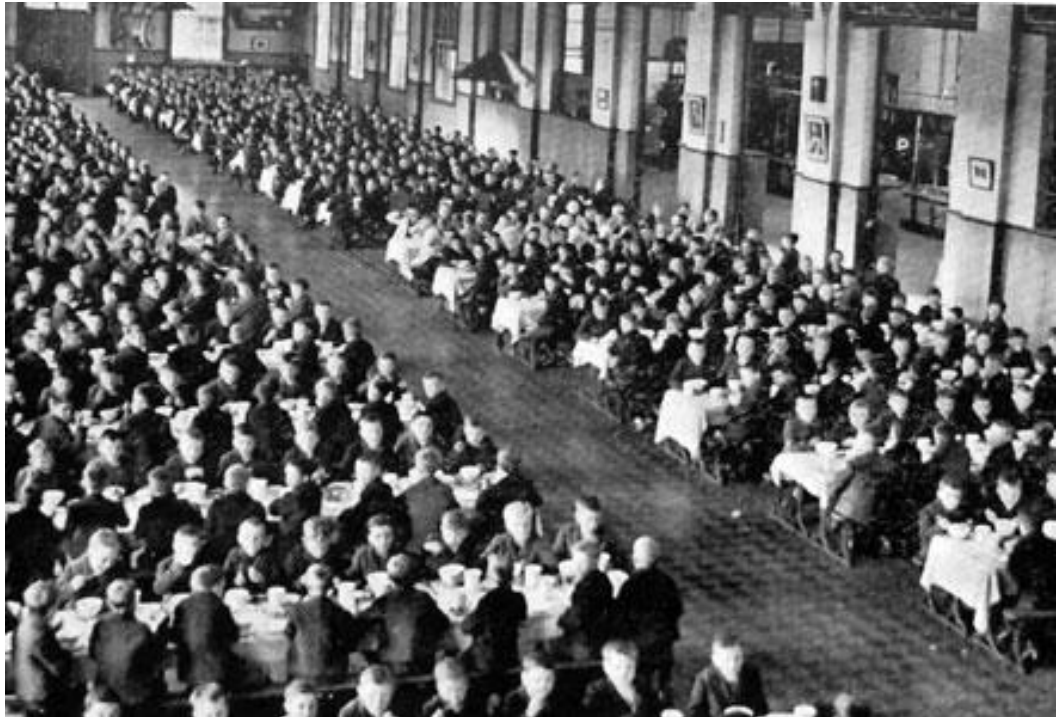


FIGURE 9 ARTANE DINING HALL (UNDATED CIRCA 1950)
Original source: CICA (2009)

One striking thing missing from this photograph is adults. Is it possible that the control of 825 boys at mealtimes did not require adult supervision? It is more likely that the Brothers patrolling the aisles were stood down for the picture. The interviews carried out by the CICA (2009) with the religious and lay staff report that the food the children received was wholesome and nutritious. By contrast, the witnesses reported that the food was generally inadequate. The standard diet described by most witnesses was:

Breakfast: porridge, bread and dripping and tea or cocoa
Main meal: boiled potatoes with vegetables and on occasion some
meat or fish
Evening meal: bread and jam and tea or cocoa
(CICA Vol. 3 2009: 45).

To compare this diet with what children were eating outside the schools we turn to the National Nutrition Survey (NNS) 1948-1950. This survey shows that 44% of all meals consumed by children under fourteen years in the lower income group residing in slum dwellings were 'bread and spread' meals. That percentage declined to 36% in the artisan group and further to 18% in the middle class groups. Bread and spread meals are 'tea etc. with bread and

butter, margarine, jam or other such spread' (NNS, Part 1: 50). This shows a similar, possibly slightly better, diet was being consumed by children outside of the institutions.

Perry et al. (2009: 5) suggest that children and young people in the mid to late 1940s were likely to be 'undernourished given the lack of variety and choice in the habitual diet'. However the NSS concludes that the average intake of nutrients and calories in the 1940s was satisfactory in accordance with the League of Nations Technical Commission recommended daily requirements of nutrients per head (NSS Part 6: 8). According to Friel and Nolan (1996) in their study into changes in the Irish food chain there was an improvement in the Irish diet between 1936 and 1961. The diet described by the witnesses who were in the schools in the 1950s and 1960s indicates that the nutritional standard of the diet in the schools did not show a similar improvement. This suggests the diet in the schools was not up to the national standard.

The CICA states that 'there was little or no access to extra food except what might be obtained opportunistically by residents working in the kitchens or the farmyards' (CICA Vol.3 2009: 45). There are many references to scavenging for food in staff waste bins and animal feed, eating vegetables while working in the fields and stealing food from younger and weaker children. Touher (1991) in his biographical account of life in Artane 1950-1958 refers to the tricks they played on each other in order to steal food from other boys' plates. On the other hand Fahy (1999), who wrote of her time in Goldenbridge between 1961-1970, recounts that tricks were played in order to dump food onto other girls' plates as it was a common practice to be forced to finish the food that had not been eaten. Working in the kitchens, for some young people, was a good experience as it provided the opportunity to access extra food and warmth (CICA Vol.3 2009: 45). Fruit did not feature on the menu except an orange as a Christmas treat. The only eggs provided were a boiled egg on Easter Sunday. The report concludes that poor standards of physical care were reported by most of the witnesses. 'Children were frequently hungry and food was inadequate, inedible and badly prepared in many schools' (CICA Vol.4 2009: 456).

One of schools in the West of Ireland was Letterfrack in County Galway. The school was originally certified to hold 75 in 1886, then 150 in 1889 and finally 190 from 1912. Letterfrack, like all the schools, was subject to two forms of inspection, one internal and the other external. The internal inspection, the Congregation Visitation, was carried out by a member of the religious Community. The primary objective of the Visitor was to ensure that the Brothers were acting in the spirit of their vocation. His function was primarily to inspect but he could also take immediate action if he encountered ‘anything of a serious nature...opposed to the religious spirit of the Community’ (CICA Vol. 1 2009: 76).

The external annual inspection was from the Department of Education. The Visitation Reports provided a valuable source of evidence for the CICA Report and it is suggested that, because they were composed for internal use, they are more critical and disapproving than the Department of Education Reports. In 1939 a Congregation Visitor to Letterfrack noted ‘that the boys looked frail, under-nourished and pale’ (CICA Vol. 1 2009: 361) but was told by the Manager that the Department of Education Inspector had been satisfied with the boys’ diet. The Report also points out that visits from the Department Inspector were pre-arranged so ‘one area of the Institution that one would expect to see improved for the purposes of an inspection was the food served on the day’ (CICA Vol.1 2009: 361).

I also looked for reference to food being used as punishment. In Letterfrack Brother Anatole describes one of the punishments was to kneel in silence during mealtimes and receive no food. He also reported that a collective punishment was the deprivation of food (CICA Vol.1 2009: 311). Reports from the girls’ schools show that one could get punished for not eating quickly enough. There are also reports of girls being forced to eat food that they found revolting. Under positive memories and experiences food is often mentioned, for example being given a sweet or a piece of bread from a ‘kind’ member of staff.

Where do the themes identified in the previous chapter: commensality, hierarchy, discipline and government, feature in this era of residential care? It

is clear to see that commensality was not so highly regarded. The children did eat together at the table but they did not necessarily enjoy the food or the company. They were under surveillance by the nuns and brothers and eating quickly and quietly would have been the order of the day. The hierarchical regime of food practices in the schools was evident as the adults generally got better quality food than the children. Hierarchy was also evident between younger and older children for example food being stolen from the younger children. Discipline during mealtimes ranged from public beatings to being forced to stay at the table until all the food was eaten. For the children in the schools governance did not provide a freedom of choice. The governance apparent in this regime was that of control, regulation and management of a national problem, children.

The majority of witnesses describe a marked improvement in their food post 1970. 'Sausages, chips, vegetables, eggs, cheese, fish fingers, cornflakes, and milk puddings became a regular part of their diet' (CICA Vol. 3 2009: 125). These improvements may have been due to the capitation grant being doubled in 1969 to the equivalent of €10.48 per week, Morgan (2009) shows that the weekly per capita income of an average family of four in that year was the equivalent of €6.16. Other contributory factors would have been: the changes to food production, retail, distribution and the availability of electricity and electrical white goods, such as deep fryers, fridges and freezers for industrial, retail and domestic use.

Industrial and reformatory schools were abolished in England under the Children and Young Persons Act 1933. The schools were re-named 'approved schools'. Another piece of legislation was passed in Britain - The Children Act 1948, which according to the Tuairim Report (1966: 2) had the fundamental principle of the importance of keeping families together. The Tuairim report raised the question of why we in Ireland were still caring for children under legislation 'which had long since been discarded by the country of origin'. The industrial and reformatory schools remained in operation in Ireland until the 1970s.

The Tuairim Report: *Some of our Children* (1966) investigated child care in Ireland and was deeply critical of the industrial school system. It recommended that children in need of care should be accommodated in smaller units and that residential child care workers should have professional training in the physical, psychological and emotional needs of children. It also recommended that the Department of Health would be the most appropriate department to administer the care of children. The Minister for Education responded by establishing a committee to examine the industrial and reformatory school system in Ireland resulting in The Kennedy Report (1970). As a result of this report the following decades would see significant changes in residential care for children and young people in Ireland.

3.6 Group homes 1970s - 1990s

Gilligan (2009) suggests that this era in residential care for children was concerned with deinstitutionalization and professionalization. The Kennedy Report into Industrial and Reformatory Schools published in 1970 'is generally viewed as a pivotal moment in the history of residential child care in Ireland' (O'Sullivan 2009: 308). The report is prefaced with:

All children need love, care and security if they are to develop into full and mature persons. For most children this is provided by a warm, intimate and continuous relationship with their parents, brothers and sisters. Children in institutions have for the most part missed this happy relationship. If they are to overcome this deprivation they must, therefore, be given love, attention and security by those in whose care they are placed. The recommendations made by the Committee in this report are based on the assumption that all those engaged in the field of Child and Family Care agree that this must be their fundamental approach to the work they are undertaking (Kennedy Report 1970: v).

The Report recommendations included: that child care should be focused on keeping families together, that residential child care should be considered only as a last resort and, when it was required, that children should be accommodated in small group homes. The Report also recommended that the Children Act, 1908 needed to be up-dated. The Taskforce into Child Care Services was an inter-departmental working party established in 1974 to

review to what extent the recommendations of the Kennedy Report had been put into practice. The final report was not published until 1980. The working party found that the institutional system was being replaced by the group home model. With the aid of grants from the Department of Education purpose built group homes had been erected, private homes had been purchased and adapted for group homes and existing premises had been converted to the group home model. From the 1970s onward residential child care also began to shift from the voluntary to the statutory sector.

The Task Force Report (1980) refers to a most striking feature of the pre-Kennedy system of residential care: ‘the alarming complacency and indifference of both the general public and the various government departments and statutory bodies responsible for the welfare of children’ (Task Force Report on Child Care Services 1980: 182). During the 1980s some of the survivors began to talk publicly about their experiences of physical and sexual abuse in the schools. Support groups were formed, books were published: Mannix Flynn, *Nothing to Say* (1983), Paddy Doyle, *The God Squad* (1988), Patrick Touher, *Fear of the Collar* (1991) and Bernadette Fahy, *Freedom of Angels* (1999). This all culminated in public outrage after the screening of the RTE documentary *States of Fear* (1999). On the 11th of May 1999 the then Taoiseach Bertie Ahern called a press conference to announce the establishment of the Commission to Inquire into Child Abuse and to offer an apology to the victims of childhood abuse in the industrial schools and reformatories:

On behalf of the State and of all citizens of the State, the Government wishes to make a sincere and long overdue apology to the victims of childhood abuse for our collective failure to intervene, to detect their pain, to come to their rescue (CICA Vol.1 2009: 1).

The Kennedy report was a crucial turning point in residential child care in Ireland and was the beginning of a long sequence of reports, recommendations, guidelines and legislation concerning children and families. The table below (Table 1) is based on the Timeline of Strategic, Policy and Legislative Developments in the Children’s Sector (CAAB 2010: 4) and illustrates the most significant of these from 1970-2000.

TABLE 1 REPORTS, RECOMMENDATIONS, GUIDELINES AND LEGISLATION 1970-2000

| | |
|------|---|
| 1970 | The Kennedy Report on Reformatory and Industrial Schools Systems The Health care Act, 1970, the health authorities' assumed overall responsibility for children. |
| 1974 | Task force into child-care services established |
| 1980 | The Taskforce report on Child-Care Services published |
| 1983 | Boarding Out of Children Regulations, 1983 |
| 1987 | Child Abuse Guidelines |
| 1991 | Child Care Act |
| 1992 | United Nations Convention on the Rights of the Child Ratified |
| 1994 | Health Strategy |
| 1995 | Child Care (Placement of Children in Residential Care) Regulations 1995 Child Care (Placement of Children in Foster Care) Regulations 1995 Notification of suspected cases of Child Abuse between Health Boards and Gardaí The Child-Care and Family Support Services Review of Adequacy 1995-1998 |
| 1996 | Focus on Residential Child-Care in Ireland 1996 published Child Care (Standards in Children's Residential Centres) Regulations 1996 Guide to Good Practice in Children's Residential Centres 1996 The Report on the Inquiry into the operation of Madonna House 1996 |
| 1998 | 'Learn to listen' The Irish Report of a European Study on Residential Child-Care |
| 1999 | The Standards and Criteria for the Inspection of Children's Residential Centres Children First National Guidelines for the Protection and Welfare of Children Social Services Inspectorate (SSI) established |

This phase in residential child care could be described as prolific in the amount of research, reports and investigations. Molloy (2010) suggests that there was very little positive literature in this phase and, while the Kennedy Report focused on the need for reform, there is little written material on how that reform took place. The first study to examine children's experiences of everyday life in care was conducted in 1998 in Sisters of Mercy homes that operated within the new group home model (Clarke 1998). Clarke's study did not focus on food but did acknowledge that food was significant to comfort,

welcome and hospitality in the centres. It can be assumed that the food provided to the children and young people from the 1970s was similar to that of the national diet.

For the 1970s, food like prawn cocktail, coq-au-vin and black forest gateau are perhaps what the recipe books of the time would suggest. For the majority of people such luxury foodstuffs did not feature in the daily menu. The daily menu in my own 1970s' childhood was: toast for breakfast, a jam or cheese sandwich for lunch and for dinner a small portion of meat and two vegetables - one was potato and the other often tinned.

While some convenience foods were beginning to appear in the shops these were relatively expensive. James (2010) suggests that the new production methods of the time, not just in the food but also in packaging, increased the availability of new foods. He discusses the outer-space qualities of the food using the example of the freeze-drying of potatoes that was then reconstituted with boiling water to produce instant mashed potato - Smash. Coveney (2006) argues that the increase in the availability of convenience foods did not accidentally coincide with the increase in women joining the labour market. Convenience foods helped women to fulfil their 'domestic obligations as food providers and participate in the paid workforce' (Coveney 2006: 108).

Perry et al. (2009) compared data from 1948, the 1970s and 2002 on children's heights and weights and found that children and young people have increased in both height and weight since the 1948. They suggest that the increase may have been beneficial for the 1970s' cohort, as it was for the majority of witnesses from the CICA (2009), who reported a marked improvement in their food post 1970. Perry et al. point to the disproportionate weight to height increase for the 2002 children as a significant public health concern. Perry et al. make no reference to the improved nutritional quality of food available to the 2002 cohort being associated with the changes in the height and weight of Irish children.

This history of residential care for children in Ireland has helped to put in context how the statutory care of children has changed over the past three centuries. Using food to view that history has shown how perceptions and

attitudes towards children in general have changed significantly over that period. While time appeared to stand still in the industrial and reformatory schools (1850-1970) post 1970 residential care in Ireland changed dramatically. The industrial schools closed and the new group home system was introduced. One of the most significant findings of the Kennedy Report (1970) was that children in the care of the state in Ireland were not being sufficiently cared for.

3.7 Residential Care 1990s – onwards

Since the Kennedy Report (1970) residential care for children and young people in Ireland has gone through significant change. The remaining industrial schools closed and residential care centres became smaller, less obviously institutional and more home-like: a trend that has continued to the present day.

Gilligan (2009) suggests that residential child care in the 1990s saw the beginning of the phase of secularisation, specialisation and accountability. According to the Focus Report on Residential Child Care (McCarthy et al. 1996) the religious orders began to withdraw from the provision of residential care. However the report shows that in 1996 the majority of health board group homes were still under the management of the religious orders and voluntary groups. Some of the reasons for the withdrawal by the religious orders may have been the diminishing numbers of people joining the orders, the increase in trained lay staff or the numbers of children being fostered rather than being placed in residential care. This increase of foster care resulted in residential care becoming a more specialised service.

According to O'Sullivan (2009) the final religious order to withdraw from residential care was the Sisters of Mercy in 2003 and by 2008 the vast majority of residential centres 'were managed directly by the State or its agents' (CICA-Vol 4: 247). Kennedy (1996) argued that in 1996 the child care system in Ireland was fragmented because the Departments of Health, Education and Justice still shared the responsibility for child care, despite the recommendations of the Kennedy Report in 1970. The Department of Education did not end its administrative role in residential child care until

2007. Kennedy also stressed that a National Strategy for children was required because there was no policy for ‘the training of child care workers, the funding and staffing of child care centres and appropriate staff/client ratios (the regulations still do not specify numbers), or the inspection, monitoring and evaluation of child care centres’ (Kennedy 1996: 274).

The National Children's Strategy 2000 - 2010, *Our Children - Their Lives* was published in November 2000. It was a ten-year plan that envisaged:

An Ireland where children are respected as young citizens with a valued contribution to make and a voice of their own; where all children are cherished and supported by family and the wider society; where they enjoy a fulfilling childhood and realise their potential (DoHC 2000).

Training for residential child care workers began in the early 1970s. The Social Services Inspectorate (SSI now HIQA) was established in 1999 and was empowered under section 69 of the Child Care Act, 1991, to inspect the social services functions of Health Boards, including children’s residential centres.

Another major change at this time was the use of foster care as an alternative to residential care. The number of children in the care of the state has fluctuated since the 1950s when the number was high with approximately 12,000 children in care. By the end of the 1960s the number dropped to 4,200 and 75% of those were in residential care. The number began to rise again in the 1970s and then dipped in the early 1980s but there has been a steady increase from the mid-1980s until today. Some of the reasons for the increase may be: greater public awareness of child abuse and neglect, an increase in the number of trained social workers and social care workers, an increase in the population of Ireland and, due to the present economic crisis - the increasing number of people living in poverty. The Central Statistics Office (CSO 2014) show that between 2008 and 2012 people who were living in consistent poverty almost doubled from 4.2% to 7.7%.

According to the HSE in 2013 there were 6,466 children in the care of the state of whom the majority were in foster care. The Department of Children

and Youth Affairs report that 369 children were in various residential care settings (DCYA 2013) with 321 in residential centres, 15 in high support centres and 23 in special care. There were 161 such centres for young people, including 80 in the statutory sector and 81 in the non-statutory sector (HIQA 2009: 30-32). One reason for not getting a definitive answer to the numbers of children in care and the centres that provide that care is that children move between residential and foster care and centres open and close according to need. Gilligan (2009: 3) suggests that residential care today is used 'to serve challenging or marginal populations within or on the edge of the child welfare system'. In other words, residential care can be viewed as a last resort used to accommodate children with more complex or higher levels of need who cannot be placed in foster care.

As the numbers above show foster care is currently the preferred option for the state care of children in Ireland. The latest figures show that the numbers of children in state care are increasing but the number of children in residential care is decreasing by comparison. The National Children in Care Inspection Report (2008) shows there were 5,449 children in the care of the state, in 2008, 400 of whom were in residential care. In 2013 the number of children in care had increased to 6,466 and the number in residential care was 369. The decrease may be due to the HSE launching a campaign in 2008 to recruit more foster carers.

3.8 Contemporary practice

Brady et al. (2003) identify a number of theories and concepts that have strongly influenced child and family services in Ireland. They include child development (Erikson 1902-1994), resilience (Gilligan 2009) and attachment (Bowlby 1958). Contemporary practice of residential care in Ireland is influenced by the North American approach of Child and Youth Care (CYC) and the Northern European tradition of social pedagogy. Both these approaches recognise the significance of young people and worker relationships and workers' participation with the young people in their everyday lives.

To provide a clearer picture of how residential care for children and young people works at present I will draw on: the legal framework for the admittance to care, the most recent demographic of children in care and the reasons for admittance, current policy and contemporary practice for alternative care in Ireland.

The ‘family’, founded on the institution of marriage as in most European countries, is considered as ‘the ideal environment to bring up children and is given special protection in Ireland under Article 41 of the Constitution’ (Nestor 2004: 3). Under Article 42.5, the State, in exceptional cases when parents fail in their duty towards their child, must supply the place of the parents.

In January 2014 Tusla the Child and Family Agency (CFA) was established as the new dedicated State agency with responsibility for improving wellbeing and outcomes for children. The CFA operates under the Child and Family Agency Act 2013 and has responsibility for improving wellbeing and outcomes for children through child protection, early intervention and family support. It also has statutory responsibility to provide alternative care services under the provisions the Child Care Act, 1991, the Children Act, 2001 and the Child Care (Amendment) Act, 2007. The CFA’s responsibilities also include the provision of aftercare services, services for children who are homeless or children who are separated and seeking asylum.

The CFA must act in every case where there is concern of child protection raised by any interested party. The case will be assessed by CFA social workers. According to McHugh and Meenan (2013) if, on investigation, a social work team decide that an intervention is necessary then it will always focus on attempting to keep the family together and may offer family support services. If or when it is decided that it is not possible for the child to stay with the parent or guardian then they will be taken into alternative care. Social work departments must apply to the courts, who have a range of powers for dealing with cases where children are deemed at risk of abuse or neglect. The court can decide what kind of care is needed and what access parents or relatives should have to the child. At present, children who require admission

to alternative care can be accommodated through placement in foster care, placement with relatives or residential care. There are also a number of care orders that can be applied for:

Emergency care order: maximum of 8 days in care

Interim care order: maximum 29 days in care but can be extended

Care order: can continue until the child reaches eighteen

Supervision order: maximum 12 months may be renewed

Interim special care order: maximum 28 days but may be extended

Special care order: maximum of 6 months but may be extended

A supervision order involves the child being visited and monitored in their own home by the CFA and the others involve the child being taken into care by the CFA. There is also the option of voluntary care under section 4 of the 1991 Act. In cases where parents are unable to cope due to illness or other problems they may agree to a child being taken into the care of the CFA. In these cases the CFA must consider the parents' wishes as to how the care is provided. A child cannot be kept in voluntary care without the consent of the parent or person acting *in loco parentis*. If the parent wishes to remove the child from the care of the CFA and the CFA believe that the child will not receive the care and protection required from the parent then they must apply for one of the orders above. The CFA is obliged to maintain children in voluntary care for as long as their welfare requires it. According to the national advocacy service for young people in care (EPIC 2011), the majority of children in care in Ireland are in voluntary care. The most recent published data shows that of the 2,070 children admitted to care in 2012, 63% were under a voluntary care order (Tusla 2012: 64).

The CFA recognise that a child returning to the family home or foster care is not always possible and, as McHugh and Meenan (2013) suggest, residential care can be the best option for some young people because living with a foster family could be a constant reminder of their own dysfunctional family home and may be associated with distressing situations. Residential care can be the preferred option for some young people. It can also be used to keep a sibling group together.

Residential care at present serves an increasing marginalised population within the child protection system and according to Gilligan (2009: 15) ‘its current function can be argued as a “fall-back” to foster care’. The current situation produces challenges for the young people living in the centres and the workers employed there. The workers have to develop skills for working with some of the most vulnerable and troubled hard-to-serve young people. According to Gilligan (2009: 9) residential care in Ireland ‘embraces a number of models for different groups of children and young people’. A residential centre is defined by CAAB (2009: 4) as: ‘any place where a child or young person is accommodated, usually as part of a group, and cared for by trained child care professionals’. At present the CFA (2015) define the services as residential, special or higher support. Residential encompasses mainstream care on a respite, short-term or long-term basis. Special care provides short-term, stability and safe care in a secured therapeutic environment. The use of residential high support units has recently been phased out (CFA 2014) but the CFA remains committed to providing higher support/intervention to meet individual need as required.

Residential care is a very costly way to look after children in care. McHugh and Meenan (2013) quote an Irish Times report from 2009 that suggests €135 million was spent on residential care for approximately 400 young people in that year. The CFA (2014: 22) budget for 2014 shows that €110 million was broadly assigned for foster care and €90 million was assigned for residential care. Clough (2000) argues that the cost comparison between residential and foster care is often distorted because many of the expensive aspects of fostering are excluded from the costings. Recruitment, training, support and housing are unlikely to be included in the figures because they are paid for in other ways.

The CFA states that it is only when all other options have been exhausted that a child will be placed in residential care:

Every effort is made to place children and young people within their extended family (Relative Foster Care) or in a Foster Care placement (CFA 2014).

According to McHugh and Meenan (2013) the function of residential care is to provide a safe nurturing environment to care for children and young people who cannot live at home or with an alternative family for a period of time. The Draft National Standards for Residential and Foster Care for Children and Young People (HIQA 2010: 49) propose the environment should be ‘comfortable and homely’. The CFA (2015) maintain that the objective of residential care is to provide a physical, emotional and psychological *safe space* in which children and young people ‘can heal, develop and move forward in their lives’. The skills and knowledge required by the workers in residential care are diverse:

Skills and knowledge...drawn from a number of different disciplines, ranging from the directly practical – nutrition, recreation and health care, for example – to personal, people centred skills - such as care and control, communicating with children, counselling and family work, backed by an in-depth and detailed knowledge of child development (Residential Forum 1998: 11 cited by McHugh and Meenan 2013)

The numbers of children and young people in care continues to fluctuate as table 2 below shows. The National Children in Care Inspection Report (2008) shows there were 5,449 children in the care of the state in 2008, 400 of whom were in residential care. In 2013 the number of children in care had increased to 6,466 yet the number in residential care had decreased to 369. This decrease may be due to the HSE launching a campaign in 2008 to recruit more foster carers. The most recent figures from the CFA for April 2015 show that the overall number of children in care has declined to 6,420 and the figure for residential care has declined further to 348 (CFA 2015). This, as Gilligan (2009) indicated, would suggest that residential care today serves an increasingly marginalised population within the child care system.

TABLE 2 NUMBERS OF CHILDREN IN CARE

| | Children in care | Residential care | Percentage |
|------|------------------|------------------|------------|
| 2008 | 5449 | 400 | 7% |
| 2013 | 6466 | 369 | 6% |
| 2015 | 6420 | 348 | 5% |

The gender balance of children and young people in residential care is reasonably equal. The primary reasons for admission into the care system according to the CFA (2012: 64) were: child welfare concerns (53.9%),

neglect (28.6%), physical abuse (8.4%), emotional abuse (7.4%) and sexual abuse (1.7%). According to the CFA ‘most young people are placed in residential care because their behaviour has become too challenging to be managed in any other care setting’ (CFA 2015). McNicholas et al. (2011) found that almost 90% of children in residential care in the Dublin area had behavioural problems. In addition, McElvaney et al. (2013: 29) maintain that the mental health needs of children in care or in secure accommodation are significant, ‘with high rates of mental health problems, social, family and educational problems; aggression, substance abuse and self harm’. In a study of psychiatric disorders amongst looked after children in Britain Ford et al. (2007) found they had significantly higher levels of psychopathology, educational difficulties and neurodevelopmental disorders than their peers. The complex mental health issues manifested by children in care include:

Attachment difficulties, relationship insecurity, sexual behaviour, trauma-related anxiety, conduct problems and defiance, and inattention/hyperactivity, as well as uncommon problems such as self-injury and food maintenance behaviours (Tarren-Sweeny 2008: 346).

McHugh and Meenan (2013: 247) maintain that *all* children in care will ‘have experienced a degree of life trauma’. They may be dealing with feelings of loss or abandonment. They suggest that young people in residential care, who may have experienced multiple placement breakdowns, can have additional problems with attachment and building trusting relationships with adults.

The CFA (2015) stress that the development of relationships between the workers and the young people in their care are of utmost importance:

Through these relationships, Centre Staff, Managers and Social Workers develop Care and Placement Plans that support their efforts to address the issues that are preventing children and young people from living at home or in Foster Care with a view to facilitating their earliest possible return (CFA 2015).

McHugh and Meenan (2013: 251) suggest, the task of relationship building in residential care can be challenging. Professional boundaries need to be established and maintained when forming relationships between workers and the young people. Cooper (2012: 35) suggests that it is easy for clients in

social care situations ‘to become confused about the nature of the relationship’ and staff need to work within their boundaries to prevent being seen in the parental role or as a friend. Maintaining professional boundaries may be more difficult in residential care settings because the workers ‘personal qualities’ are ‘placed at the forefront of the task’ and ‘putting the personal at the heart of the work with children introduces a range of boundary issues (Smith 2009:119). Smith also suggests that when considering what professional means one should begin with what the job is:

If the job is to make intimate human connections with those we work with to help them grow and develop then conceptions of the professional ought to support this. Assumptions that inhibit such relationships can be argued to be unprofessional; they get in the way of what we should be doing when we care for children (Smith 2009: 136).

Another challenge in developing relationships is the first encounter. Some young people may have a clear understanding of why they have been placed in the centre or they may be confused, frightened or angry. This may result in behaviour that could ‘be “normal” and stable or unpredictable and dangerous’. Similarly any person removed from their everyday home and admitted to hospital, prison or residential care for older people for example could display similar behaviours due to disorientation and distress (Felski 2000).

Smith et al. (2013) also discuss the centrality of relationship building and recognise the challenges that can be present in the first encounter between the young person and the worker in the centre. The workers have to manage the young person’s anxieties while simultaneously managing their own. When a young person is being admitted to the centre the workers will have been informed of the young person’s background and, as Smith et al. (2013: 20) suggests, reputations and in particular ‘reputations of challenging behaviour’ can provoke anxiety for the workers. The worker has to work through their own unease and find a way to initiate a connection with the young person. Relationships in residential care, as in life generally, are complex and they alter and build over time. Everyday activities and critical events are central to relationship building (McHugh and Meenan 2013; Smith et al. 2013). Relationships develop through the humdrum of everyday living in the centres.

Food and eating practices play a significant role in establishing the routine, rhythm and rituals of daily life in residential care (Punch et al. 2009; McIntosh et al. 2010; Emond et al. 2013).

3.8.1 Routines, rhythms and rituals

The aim of residential care is to provide a safe space in which children and young people can heal, develop and move forward in their lives. Smith et al. (2013: 20) suggest it is Maier's (1979) concept of the 'core of care', the everyday routines, rhythms, and rituals in the centre, that help young people to develop a sense of safety. Maier views 'routine' as representing the structure of the centre – what happens, where and when. Routines offer a sense of predictability that may have been lacking in the young person's life before coming into care. However, he cautions that there must be some flexibility to the set routines. Another key component of Maier's 'core of care' is 'rhythmic interactions' that is when workers and the young people find themselves 'in tune'. According to Smith et al. (2013: 21) Maier's idea of rhythm may be apparent in 'what a healthy residential home might aspire towards'. Rhythmic interactions are apparent when 'children and adults share moments and move ahead together' (Maier 1979: 6). Tuning into other people's rhythm can be momentary, for example: noticing that you are walking in step or feeling hungry at the same time.

For the routine and rhythm of the centre to run smoothly Smith et al. (2013: 21) maintain that there must be a degree of acceptance from the young people that 'the expectations that frame routines are reasonable and sensible'. For example: the young people understand why the workers think it is a good idea for everyone to eat together at the table.

Smith et al. (2013: 21) also suggest that 'appropriate rituals of care' can help to bring about a degree of acceptance of how things are done. Rituals, they suggest, 'speak of personal connection' they develop over time and have particular meaning to those involved. Social scientists and in particular anthropologists have accepted that collective rituals help to bind groups together (Whitehouse and Lanman 2014). Durkheim (2008 [1915]) viewed

rituals as social instruments used to establish collective representations and community identity. Goffman (1967) on the other hand considered rituals to be patterns of behaviour that could enhance or diminish group cohesion. Participation in rituals can determine whether you are part of the group or not. Rituals can be individualised behaviour, for example: how a young person prepares their breakfast in the morning. They can also be collective: how a birthday is celebrated in the centre. Relationships between workers and the young people are created and recreated by the routines, rhythms and rituals of daily life in residential care. They are central to residential care practice (Smith 2009; Kendrick 2012; McIntosh et al. 2011; Smith et al. 2013) and will be explored further in the workers' questionnaire.

To recap thus far, the publication of the Kennedy Report (1970) was a pivotal point in residential care for children and young people in Ireland. The report coincided with the emergence and dissemination of two major theories: one was the critique of institutions by Erving Goffman (1961) and the other was attachment theory, the joint work of Ainsworth and Bowlby that began in the 1950s (Bretherton 1992). Both these theories reflect the changing attitudes towards the care system and have shaped the current landscape of public care for children. It was from this point that the word 'care' entered the lexicon of residential care. Care is a word that is used widely but it is difficult to define. Steckley and Smith (2011: 181) argue 'that despite the centrality of the term within the title the meaning of "care" in residential care is largely unexplored'. What follows is an exploration of what care means in residential care and to further develop an understanding and definition of care I turn to the feminist ethics of care.

3.8.2 Defining care

Care has multiple meanings but basically 'it is a basic human capability serving fundamental human need' (Lynch et al. 2009: 410). According to Nussbaum (2001: 264) when we talk about love and care (she rarely speaks of one without the other) 'we are talking about emotions and about complex patterns of behaviour, mediated not only by desire but, also by habit and social

norms'. Feeling loved and cared for throughout our lifespan is a prerequisite to human development and flourishing (Lynch et al. 2009; Feder Kittay 1999).

Children and young people living in residential care are perceived as having had inadequate care or control within their birth families (McIntosh et al. 2010). Goldson (2004: 79) raises the question, 'is care possible without an element of control, and can control be caring?' For children and young people placed in residential care there is an assumption that both terms are inextricably linked but what do the terms actually mean? There have been significant contributions to theories of control that will be discussed in greater detail in chapter six. Duffy (2011) suggests that the term care has become a buzzword among academics and advocates that is used in ways that assumes a shared implied knowledge of what care is.

According to Maier (1979: 173) 'true caring' represents the reciprocity of care received and care given. He brought together child development and child care into his conceptual framework of care. He suggests that if one was to reflect on a personal experience of nurturing care that it would involve: physical comfort, knowledge that the experience would endure, most probably with a familiar person. This is not dissimilar to the young people reported on in Holland's (2010) study whose definition of care was: an enduring relationship with a fair and reliable carer that manifests in everyday acts. The following three figures represent data collected on the meaning of care. The first figure (Figure 10) represents data collected by Holland (2010) from her project that explored how care is conceptualised and practised in the everyday lives of young people living in care through their care relationships.

FIGURE 10 YOUNG PEOPLE'S UNDERSTANDING OF CARE
(Original source: Holland 2010 p. 1674)



The figure shows what the young people thought a worker cared by being: fair, reliable, on their side, performing everyday acts, the care lasted over time and they contrast it with not caring. The following figures (Figure 11 and 12) show data collected by Byrne (2013) from social care practitioners and the social care students on the meaning of care.

FIGURE 11 SOCIAL CARE PRACTITIONERS' DEFINITION OF CARE
(Byrne 2013)



The definitions recorded from questionnaires completed by the social care practitioners are shown in Figure 11. They defined care as: an action, providing emotional and physical support, to be on the young people's side and to cause no harm. The workers also recognised that it was hard work and that they had to practice self-care. In addition they identified the word 'care' as meaning the professional practice of 'alternative care' as opposed to care in the family home.

FIGURE 12 SOCIAL CARE STUDENTS' DEFINITION OF CARE
(Byrne 2013)



Finally, Figure 12 in this series shows how the social care students defined care. As is evident the use of buzzwords such as empowerment and enabling is evident. This points to the fundamental question - can we teach students how to care? Costello and Haggart (2008: 52) suggest that it is not whether students can be taught how to care but 'how educators design teaching and learning situations that facilitate students to learn to care more effectively'.

The definitions given by the young people (Holland (2010), the social care practitioners and the social care students (Byrne 2013) highlight that doing care is something that is difficult to define because for the people who give and receive care it is 'a word which is value-laden, contested and confused' (Shakespeare 2000: ix). According to Steckley and Smith (2011: 182) there has been a notable failure to reflect on 'what might be meant by "care" in residential care'. To further develop an understanding and definition of care I now turn to an examination of the feminist ethics of care.

3.8.2 Ethics of care

Holland (2010) and Steckley and Smith (2011) use the feminist ethics of care perspective to explore 'care' in residential care for young people. They are in agreement that care struggles to be acknowledged in justice dominated practices. Holland (2010) argues that the ethics of justice dominates the policies and practices of residential care for young people and those policies and practices often overlook aspects of the ethics of care. In agreement Steckley and Smith (2011: 191) suggest that justice is concerned with 'rights, protection, best practice, evidence, standards and inspection' and that in such a climate care struggles to be recognised.

Carol Gilligan (1982) identified that women's morality centred on the ethics of care and compassion rather than the more male centred rules and regulations associated with justice. Fisher and Tronto (1990) shift the emphasis from gender to the importance of ethics of care and justice for women and men thus moving away from gender essentialism. They identified four phases of care: caring about, caring for, caregiving and care receiving. Tronto (1998) suggests

that distinguishing these four phases of care offers us a more complex view of what good care should be and enables us to recognise that:

There is an ideal form of caring [...] in which those who cared about a problem take responsibility, provide care and receive thanks when all goes well [but] in reality, the process of care rarely occurs in a perfect way (Tronto 1998: 63).

Lynch et al. (2009) have expanded feminist scholars' work (see Gilligan 1982; Fisher and Tronto 1990; Feder Kittay 2001) and draw the attention of the sociological and related disciplines to the affective domain. Lynch et al. (2009: 12) identify four major social systems in which equality and inequality can be produced: 'economic, political, cultural and affective'. The affective system, they argue, is concerned with love, care and solidarity. For Lynch et al. love and care have been treated as private matters, 'not subjects of sufficient political importance to be mainstreamed in theory or empirical investigations, while the subject of solidarity has received the least attention' which goes some way to explaining why the affective system has received little serious account (Lynch et al. 2009: 12). They argue that neglecting the reality of dependency for human beings throughout their lifespan generates two important forms of inequality: one, inequality in how people's need for love and care are satisfied and the other, inequality in the work that goes into satisfying that need.

According to Smith et al. (2013: 42) expressing emotions such as love has been discouraged of late in residential care and 'fear rather than love has been the dominant emotion'. Smith (2009: 124) argues that the practice has become 'risk averse and child protection dominated' resulting in a shift away from a relationship-based job where 'love is deemed unprofessional'. In such a setting, if the affective system is not brought to the fore, there is a danger that the significance and importance of the relationships between young people and workers in residential care will become further marginalised.

Residential child care in Ireland is used as a last resort, as the Kennedy Report (1970) recommended, and the majority of children and young people living in residential care today may have experienced multiple unsuccessful placements

within foster care. Therefore, as Gilligan (2009) suggests, residential care centres provide care for young people with a diverse range of needs and often challenging behaviours. Lynch et al. (2009) suggest that maintaining care relationships involves time and energy and care work can be both pleasurable and burdensome. Fox (2002: 2) stresses that caring for the young people who live in residential centres who no one else will care for is hard work because 'these kids don't come easy to care for'. According to Noddings (2002) children need minimal physical care to survive, but to grow they need much more. Through the development of caring relationships with workers some young people living in residential care learn how to accept care.

Holland (2010), discussing the ethics of care and looked after children, recognises that we are all in caring relationships and that we are all at different stages of our lives, either as care-givers and/or care-receivers. She also reminds us that the ethics of care literature has concentrated mainly on adults and that children are depicted as passive care-receivers. Fisher and Tronto (1990) argue that care is embedded in relationships and should not be viewed as a one-way giving of services to a dependent receiver. Banks (1998: 227) distinguishes the ethics of care from unconditional caring. Unconditional caring is based on relationships of caring between connected individuals as opposed to an external ethics of justice based on duty. According to Lynch et al. (2009: 47) 'paid care work is definitively emotional work, although it can be undertaken with varying degrees of emotional involvement'.

To conclude, discussions of the ideal of care are mainly absent from critical social care literature. Meagher and Parton (2004: 11) counter that care has been 'the core of social work values, theory and practice since social works inception'. They argue that unless care is 'relocated at the centre of debates, policies and practices, what makes social work (and social care more generally) will be lost.

3.9 Residential care centres – homely homes?

Having explored the definitional and ethical dimensions of care we will now look at the location where care is practised. Today young people in need of residential care are accommodated in community based 'homely' homes. According to the HIQA Inspection Reports (2002 -2011) the majority of residential centres in the HSE Western Area are located in houses situated on ordinary streets and housing estates. The young people have their own bedrooms that they can personalise and the furnishings and facilities in the communal areas are domestic in style. The current National Standards for Children's Residential Centres (2001), under Standard 10 Accommodation, require:

10.1 The centre is kept in good structural repair and decorated to a standard which creates a pleasant ambience.

10.2 The furnishings and facilities are adequate and sufficient for the number of young people living in the centre.

10.3 The centre is adequately lit, heated, ventilated and has suitable facilities for cooking and laundry and all equipment is as domestic in style as possible.

10.4 Space is provided within the centre for young people to have visits from friends, family members or social workers that is private and will not disrupt the rest of the centre.

10.5 Young people have a room to themselves.

10.6 The centre has age appropriate play and recreational facilities which are available to young people.

10.7 The centre involves young people in decision making when physically relocating, furnishing and decorating the premises.

10.8 Young people have access to a space within the centre where their personal belongings can be kept safely and securely.

10.9 The centre is adequately insured against accidents or injuries to children and details are made available for inspection purposes (DoHC 2001: 31).

The Draft National Standards for Residential and Foster Care for Children and Young People (HIQA 2010: 49) requires under Standard 17: the Living Environment – ‘that each child and young person lives in a comfortable and homely environment’. This raises the question - what does ‘homely’ mean? The criteria by which HIQA judge a homely environment includes: the centre conveys a message of welcome and comfort, the furnishing and facilities are domestic, each young person has their own bedroom, photographs of the young people are on display and each young person has an input into decisions about decoration and furnishing. They also recommend that children should participate in domestic chores to develop life skills and to promote identification with the centre – so they feel more at ‘home’.

‘Home’ and ‘homeliness’ are elusive concepts, according to Annison (2000). The meaning of homeliness is shaped by social norms and values but also personal preferences, so what makes one person feel at home will differ from what another would choose. The meaning of home has attracted significant attention from the fields of sociology and geography in recent years (for overviews of the literature on home see Mallett 2004; Manzo 2003; Miller 2010). Christensen et al. (2000) suggest that the contemporary family home in Europe and North America is based on a *house* that, through time, love and care, is transformed into a *home*. It is a ‘space and place where identities are worked on: children develop their social competence and demonstrate and enact their growing maturity at home and in movements in and away from this space’ (Christensen and James 2000: 143).

Bell and Valentine (1997: 14) define a home as being ‘quintessentially a ‘private’ space’ but, for children and young people living in residential care centres, their home is also a public space. Home can be as simple as where you live, but it also has an emotional element, for instance - your parent’s home or your home country. Exploring social identity, Christensen and James (2000: 140) place ‘the home as the key source of rootedness’. Clark et al. (2014: 14) suggests that young people living in residential care may have a ‘fractured sense’ of home. They may not identify the centre as their home. Several young people living in residential care, interviewed by Dorrer et al. (2011: 26), said the centre was not their home and ‘their own family or community was still

where they belonged'. Dorrer et al. argue that today's residential home is 'a three-fold space that combines characteristics of 'home', 'workplace' and 'institution' (ibid: 21). Peace and Holland (2001), in their study of small home care settings for older people, explored the tensions between domestic and institutional living and found that 'homely residential care' may be a contradiction in terms.

Further reading of the HIQA Inspection Reports (2002 -2011) indicates that a residential centre with an average of four young people in residence will have approximately eighteen adult staff on duty in one week. Ward (1997: 29) identified that residential care has one core feature for young people: they are 'being looked after away from their home by [many] people who are not their parents'. Nevertheless, Petrie et al. (2006) suggest, there is a similarity between parenting and residential care work because of the relationships social care practitioners have with the children that they look after and the responsibilities they have for the children's care.

Cliffe and Berridge (1991) discuss the closure of the large institutional children's homes in the 1950s in the UK and the shift towards smaller group homes that were staffed by resident house parents. Living together in such an arrangement may have provided the workers and the young people with opportunities for more conventional adult/child relationships found in conventional homely homes. That era of residential care has also passed: at present residential care centres are staffed by qualified non-resident workers. It should be noted that today the workers often work a twenty-four hour shift two or three days a week. There will always be at least two workers on duty because of child protection guidelines. Therefore the young people will be having different 'parent like' relationships on a daily basis with many different workers – not a situation that would be found in the majority of conventional family homes. The ratio of adults to children in the centres represents an institutional aspect of residential care, rather than a homely aspect.

Home is, according to Bell and Valentine (1997), one of the most important sites in our everyday lives. Young people living in residential care and the workers share the space to carry out bodily practices such as sleeping, washing

and, of particular interest here, food preparation and consumption. Cooking and eating in the home, Bell and Valentine maintain above all, plays an important part in establishing household relationships and identities.

3.10 Food in residential care centres

The majority of sociological work on food and children has concentrated on the homes of nuclear families consisting of adults with young children. There is a clear hierarchical divide between adults and young children. However, as children become teenagers, as the children in this study are, the hierarchical rules of the table are resisted and contested. As discussed in chapter one the dining table, according to Visser (1991: 54), is 'a constraining and controlling device, a place where children eat under the surveillance of adults'. Coveney (2008), Wills et al. (2008), Bell and Valentine (1997) and Grieshaber (1997) are in agreement that power and resistance occurs at mealtimes between adults and children. McIntosh et al. (2010: 290) found that 'relations of power and resistance [...] are routinely played out through food'. It is possible that similar battles occur at the dining tables in residential care centres in Ireland.

We have come a long way from the large institutional settings where the image of Oliver Twist asking 'for more' has become synonymous. Today, when considering the institutional feeding of children, it is more likely that [celebrity chef and food activist] Jamie Oliver would come to mind. The National Standards for Residential Care Centres specify under the provision of food and cooking facilities:

6.9 Young people have adequate quantities of nutritious and appetising food and their preferences are taken into account in planning menus. Young people who are vegetarian or who have special dietary requirements are offered a range of suitable and nutritious food.

6.10 Young people have easy access to food, and are gradually encouraged to develop healthy eating habits.

6.11 Staff and young people eat meals together and these are regarded as a positive social event (DoHC 2001).

The Welsh National Minimum Standards for Children's Homes (DoH 2002) go even further under provision and preparation of meals. According to Standard 10.2 meals should be 'well-managed, orderly, social occasions'. The inclusion of 'well-managed' and 'orderly' harks back to the workhouse and the industrial schools. The social aspect being included in the standards both here and the UK suggests that the ideal image of the family dinner table, or commensality, is a highly regarded aspiration for the regulation of young people in residential care. The Standards also point to the tensions between care and control – mealtimes being positive and social could, on the one hand, mean the priority is that young people and the workers are comfortable with one another while their physical needs for sustenance are being met. On the other hand stipulating this requirement in a Standard suggests that social mealtimes may not occur without regulation from the authorities.

So the ideal appears to be that the resident group should be sitting at the table. But what are they eating? Even though the regulation states that an appetising and nutritious diet should be provided nowhere within the literature is there any mention of what such a diet may be. In Britain the Caroline Walker Trust (CWT) produced a guide: *Eating Well for Looked After Children and Young People* (2001) to provide nutritional and practical guidelines for people working in residential and foster care. CWT recognised that while many aspects of children and young people's care was regulated, there were no guidelines 'to enable the nutritional quality of the food to be monitored'. This suggests that CWT believe that food in residential care is under-regulated and in need of greater surveillance. For McIntosh et al. (2010: 297) residential care centres are 'regulated spaces where control and surveillance are the norm'. They found 'surveillance within an institutional context can be subverted and resisted' by the young people and the workers and the young people have ambivalent relations 'towards surveillance practices in relation to food' (ibid: 301).

McIntosh et al. (2010), Dorrer et al. (2011), Punch et al. (2011) and McManus and Morrison (2009) in their studies into food practices within residential child care in Scotland raise the question of flexible and alternative eating arrangements. The children and young people do not think that they should

always eat at the dining table and that if they were at home they could eat where, when and what they like. The staff, on the other hand, say that mealtimes around the dining table is an opportunity to produce a 'homely' feel to the centre. There is an assumption here that the workers, through their hierarchical position as both workers and adults, overrule the young people. According to Dorrer et al. (2011) the rigid and inflexible food practices may result in contributing to the institutionalisation of the centres.

The Standards in Ireland require that residential care workers' meal breaks are taken with the children and young people. So mealtimes are not a 'break' as they would be for the majority of workers in other occupations. Sitting at the dining table for residential care workers entails: eating the same food as the residents, being a positive role model around food, encouraging good table manners and being social. Sharing meals with clients is not expected of the workers in the majority of 24-hour care facilities for example - residential care for older people or hospitals. However, recognition of the social aspect of working in the young people's living space is a particular feature of both the North American approach of Child and Youth Care (CYC) and the Northern European tradition of social pedagogy. The social aspect is an important, and for some social care practitioners the key element, of social care practitioners' work in Ireland. Lalor and Share (2013) suggest that it is the ordinary and informal activities of everyday life that provide opportunities for relationships to be developed between the workers and the young people.

Another consideration is, in providing this appetising and nutritious diet, who is doing the cooking? Not all residential centres employ a chef and, even if they do, they will not work seven days a week so the residential child care workers on a rota basis will do the cooking. Not everyone enjoys cooking or is adept at it so cooking may be seen as a chore.

In 2005 Gallagher received much media attention for her article 'Too clever to care' when the level of nurses' qualifications were said to be standing in the way of performing personal care tasks for patients. Smith (2009) suggests that a similar situation may be occurring within residential care for young people and one result of the professionalization of residential care work is that too

many workers want to be involved in therapeutic interventions, while too few want to get involved with the everyday care. This suggests that there may be a hierarchy of care work and it may be assumed that this could impact on social care practitioners' preparedness to cook or clean.

The Draft Standards (HIQA 2010) suggest that young people should participate in cooking, cleaning and other domestic chores to assist developing life skills. Save the Children (Hobbiss 1998) published a report on young people who had recently left residential care and their experiences in relation to food. They suggested that young people leaving care in the UK did not feel they had adequate preparation to live independently, especially with cooking and shopping skills. The young people questioned said their involvement with the preparation of meals was: table laying, washing up or vegetable preparation. Reasons for the young people's minor involvement may include: the employment of a professional chef or health and safety regulations restricting access to the kitchen. McIntosh et al. (2010: 294) reflecting on the organisation of food provision in the residential centres in Scotland found that the kitchen 'was subject to a panoply of health and safety regulation and elevated levels of supervision and surveillance'. The national advocacy service for young people in care EPIC (Daly 2012) report some progress has been made in Ireland and the number of young people considered to have adequate skills to live independently has increased in recent years.

HIQA is the Authority responsible for the registration and inspection of residential centres for children and young people. HIQA is an independent Authority and advises the Minister of Child and Youth Affairs and the CFA as to the level of compliance with the National Standards. To promote confidence and inform the public they publish the findings of their inspections online. To establish how HIQA monitors food and eating practices I reviewed the first 20 reports dating from October 2013 - June 2014. The reports show that the standard for the provision of food and cooking facilities is not always reported. The inspectors did not comment on food and cooking facilities in half of those reports. The following statements reflect a selection of their comments on the centres inspected. The first statement is an inspector's conversation with a young person enquiring if standards are being met:

The young person at the unit told inspectors that they were happy with the food available and that their preferences are taken into account when planning menus. Inspectors found that there was fruit, snacks and drinks available to young people at all times.

The following statement shows that the inspectors judge if the environment is domestic in nature. I should note here that the Draft National Standards (2010) that require a homely environment are still draft, therefore the inspectors are not monitoring for compliance with homeliness as yet:

The kitchen and dining area was similar to that of a family home and was domestic in design and furnishings.

I was interested in how the inspectors judged the food and looked for references to them eating with the young people and workers. The statement below shows that the inspectors do eat with the resident group during the inspection. There were also references to the atmosphere at the table and generally the comments were that the mealtimes were positive social occasions:

Inspectors joined them for lunch on one of the days. The food was wholesome and nutritious.

The inspectors also reported on the monitoring of young people's food and eating practices and, as seen in the statements below, they also show an interest in the workers' eating habits:

Inspectors found that the monitoring of the dietary intake of young people required improvement.

One unit manager told inspectors that she monitored staff to ensure that they role modelled healthy eating habits for the young people at the unit.

The HIQA inspection can be either announced or unannounced. After reading the statement below I double-checked and this inspection had been unannounced:

The children told the inspector that they liked to cook, especially baking cakes and the inspector saw the lovely cakes they baked for the staff team the evening prior to the inspection.

On the whole, the inspection reports, when food and cooking facilities are

referred to, are positive. The inspectors look for the Standards being met and report: that a sufficient quantity of healthy and nutritious food is on offer; that mealtimes are positive social events; that young people are consulted on menu choice and if the young people are not consuming the healthy food on offer they recommend that the workers monitor the situation. Reading, the inspection reports indicate that food is not high on the inspectors' list of priorities. Further investigation into how the inspectors judge compliance with food and eating practices would be beneficial to understanding how the National Standards are interpreted by HIQA inspectors.

3.11 Conclusion

This study set out to elicit the significance of food and eating practices in Irish children's residential care settings. Focusing on the table, it explores aspects of everyday life in residential care centres. The literature review began with the introduction of the metaphorical table as a means to introduce the theoretical concepts of commensality, hierarchy, discipline and government. Those theoretical concepts have guided the data collection throughout the first three chapters. Chapter two discussed selected themes on the sociology of food and where children feature within that literature and focused on three areas: children's subordinate position to adults, how children are inculcated into the foodways of their culture and concerns about children's health in relation to food.

Chapter three provided a history of residential state care for children and young people from 1703 to the present day with a specific focus on food and eating practices. Using food and eating practices to view this history has shown that from 1703 until the 1970s children in residential state care in Ireland were very often hungry. Everyday life in the industrial and reformatory schools is well documented by the CICA (2009) and in biographical accounts of life in the schools (for example: Touher 1991; Fahy 1999). Children living in the industrial and reformatory schools were part of a strictly controlled regime described in some of the schools prior to the 1970s as: Mass, work, breakfast, school, lunch, work, supper and bed. Play and recreation were described as peripheral to everyday life (CICA Vol. 3 2009).

Residential care has become more domestic in nature and strives to remove itself from association with the institutional care of the past. The Kennedy Report (1970) was a critical point in residential care in Ireland. The report reflected the changing attitudes to children and transformed alternative care for children resulting in their being 'cared for' in 'homelike' environments. In contemporary practice relationship building between workers and young people is recognised as being central to residential care services. Those relationships are created and recreated by the routines, rhythms and rituals of daily life in the centres.

The exploration of what care means in residential care highlighted doing care is something that is difficult to define because, for the people who give and receive care, it can be a contested concept. To further develop an understanding and definition of care I use the feminist ethics of care and found that care struggles to be acknowledged in the justice dominated practices of residential care. Today young people in need of residential care are accommodated in community based 'homely' homes but home is also a complex concept. The meaning of homeliness is shaped by social norms and values but also personal preferences. Further confusing the concept of home in residential care is that it is the young people's home and the workers work space.

Reviewing food and eating practices this research shows that children have eaten at a table in residential care throughout its history but they did not necessarily enjoy the food or the company. Eating at the table, or commensality, remains a highly regarded aspiration of the regulators and the workers in residential care centres today. Children in the past ate under the surveillance of the nuns and brothers and eating quickly and quietly would have been the order of the day. There remains a high degree of surveillance within residential care at present but it is administered with a lighter hand. The hierarchical regime of food practices in the industrial and reformatory schools was evident and adults generally got better quality food than the children. In addition, children had no say in what they were given to eat. Today HIQA inspectors can quantify the young people's input into menu choice. In the past discipline during mealtimes ranged from public beatings to being forced to

stay at the table until the uneaten food was eaten. At present, not being allowed to eat anywhere but the table may be as far as the discipline of food and eating practices extends. Government within the schools was apparent in the strict regimes of control, regulation and punishment. The literature indicates that today there is a semblance of freedom of choice in the food and eating practices for the workers and the young people in the daily life in residential care. A notable absence from the literature reviewed is an understanding of everyday life in residential care today in Ireland not least in terms of food and eating.

In the following chapter the methodological approach taken for this study is presented. A mixed methods design has been chosen as the most appropriate method to elicit the significance of food and eating practices in residential care centres for young people in Ireland. The chapter discusses mixed methods as the emergent third research paradigm that is underpinned by pragmatism.

Chapter Four: Methodology

4.1 Introduction

Mixed methods is the chosen methodological approach for my research. This chapter draws on the relevant literature to support this approach. I begin with an exploration of mixed methods research. Mixed methods is a relatively recent addition to the range of social research paradigms therefore a discussion of its progression, some of the internal debates between mixed methods scholars and a number of strengths and weaknesses are presented. Finally justifications for applying mixed methods to my research are identified.

This project uses a mixed methods approach to elicit the significance of food and eating practices in residential care centres for young people in Ireland. According to Giddings (2006: 198) ‘methodology guides how a researcher frames the research question, and decides on the process and methods to use’. The method is similar to a recipe in that it shows how you get to the finished product. This mixed methods project uses qualitative and quantitative methods: focused ethnography in five residential care centres, a quantitative survey of 92 workers employed in residential care and photo-elicitation with a further 43 social care professionals. By using both qualitative and quantitative approaches I will attempt to bridge the epistemological divide between the two dominant research paradigms and produce a fuller understanding of the significance of food and eating practices in residential care settings for young people.

4.2 Mixed methods

Mixed methods is defined by Creswell and Plano Clark (2011) as collecting, analysing and mixing qualitative and quantitative data in a single study to provide a better understanding of research problems. Mixed methods offers a pragmatic approach to research and broadly speaking is a mixing of the two dominant research paradigms. Mixed methods research is an emergent methodological movement within social science research. Plano Clark et al. (2008: 364) suggest that while researchers have been debating and employing multiple methods in studies for many years, only recently has mixed methods

been viewed as ‘a unique research approach that has philosophical foundations’. Mixed methods is referred to as the ‘*third wave* or third research movement’ (Johnson and Onwuegbuzie 2004:17) and has increased in popularity since the turn of the millennium. Interest began to grow in this research paradigm in the late 1980s, which saw the beginning of influential works being published (Gage 1989; Greene et al. 1989; Johnson and Onwuegbuzie 2004; Denscombe 2008; Teddlie and Tashakkori 2009; Tashakkori and Teddlie 2003, 2010; Hesse-Biber 2010; Feilzer 2010; Creswell and Plano Clark 2011). The mixed methods community are in agreement that this emergent method was born as a result of the paradigm wars. Cameron and Miller (2007) suggest that out of the struggle for primacy between the two dominant paradigms mixed methods arose like the phoenix to become the third methodological movement.

4.2.1 Paradigm wars

Johnson and Gray (2010) maintain the paradigm wars are not a new phenomenon and have their roots in ancient philosophy. Debate, then as today, ‘continues and affects how we view knowledge, what we look for and what we expect to find’ (Johnson et al. 2007: 113). According to Denzin (2010) there have been at least three paradigm wars between 1970 and the present. The first concerning postpositivists and positivists (1970 – 1990) marked the end of positivism’s ascendancy. The second war was between postpositivists, constructivists and critical theory paradigms (1990 – 2005) and involved debates over which paradigm was more revolutionary or more empowering. This war left an opening for new debates about paradigm superiority. The third and current war (2005 – present), according to Denzin (2010), is between evidence-based methodologists and the mixed methods, interpretive and critical theory schools. In this era a pragmatic ‘what works’ approach of using both quantitative and qualitative methods in the same empirical research has become acceptable. This war, Denzin maintains, has left an opening for the evidence-based research movement to enter the fray as arguments on the reliability of mixed methods continues.

According to Teddlie and Tashakkori (2009: 804) mixed methods is the result of ‘a judicious rejection of the false dichotomy between the two dominant research communities’ - qualitative and quantitative. It has also been argued that mixed methods transcends the paradigm wars and offers a logical and practical alternative (Johnson and Onwuegbuzie 2004; Teddlie and Tashakkori 2009; Feilzer 2010; Creswell and Plano Clark 2011). Despite these discussions on mixed method research, strategies continue to be framed by the qualitative/quantitative dichotomy suggesting transcendence has yet to be completed. Discussing paradigm differences within mixed methods, Harrits (2011: 151) argues that the paradigm wars are positioned both externally and internally to mixed methods research because qualitative and quantitative paradigms are ‘involved in the ways MMR [mixed methods research] is justified and carried out’. Mixed methods, according to Sandelowski (2013), has established a new binary between mixed and mono method research while at the same time reinforcing the qualitative and quantitative divide.

While Denzin (2010) maintains that paradigm wars continue, Warde (2014: 55) argues that ‘confidence in the incommensurability thesis has declined’ resulting in mixed methods evolving into an established design structure and as such there is internal debate within the mixed methods community as to its future direction.

4.2.2 Internal debates within the mixed methods community

The recent growth in mixed methods research has resulted in critical commentary within the mixed methods community (Mason 2006; Giddings 2006; Giddings and Grant 2007; Symonds and Gorard 2008; Sandelowski 2013). Creswell (2011) identified that debate not only centres on philosophical and theoretical issues but includes the changing and expanding definitions of mixed methods research and concerns for what drives the increasing interest in this method.

One such debate centres on the construction of an alternative framework that accommodates both qualitative and quantitative world views equally. Feilzer (2010: 7) maintains that there is some disagreement amongst mixed method researchers as to what their alternative framework should be. Mason (2006:

10) maintains that there is limited methodological debate as to the ‘theoretical underpinnings and implications’ of mixed method research strategies. She makes a case for mixing methods in a qualitative driven way to move beyond the paradigm stalemate and find effective, creative and innovative research to transform our ways of seeing and asking questions about the social world. Symonds and Gorard (2008) argue that mixed methods’ logical underpinnings are founded in philosophy rather than in empirical reality. They suggest that creating mixed methods as a third paradigm may be a fallacy because the construct validity of mixed methods can only ‘hold true for those researchers who are philosophically committed to bipolar paradigms’ (Symonds and Gorard 2008: 10). There is also unease that mixed methods privileges the quantitative paradigm (Hesse-Biber 2010; Creswell 2013). Giddings and Grant (2007: 52) are concerned that mixed methods could become ‘a Trojan Horse for positivism’. They are concerned that mixed methods could serve to maintain the marginalisation of non-positivist research methodologies.

Mixed methods research continues to grow in popularity and is currently favoured by government and research funders. Gage (1989) argued that the paradigm wars were not merely intellectual disagreements but an attempt to gain a greater share of research funds. A critique of mixed methods by Giddings (2006: 196), who describes herself as an enthusiastic supporter of the method since 1999, suggests that mixed methods fits well within the current economic climate that requires researchers ‘to do more for less’ and funding agencies support pragmatic mixed methods because ‘they take less specific methodological expertise, take less time, and when compared with qualitative research, produces more generalizable findings’ (ibid: 201). Giddings and Grant (2007) argue that the potential for mixed methods research to establish itself as a powerful form of research inquiry that offers rich and contradictory findings may be lost if a critical deciding factor of methodological choice is to win funding.

Notwithstanding - and perhaps resulting from - these internal debates, mixed methods has developed over the past few decades as an approach with its own journals, textbooks and conferences. Denscombe (2008: 170-283) maintains that mixed methods research ‘has evolved to the point where it has a separate

methodological orientation with its own worldview, vocabulary and techniques’.

4.2.3 Unpacking the ‘mixed’ in mixed methods

Mixed methods is considered emancipatory as it purportedly welcomes ‘all legitimate methodological traditions’ (Greene 2005: 207). The term *mixed* in mixed methods is used in a variety of ways to refer to combinations of research elements. Creswell and Plano Clark (2011) present an argument that collecting, analysing and mixing qualitative and quantitative data in a single study provides a better understanding of research problems. According to Denscombe (2008) researchers also use mixed method to: improve the accuracy of their data, to compensate for strengths or weaknesses associated with one of the methods, to develop analysis by building on initial findings or to aid sampling.

Tashakkori and Teddlie (2003) suggest that identifying the basic procedures for using qualitative and quantitative elements in a single study is one of the most complex and controversial issues in the mixed methods community. In 2003 they identified 40 types of mixed methods designs. It can be assumed that the number may have increased in the past decade. Johnson et al. (2007: 118) identified 19 separate definitions. They found that in 15 of the 19 definitions ‘quantitative research and qualitative research is *what is mixed*’ (italics in original) and it is where and when the mixing occurs that has to be considered. Figure 13 (Johnson et al. 2007) illustrates the continuum of the three paradigms and the subtypes of mixed methods research.

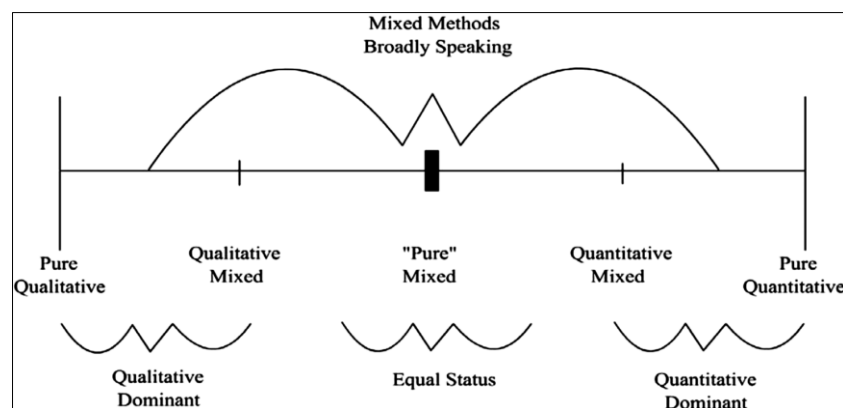


FIGURE 13 MAJOR RESEARCH PARADIGMS AND SUBTYPES OF MIXED METHODS RESEARCH

Creswell and Plano Clark (2011) have produced a textbook on designing and conducting mixed methods research but they do not present a fixed design for mixed methods so the mixing of the methods can occur at any or all stages. Therefore they could be positioned at any of the central points on the continuum in Figure 13. Tashakkori and Teddlie (2003: xi) on the other hand advocate that ‘a truly mixed approach methodology would incorporate multiple approaches at all stages’. They could be positioned at the pure/equal status point in Figure 13. Morgan (2007: 71) suggests that different approaches to theory and data should not be limited and ‘a more interesting option is to explore the potential for working back and forth between the kinds of knowledge produced by both qualitative and quantitative research’. Morgan (2007) for the purpose of this illustration could be positioned at either the qualitative or quantitative dominant points on the continuum.

Mason (2006: 20) argues ‘if the social world is multi-dimensional, then surely our explanations need to be likewise’. She maintains that the mixing of methods and data requires one primary theory or set of questions, and one logical philosophy to assemble the pieces to produce ‘the picture’. For researchers choosing mixed methods tensions may be created in the attempt to mix different philosophical positions or paradigms (Greene, 2007). The four dominant paradigms are postpositivism, constructivism, transformative and pragmatism. Pragmatism has gained considerable support as a stance for mixed methods researchers (Feilzer, 2010; Denscombe 2008; Morgan, 2007; Johnson & Onwuegbuzie, 2004; Tashakkori and Teddlie 2003).

4.2.4 Pragmatic approach

A pragmatist, according to Leckenby and Hesse-Biber (2007: 269), should, instead of looking at the problem from their individual epistemological standpoint, look instead to the research question and the ‘best method or methods’ to solve the problem. Pragmatism is not new to the social sciences. It was influenced by North American Philosophy and in particular John Dewey and William James in the late nineteenth century. The pragmatic method, according to James (1907) is to try and interpret an idea by tracing its

corresponding practical consequences. Pragmatism has been viewed as being practical rather than contemplative (Russell 1946: 42).

Pragmatism is a response to the either/or choices associated with the paradigm wars. However, mixed methods creates another choice, because it is presented as the third paradigm it is considered as one of only three viable options for doing research (Dellinger and Leech 2007; Symonds and Gorard 2010). Mixed methods researchers agree that the dividing lines between the qualitative and quantitative paradigms are more blurred 'than typically suggested and that antagonism between paradigms is unproductive' (Johnson et al. 2007: 117). These arguments suggest that by employing mixed methods researchers do not have to choose between the dominant paradigms and they should leave their options open as to what works best.

According to Denscombe (2008: 273) pragmatism can be identified in four separate ways: a fusion approach; the third alternative; a new orthodoxy or expedient. The *fusion approach* seeks to challenge the unproductive dualism of the paradigm wars. The *third alternative* is seen as an additional option for researchers who believe that their problem cannot be solved by using quantitative or qualitative approaches alone. A *new orthodoxy* stems from the belief that it is not only allowable to mix methods but that it is 'desirable to do so'. Finally within an *expedient* approach, according to Denscombe and similar to Giddings (2006), there is a danger of mixed methods being associated with expediency - 'there is a common sense use of the word pragmatic which implies a certain lack of principles underlying a course of action' (Denscombe (2008: 274). He stresses that this is not the philosophical meaning of pragmatism that should be associated with mixed methods.

Brannen (2005: 7) views the choice of methods as 'being driven by philosophical assumptions, pragmatism and politics'. The relationship between the researcher and the research process is complex. The researcher has to reflect on his/her decision to carry out the research in the first place and the decision making processes in how the research is done. 'All research is interpretive' (Cameron 2011: 100) so methodological choice does not exist in a philosophical vacuum but is guided by the researcher's individual

worldview. Cameron suggests that it is important that the paradigms upon which the research is based should be fully understood and made clear. This exercise requires the researcher to examine their personal assumptions and theories. Creswell and Plano Clark (2011) recommend that a mixed methods researcher should state whether or not they have a theoretical stance. As a social scientist I am both familiar and comfortable in the qualitative theoretical position. Therefore this mixed methods study will be weighted towards the qualitative paradigm.

4.2.5 Qualitative approach

... [Q]ualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them (Denzin and Lincoln 2014: 3).

Qualitative research offers a variety of approaches and focused ethnography is the selected method for this study. Traditional ethnographies study the behaviour of people in their natural environment rather than under experimental conditions. The researcher spends protracted periods of time in the field and over time a complex and nuanced picture of the culture develops. Fieldwork commences with emerging theories of what to observe and builds those theories with the data collected in the field. This method explores rather than tests social phenomena. The method is inductive with concern for the production of 'thick' descriptions using an interactive process. A thick description of a social event takes into account not only what is seen but the context and experience that makes the event meaningful. Researchers interpret what is meaningful to the participants and themselves therefore 'what we call our data are really our own constructions of other people's constructions of what they and their compatriots are up to' (Geertz 1973: 9 cited by James 2001: 247). The researcher is personally involved, observes, questions and uses theoretical purposive sampling to fit the specific research problem.

Focused ethnographies differ from conventional ethnological ethnography because they are practised in one's own culture and focus on specific parts of it. The introduction and definition of focused ethnography is credited to Knoblauch (2001 published in English 2005). Focused ethnography is typified

by and illustrated below in Figure 14: short-term field visits, a preconceived research question by a researcher with insider or background knowledge of the cultural group and intensive methods of data collection such as video or audio recording (Wall 2015; Kühn 2013; Higgenbottom et al. 2013; Knoblauch 2005). Focused ethnography does not attempt to study the entire social field the researcher focuses on an individual part (Kühn 2013).

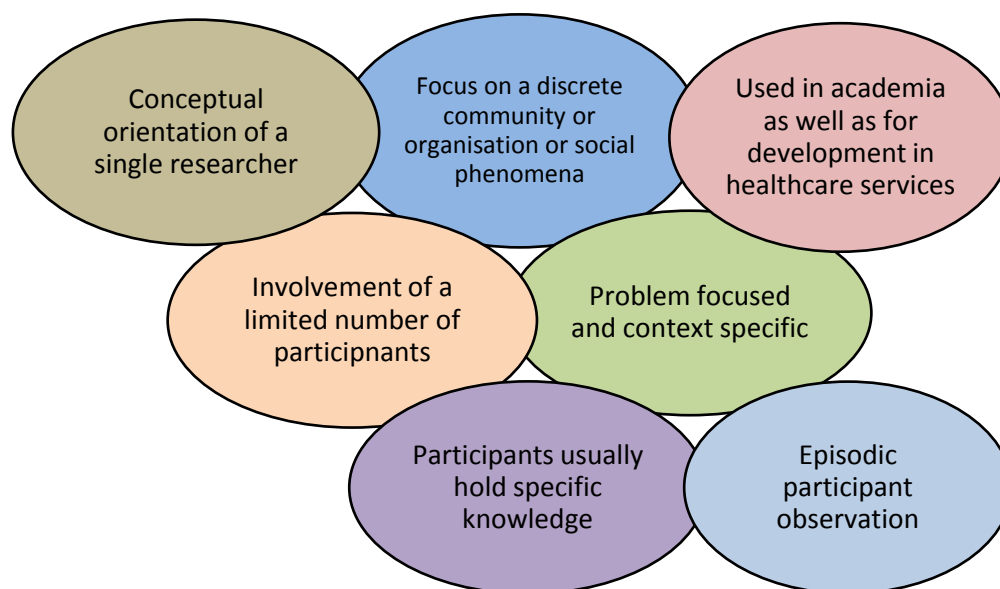


FIGURE 14 CHARACTERISTICS OF FOCUSED ETHNOGRAPHIES

Original source: Higginbottom et al. (2013 adapted from Muecke 1994)

In this case I do not attempt to portray a complete picture of residential care for young people in Ireland. I focus on the one particular aspect - the food and eating practices at the table. According to Wall (2015: 3) focused ethnography is primarily used in practice-based disciplines such as nursing and health research ‘as a pragmatic and effective way to capture specific cultural perspectives’. It is often used for collecting specific information in settings where active participation is difficult, for example hospitals (Higginbottom et al. 2013). Focused ethnography is appropriate when conducting social research in diverse or specialised fields of study (Wall 2015; Knoblauch 2005). A residential care centre is such a field of study.

According to Kühn (2013: 2) focused ethnography may appear to be a quick and easy method to implement, however ‘a deep engagement with ethnographic method and ethnographic research-norms’ must be addressed before the study commences. Criticisms of ethnographic studies point to the potential lack of objectivity of the researcher and the difficulty of maintaining status as an independent observer. In qualitative research designs ‘the researcher is the main instrument of data collection’ (Bryman and Bell 2007: 423). Denzin and Lincoln (2014: 416) suggest that all observation involves to some degree the participation of the researcher and therefore there is ‘no pure, objective and detached observation’. The received positivist view is that the researcher should not influence the phenomenon observed or vice versa (Guba and Lincoln 1994; Silverman 2011). Monahan and Fisher (2011) maintain that it is a popular misconception that quantitative methods are less biased or more objective than qualitative methods. Observers from both communities ‘have powerful effects on the ability to measure and interpret the world’. Therefore, the observers’ presence should not be disregarded, as all knowledge is subject to the interests of the scientists creating it.

4.2.6 Quantitative approach

Quantitative research is associated with positivism that dominated the philosophy of science during the twentieth century. Positivism, amongst many other things, is concerned with variables. It aims to explain cause and effect relationships by testing hypotheses and theories using data produced numerically by measuring, counting and/or scaling. Its methods are standardized and structured. The researcher, it is assumed, remains neutral and uses probabilistic large scale sampling. The results can be generalized and are easily replicated. Critiques of quantitative methods include the assumption that facts are true and the same for all people all of the time (Silverman 2014). Quantitative methods may also fail to take account of people's individual capacity to interpret their experiences, construct their own meanings and act on these.

Quantitative methods work well for research objectives that require objective measurement such as people's attitudes with regard to food and eating habits. Questionnaires, according to Miller and Deutsch (2009: 120), are 'one of the most widely used and most useful quantitative methods in food studies. Self-administered questionnaires and food frequency questionnaires have been used extensively in data collection on children, young people and adults' eating habits in Ireland (IUNA Surveys: National Teens 2006, Children's 2004 and Adults Nutrition 2011; Kiely et al. 2011; Growing Up in Ireland 2012).

Questionnaires are a convenient and inexpensive way to accumulate large amounts of data in a short amount of time. An extensive geographical area can be covered, they offer greater assurance of anonymity and results can be processed quickly. Criticisms of questionnaires include, due to data not being collected at the individual level, there is no opportunity for clarification of questions or responses. Self-reported data, according to Miller and Deutsch (2009), may be impeded by the presence of social desirability or social approval. However, a respondent's desire to avoid criticism or gain approval may be evident in most data collection methods.

4.2.7 Reflexivity

Reflexivity is a term used in research methodology that refers to 'a reflectiveness among social researchers about the implications for the knowledge of the social world they generate' (Bryman 2008: 698). According to Hertz (1996: 5) reflexivity developed out of a change in our understanding of data and its collection.

The reflexive ethnographer does not simply report "facts" or "truths" but actively constructs interpretations of her experiences in the field (Hertz 1996: 5).

According to Reed-Danahay (2007) there is an increasing emphasis for self-disclosure and self-display within the written text. Reflexivity recognises that the researcher and his or her language are inevitably part of the phenomenon that is under investigation (Spencer 2007; Finlay 2002). When researchers practice reflexivity it allows them to reflect on how their research agenda may affect all stages of the research process (Hesse-Biber and Johnson 2015). Why

a particular design appeals or why you may be attracted to some themes during data analysis and not others.

Berger (2013) suggests that reflexivity has become a crucial strategy in the process of generating knowledge through qualitative research. Hesse-Biber (2010: 29) maintains that reflexivity also plays a critical role in mixed methods research. She recommends that before embarking on a mixed methods venture the researcher should consider their own research assumptions in addition to what values, attitudes and concerns they bring to the project. As stated I am drawn to and more comfortable with qualitative research. I am interested in 'the complexity, variation and multifacetedness of the social world' (Hesse-Biber 2010: 32) a view of social reality that is difficult to capture using quantitative methods. I am also a pragmatist and as such looked beyond qualitative methods to answer the research problem.

Reflexivity involves positioning the researcher in the research (Hesse-Biber and Johnson 2015) because the researcher's identity, perspectives, experiences and values have influence at every stage of the process. According to Hesse-Biber and Johnson (2015: 151) because 'scientific practice is a human practice' it is vulnerable 'to failing, error and mistakes'. They maintain that scholars should have a responsibility 'to account for themselves' and using reflexivity can therefore be viewed as an ethical exercise.

There are varying ways that reflexivity can be used in practice. Daly (2008: 188) suggests that at a general level reflexivity is 'concerned with examining and monitoring the role we play in shaping research outcome'. According to Finlay (2002: 532) being reflexive in practice is difficult because it is loaded with 'ambiguity and uncertainty' due to the thin line between personal disclosure and excessive self-analysis. Reflexivity, according to Daly (2008), begins from the principle that the researcher's personal and professional experience needs to be acknowledged as life experience affects the research process. Reflective self-awareness, according to Muncey (2010), is fundamental to being human because we can adopt different perspectives towards ourselves by standing back and reflecting. Individuals exist in multiple identities that are not fixed in terms of what it means to be a

researcher. A researcher's identity, according to Daly (2008: 190), 'is something that is interactively created in the research setting'. Reflexivity raises our awareness of changing identities.

Hanrahan (2003) suggests that objectivity in research is still apparent, especially when it comes to academic writing. Lincoln et al. (2014: 123) maintain that ethnographers schooled in positivist inquiry find it difficult to position themselves 'deliberately and squarely within their text'. There is an expectation that academic writing should be impersonal and authoritative (Hanrahan 2003). The voice of the author is often absent in academic writing and presented in the third person. Conversely, Geertz (1988 cited by Lincoln et al. 2014) argues 'the authorial voice is rarely genuinely absent, or hidden'. Hertz (1996: 7) discusses the struggle of how to present the author's voice. She proposes that there are three possible voices within the written text: one being the voice of the author, the second being the presentation of the participants voice and the third being when the self (the author) is the subject of the research. I decided to use the first person singular in this thesis to demonstrate that the knowledge presented is not objective but subject to my interpretation and analysis. I am not the subject of this research but the text includes references to my sense of what was happening and personal experiences. Fonow and Cook (2005: 2219) claim that:

Reflexivity has come to mean the way researchers consciously write themselves into the text, the audience's reactions to and reflections on the meaning of the research, the social location of the researcher and the analysis of disciplines as sites of knowledge.

Discussions of reflexivity draw attention to the importance of 'recognising the social location of the researcher' (for example Hertz 1996; Finlay 2002; Nencel 2014). As a Northern Irish Catholic working class woman who grew up during the height of the conflict, I am challenged by pinning my colours to the mast. However, that background raised my awareness that structures of equality exist and directed me towards feminism and socialism from a young age. I am aware that my biography affected my choice of academic texts that has guided this research.

Using reflexivity to view how my position has impacted on this research: first I am a social care practitioner who believes that research is a powerful tool that can give a voice to marginalised groups: in this case people who live and work in residential care. Second I am a sociologist with an awareness of some of the issues and challenges of feeding people that lead to explore the practicalities of food in residential care. Third I am a chef with a deep interest in the sociology of food which influenced the process and drew me towards the social aspects of food and eating practices.

Reflexivity can, as Finlay (2002: 541) maintains, ‘give voice to those who are normally silenced’. That could also refer to me as a novice researcher. I undertook this research for several reasons, including: *pragmatic* - to conclude the requirements for a PhD, *empirical* - to contribute to the knowledge and understanding to the research problem and *intellectual* - to learn how sociological knowledge is created. Reflexivity has enhanced my epistemological awareness that personal experiences impact on research. By positioning myself in the text I have found my voice and identity as a researcher.

4.2.8 Strengths and weaknesses of mixed methods

Mixed methods has been heralded as the approach that offers ‘the best of both worlds’ (Giddings 2006: 195) but like the qualitative and quantitative approaches there are advantages and disadvantages to using this method. Johnson and Onwuegbuzie (2004: 21) identified some of these that are presented in Table 3 below.

TABLE 3 STRENGTHS AND WEAKNESSES OF MIXED METHODS

| Strengths | Weaknesses |
|---|--|
| Can answer a broader and more complete range of research questions because the researcher is not confined to a single method or approach. | Can be difficult for a single researcher to carry out both qualitative and quantitative research, especially if two or more approaches are expected to be done concurrently. |
| Use the strengths of an additional method to overcome the weaknesses in another method by using both in a research study. | The researcher has to learn about multiple methods and approaches and understand how to appropriately mix them. |

| | |
|--|--|
| Can provide stronger evidence for a conclusion through convergence and corroboration of findings (this is the principle of triangulation). | Methodological purists contend that one should always work within either a qualitative or a quantitative paradigm. |
| Can add insights and understanding that might be missed when only a single method is used. | Can be more expensive. |
| Can be used to increase the generalizability of the results. | Can be more time consuming |
| Qualitative and quantitative research used together produces more complete knowledge necessary to inform theory and practice | Some of the details of mixed research remain to be fully worked out by research methodologists (e.g., problems of paradigm mixing, how to qualitatively analyse quantitative data, how to interpret conflicting results) |

Table 3 demonstrates some of the advantages and disadvantages voiced from within the mixed methods community. Further criticism of mixed methods includes the argument that it is not a new paradigm but for all intents and purpose triangulation. Triangulation also uses multiple data sources in the same study and has been employed by social science researchers for decades (Johnson et al. 2007). Some mixed methods researchers, according to Moran-Ellis et al. (2006), avoid the language triangulation. One reason is that triangulation is associated with validation purposes and therefore has an underlying positivist view (Giddings and Grant 2007; Hesse-Biber 2010).

Commonly voiced criticism of mixed methods research, by qualitative researchers, according to Driscoll et al. (2007: 25), is that when qualitative data is mixed with quantitative data it can lose ‘depth and flexibility’. They also contend that quantitative researchers challenge mixed methods on ‘the limitations of qualitative data for statistical measurement’. In addition they suggest quantitative researchers challenge mixed methods on small sample size ‘prospective mixed methods researchers should be aware of the sample size required to provide sufficient statistical power for the study question’ (Driscoll et al. 2007: 25).

4.3 Rationale for using mixed methods

My rationale for using mixed methods is based on the nature of the research problem. Residential care centres are complex spaces where home, work and institution overlap (Peace and Holland 2001; McIntosh et al. 2010; Dorrer et al. 2011; Clark 2014). Not unlike other living spaces there is a multiplicity of lives being lived. From a traditional ethnographic position to truly experience that life would entail living in the centre (see Emond 2000). However this, due to the limited access to the centres, was not an option for this study. From a qualitative perspective a survey would not have provided the rounded picture that I desired. My approach was derived from a series of compromises within a series of ideals. My decision to use mixed methods is a pragmatic one. As Leckenby and Hesse-Biber (2007) suggest, a researcher needs to look beyond their individual standpoint, in my case qualitative, and look at the best method or methods to solve the research problem.

To help identify the most appropriate method to investigate the research question I draw on selected empirical and theoretical literature of previous research. To guide this methodological review I concentrated on studies involving young people, food and/or residential care. This project is situated within the field of food studies that is defined by Miller and Deutsch (2009: 4) as ‘the study of people’s relationships with food’. Bentley (2011) suggests that food studies tend to be situated within the qualitative-orientated humanities rather than the quantitative driven food science and nutrition fields. Food studies employ a variety of methods. Food, according to Miller and Deutsch (2009), can be used to enhance traditional methods while some methods such as food diaries, food frequency questionnaires or *charlas culinarias* (food chats) are used exclusively within food studies. Frequently used methods within these studies include focus groups, participant observation and surveys.

Focus groups are a frequently deployed data collection method in studies concerned with young people’s food and eating practices (McKinley et al. 2005; Stevenson et al. 2007; Kearney et al. 2008; Share 2008). McManus and Morrison (2009) conducted a consultation with young people living in residential care to capture their views on food and nutrition related issues.

They conducted focus groups with fifty-one young people aged 10-18. The consultation was carried out on behalf of Who Cares Scotland, at the behest of the Scottish Government. Focus groups were chosen because they are both cost and time efficient.

Another example of the use of a focus group is to be found in the research of Kneafsey et al. (2010) who conducted a consultation on behalf of HIQA into young people's experiences of HIQA inspections while living in care.

Hennessy and Heary (2005) suggest that focus groups are advantageous to gathering information on children's views and experiences because the group provides a familiar peer environment for children. Focus groups also have the advantage that the researcher can avoid the child protection issue of one-to-one contact with an individual child.

A study using observational techniques is that of Punch et al. (2009). They researched the food practices in residential children's care in three centres in Scotland. Their qualitative study involved a year-long data collection period consisting of three-month blocks of semi-participant observations. One of the researchers (Dorrer) stayed in the centres for three to six days per week, including some overnights. They also conducted 12 group and 49 individual interviews. Their sample consisted of 16 young people and 42 adults. Punch et al. (2009) provide a broad view of the significance of the role of food in residential care for young people in Scotland.

The comprehensive study of everyday life in residential care in Ireland, *Lives in Care* (Clarke 1998), involving a review of issues, policy and practice in the Sisters of Mercy children's homes, was conducted by the Mercy Congregation and the Children's Research Centre. This study was located in 16 centres with 100 children and 144 workers. Clarke (1998: 16) used 'a range of complementary methods involving both qualitative and quantitative approaches'. The qualitative approaches included participant observation and semi-structured interviews. The quantitative approach involved a questionnaire for the young people and a demographic census. The data was collected during a two day visit to each of the centres. Clarke's study did not concentrate on food practices but did recognise that food was central to

comfort, welcome and hospitality in the centres. Clarke's choice of methods provided a clear and concise representation of everyday life in the centres.

According to Miller and Deutsch (2009: 120) a survey is one of the most frequently used and a most useful quantitative method in food studies. Food surveys consisting of: self-administered questionnaires, food frequency questionnaires, food diaries and/or structured interviews have been used extensively in data collection on children, young people and adults' eating habits in Ireland (IUNA Surveys: National Teens 2006, Children's 2004 and Adults Nutrition 2011; Kiely et al. 2011; Growing Up in Ireland 2012).

The frequently used methods of focus groups, observation and surveys were considered at the design stage of this project. Focus groups was not feasible for this study. The logistics required in assembling a large enough group of young people living in residential care was beyond the scope of this project. Just one of the centres had enough young people in residence to make up the typical composition of four or more participants. The above studies (McManus and Morrison 2009; Kneafsey et al. 2010) were sanctioned by government authorities therefore access to the research participants may have been more straightforward.

Wilk (2010: 432) argues that surveys are not the most appropriate method to elicit the complexities of the daily experience of household food practices because people tend to give aspirational answers. According to Wilk ethnographic methods provide richer examples of the complexities of food practices through observation of family meals. The objective of participant observation fieldwork is for the researcher to immerse him/herself in the participant's natural surroundings and observe their everyday activities, rituals and routines (Scott-Jones and Watt 2010). Wilk also stresses that they have a negative aspect because the dynamic of the group can be changed by having a researcher observe them eating.

My study has developed in some ways a similar strategy to Clarke (1998) who used both qualitative and quantitative approaches. I decided that deploying a mixed methods approach would best serve to answer the research question and

themes guiding the study. A mixed methods approach was deemed most appropriate to answer the question what is the significance of food and eating practices in children's residential care services in Ireland? The main impetus was to address the gap in the understanding of how food works in the centres. The qualitative element developed through time spent in the centres allowed, as Share (2007: 72) suggests, 'the study to go beyond the reporting of what, to an understanding of how and why'. The quantitative data, drawn from structured questionnaires administered to workers in residential care, provides objective numeric data on reported behaviours, attitudes and knowledge.

Ideally, for mixed methods research, quantitative and qualitative methods and methodologies should complement each other (Creswell and Plano Clark 2011). According to Bryman and Bell (2007: 21), quantitative and qualitative should be mutually informative, 'much like a conversation or debate and idea is to construct a negotiated account of what they mean together'. Mason (2006) suggests that we need to think creatively not just about research methods but about the research questions we ask. She argues that a 'qualitatively driven' approach to mixing methods offers significant possibilities for generating new perspectives of the complexities of the 'multi-dimensionality of lived experience'. As discussed, Denscombe (2008) suggests researchers use mixed methods in a variety of ways for example: by mixing qualitative and quantitative methods each method can be mutually informative or one method can have prominence over the other. In this study I use a sequential mixed methods design to: collect data in both the qualitative and quantitative phases, develop a broader view of the research problem, to balance the strengths and weaknesses associated with both methods and to build on initial findings.

This study uses a 'exploratory sequential design' (Creswell and Plano Clark 2011: 86) of focused ethnography to become orientated with and to develop a familiarity with the cultural milieu, with focus on food and eating practices around the table in residential care centres, before embarking on the quantitative survey of the workers to test and generalize the initial findings. By using the focused ethnography, the survey of the workers and the photo-elicitation, this study provides a picture of residential care from my position at

the dining table and additional views of that picture from the workers' social care professional perspectives.

I had no previous personal experience of residential care centres for young people. Therefore, to address this problem, I wanted to become orientated with the setting and see for myself the everyday food and eating practices in residential care centres. Focused ethnography based on the *observer as participant* role was selected in the hope that it would be the least intrusive instrument to gain familiarity with residential care settings and would inform the construction and design of the questionnaire for the workers. My rationale for using the quantitative method of postal questionnaire was to reach as many workers as possible and therefore minimise the limitations of the research. Gaining one-to-one access to the workers was impeded by the shift work in the centres and the time constraints of the project meant individual contact with the required number of workers was not practicable. The purpose for the mixed methods exploratory sequential design was to take advantage of different but complementary data to address the research problem: the significance of food and eating practices in children's residential care settings. Mixed methods, as Johnson and Onwuegbuzie (2004) show, is not a soft option. When using mixed methods the researcher must attempt to bridge the epistemological divide to create a fuller understanding of the research problem.

4.4 Conclusion

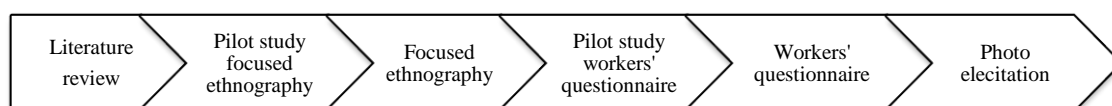
This chapter has presented the methodological approach taken for this study. As this study involved research with a vulnerable population, gaining access to a closed community and the private matter of food and eating mixed methods was chosen from a pragmatic standpoint as the most appropriate method to solve my research problem. The chosen design for this research was a sequential mixed methods design of: focused ethnography, a survey of the workers in residential care and photo-elicitation with social care professionals. This will help to develop a broad view of the significance of food and eating practices in residential care for young people from the workers' perspective. The following chapter will show how the method was implemented.

Chapter Five: Method design and implementation

5.1 Introduction

The previous chapter discussed the methodological approach that has framed the research question and the rationale for employing a mixed methods design in this study. This chapter presents the research design and how it was implemented. Figure 15 below shows the sequence of the data collection stages. The discussion begins by restating the research question and the key themes identified by the literature review. The ethical considerations for conducting research within the sensitive area of residential care are then examined at length. The process of gaining access, the pilot studies, data collection and analysis for each phase is presented including my rationale for using thematic analysis. Finally some of the limitations of the study are identified.

FIGURE 15 SEQUENCE OF DATA COLLECTION STAGES



5.1.1 Literature review and research question

To provide a contextual, perceptual, demographic and theoretical overview this study began with a review of the literature, as shown in Figure 15, and is presented in the first three chapters. The literature review identified key themes and issues used to frame the following questions that I hoped to answer in the focused ethnography stage:

- What is the significance of food and eating practices in children's residential care settings in Ireland?

The following themes, also identified, throughout the previous chapters, are the key issues used to focus and guide data collection in the field:

- Do food and eating practices within residential care reflect similar eating practices in the general public?
- Is the sharing of meals at the table *commensality* an aspiration or reality in the residential care?
- Is enactment and enforcement of *hierarchical* behaviour and *discipline* embedded in the rituals, rhythms and routines of the table?
- How does the *government* of children’s residential services in and around the table affect food and eating practices?

5.2 Research design

This research used an exploratory sequential design. According to Creswell and Plano Clark (2011) an exploratory sequential design prioritizes the collection and analysis of qualitative data in the first phase to explore the phenomenon and then designs a quantitative instrument to assess the prevalence of the variables for a larger sample. This approach facilitated the collection of data on food and eating practices in the centres that guided the design of the second stage workers’ questionnaires. The following figures (Figure 16-19) are based on Creswell and Plano Clark’s (2011) decision-making tree. The circled boxes in the figures show the choices for this particular mixed methods research study.

FIGURE 16 TIMING OF METHODS

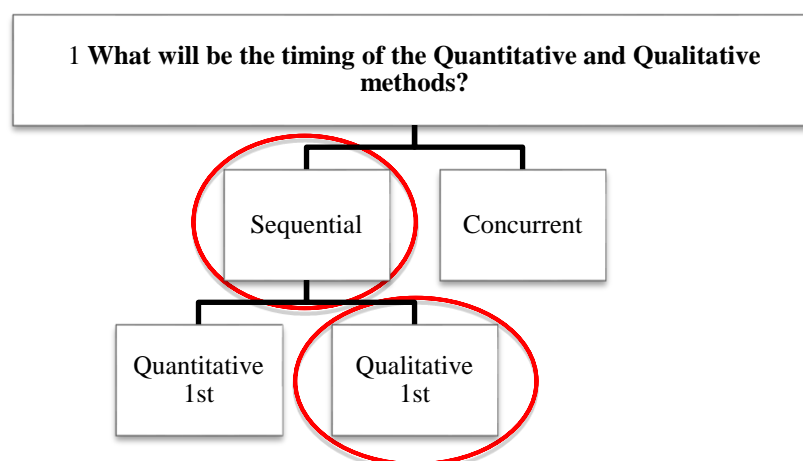


Figure 16 shows that I selected a sequential design starting with the qualitative strand. As discussed I had no personal experience of residential care centres and there is a lack of literature on residential care for young people in Ireland.

Therefore I decided to conduct the fieldwork in the centres first to gain familiarity with the food and eating practices. The collected data aided the construction of the second stage workers' questionnaires it also provided contextual knowledge within which to interpret them.

FIGURE 17 WEIGHTING OF METHODS

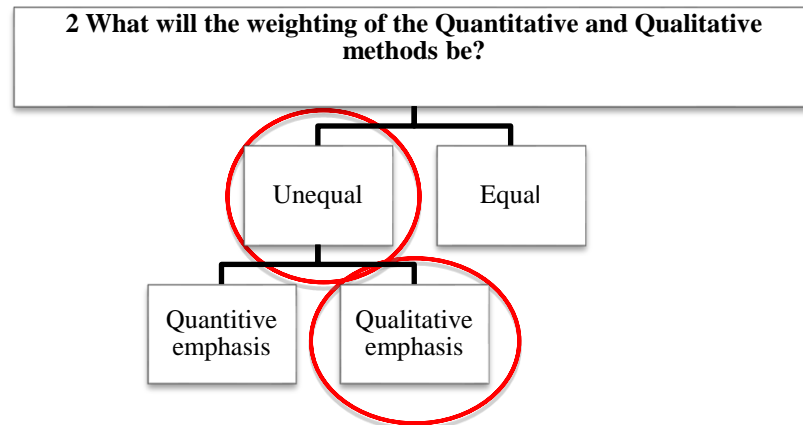


Figure 17 shows the weighting and Creswell and Plano Clark (2011) stress that the researcher should declare from the outset if the study is weighted in favour of either paradigm. As discussed my theoretical stance is positioned in favour of qualitative methods therefore this study is weighted towards that method.

FIGURE 18 MIXING OF METHODS

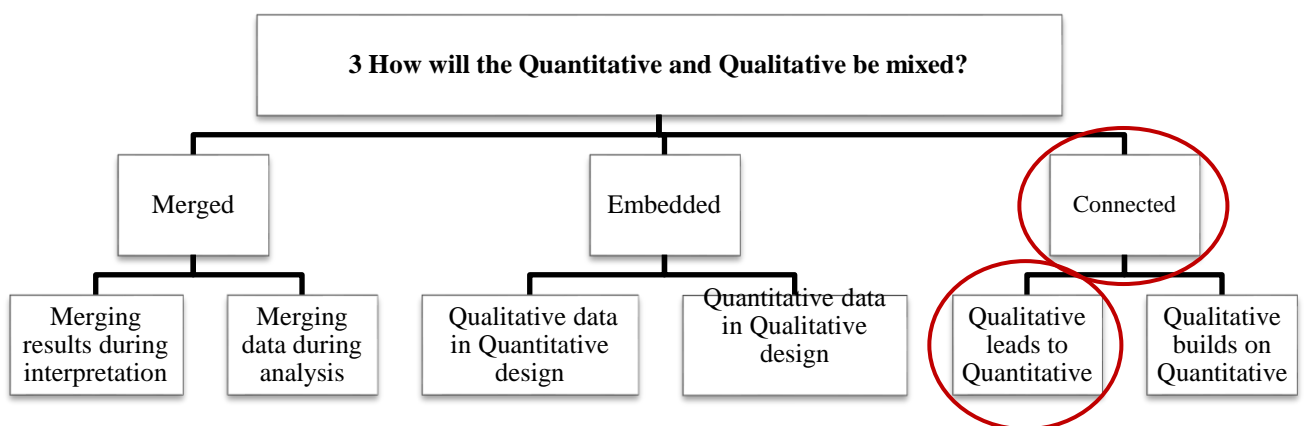
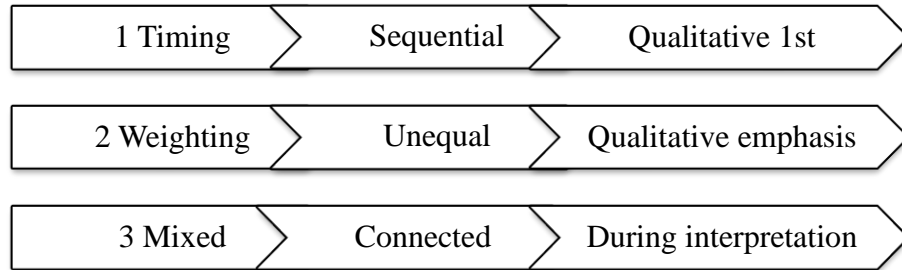


Figure 18 shows how the methods may be mixed and in this study the quantitative and qualitative methods were collected and analysed separately and connected during interpretation of the results. This involves drawing

conclusions from both strands and identifying how they connect in the final interpretation to answer the research question.

FIGURE 19 DECISIONS MADE: EXPLORATORY SEQUENTIAL DESIGN



The final figure 19 in this sequence illustrates my selected options from Creswell and Plano Clark’s (2011) decision-making tree. The steps in this design are as follows: first, collect qualitative data through a focused ethnography, in the five centres and interpret using thematic analysis; second, from that data refine quantitative questions, design and administer workers’ questionnaire then analyse that data using SPSS; third, interpret both sets of data together and discuss to what extent the findings from the quantitative data test the emerging theories identified in the qualitative findings.

As discussed I also conducted photo-elicitations using photographs of the dining tables after the workers’ questionnaire was completed. That data set did not sit comfortably within the decision-making tree however it provides a valuable and additional source of data that furthers the understandings of home.

5.2.1 Focused Ethnography

In order to become orientated with, and gain primary knowledge of food and eating practices in residential care centres it was necessary to see mealtimes in the centres. Miller and Deutsch (2009) suggest the observation is a very useful utensil in a food scholar’s toolbox. A researcher observing the food and eating practices can gain an understanding of a social group through ordinary activities.

Researchers conducting sociological field observations, according to Gold (1958), fall into four theoretical roles: *the complete participant* – is fully

involved in the social setting and often observes covertly; *the participant as observer* – the observer has a natural or non-research reason for being in the social setting; *the observer as participant* – the observer has some connection but is not naturally part of the social setting; *the complete observer* – does not take any part in the social setting. Focused ethnography typically uses the *observer as participant* role which according to Higgenbottom et al. (2013) is not as time-intensive as the *participant as observer* role.

Adler and Adler (1987) also identified a typology of membership roles for qualitative researchers engaged in observational methods: *peripheral* - researchers do not participate in the core activities of group members; *active* - researchers become involved with the central activities of the group without fully committing themselves to the members' values and goals; and *complete* - researchers are already members of the group or become fully affiliated during the course of the research. My role could be described as *active* or *observer as participant*. I was not naturally part of the setting but I was eating with the group. By joining the young people and the workers at mealtimes and observing what was eaten, with whom, where and when it was eaten I could gain knowledge of one particular aspect of everyday life in residential care centres albeit for a limited time.

Ideally, when conducting observations the people in the social setting should have time to grow used to the researcher being present so that the participants' behaviour is not altered by the researcher's presence (Hennink et al. 2011). Webb et al. (1966 cited by Bryman 2008: 266) describe those altered behaviours as 'reactive effects' which are likely to occur in any research situation where the participants know they are the focus of the study. Reactive effects can distort the data collected. According to Patton (2015) the concern should be not *if* such effects occur rather how to take them into consideration when interpreting the data. The fieldwork was conducted under the ethos of a focused ethnography study and due to the time limitations in the centres I was aware of the reactive effect. What I observed was most likely altered by my being there. Nonetheless this stage in the research was fundamental to the construction and design of the questionnaires.

5.2.2 Questionnaires

The themes identified in the first stage of data collection helped to construct the second stage quantitative questionnaires for the workers (Appendix 1). Having gained some insight into residential care I wanted to further explore if what I saw in the field was typical for other children's residential services in Ireland. The questionnaire provided the opportunity to clarify some issues. I wanted to confirm that food and eating practices within residential care reflected similar eating practices in the general public. I asked the workers if they thought food could be used as a symbolic instrument to demonstrate care as Punch et al. (2009) and Emond et al. (2013) had found. They were also asked how institutional regulations conflict with the aim to provide a 'homely' home. I was also interested in the workers' own experiences of food and how they might feel about their personal food and eating practices being placed under scrutiny of the public gaze.

In addition to developing a fuller understanding of commensality, hierarchy, discipline and government, the questionnaire covered several themes including: basic profile of the food practices; emotions and feelings; power and resistance; food regulation; and the workers' personal experience of food at work. During analysis of the fieldwork data I realised that the visual data could be explored further.

5.2.3 Photo-elicitation

The final phase of the research design for this project is a form of photo-elicitation using the photographs taken of the dining table in each centre. The photo-elicitation was used to explore the contested and contradictory understandings of institution, family and home in relation to residential care. Recent discussions with regard to the use of images in social research concentrate on two perspectives: the first is that images can be used as complex sociological methods to illustrate the data; according to the second, images are passive and used only as a medium to visualise text. Brown (2011: 199) maintains that neither of those perspectives 'offers insight into the social interaction, interpretation and reflexive process'. He demonstrates that photography can offer a powerful visual means of: 'combining

phenomenological description with hermeneutic understanding of visual social science methodology' (Brown 2011: 200). I realised that the photographs of the tables revealed numerous layers of social meaning. Spencer (2011: 240), in his discussion on the significance of visual research methods, suggests that visual research is distinct because it brings the issues of 'subjectivity, reflexivity and interpretation into sharper focus'.

A photograph does not show how things look. It is an image produced by a mechanical device at a specific moment, in a particular context by a person working within a set of personal parameters (Prosser 2006: 2 cited by Spencer 2011: 16).

Banks and Zeitlyn (2015: 10) discuss how photographs are read. They suggest that 'reading' implies that a 'message' somehow lies within the image but they argue that the reader can consider both content and context. Some people can view a photograph as information, 'as though one were looking through a window at some object beyond'. For others, 'it is the context within which the image was taken that assumes prominence'. Banks and Zeitlyn suggest that an image has both an internal and external narrative. The internal narrative is what the image communicates and is not always what was intended by the photographer. The external narrative is the social context in which the image was produced and 'the social relations within which the image is embedded at any moment of viewing' (ibid: 11).

Rose (2012) defines a photo-essay as a combination of words and photographs. However, for a true photo-essay, the words and images should have equal billing. This project is not claiming to be a photo-essay. However, the images presented do warrant due consideration.

Banks (2007) suggests an image combined with words can offer a personal experience of a social phenomenon. Banks, discussing the ethics of visual research, proposes that we have recently learned to work *with* as opposed to *on* research participants and a similar shift needs to be taken with the presentation of visual research. 'Researchers might seek to work on images, let them speak for themselves as it were', in preference to forcing 'them to conform to a predetermined intellectual agenda' (Banks 2007: 96). It is difficult to move away from an intellectual agenda when creating this textual thesis.

5.3 Ethical considerations

This research project was conducted in a sensitive area: residential care centres for young people. According to Walsh (2005) researchers considering research in areas that are sensitive should be aware that issues might arise at any stage of the research process from gaining ethical approval to the dissemination of the results. She also suggests that the researcher should anticipate possible consequences more thoroughly. The proposal for this research project was subject to approval by an internal and an external research panel.

5.3.1 Research with children

Children are seen as a vulnerable group in society with regard to competence and autonomy. Children and young people within the residential care system are viewed as being ‘some of the most vulnerable in our society’ (Kendrick et al. 2008: 79). Their journeys to residential care may include one or more of the following: neglect or physical, sexual or emotional abuse; being involved in alcohol or drug misuse; involvement in criminal offences; inappropriate sexual activity or family breakdown. For this reason I made the decision not to enquire into the background of the young people who participated in this research. The research design did not require this information and it respected the young people’s privacy.

According to Christensen and Prout (2002: 481) researchers own perspectives on childhood will have ‘important implications for his or her research practice’. It will inform their understandings and views of children and influence their methods, analysis and ethical choices. Contemporary sociological research with children pays attention to children’s perspectives. This research is positioned within the new sociology of childhood, where children are viewed as active agents who are the experts on their own lives (Kellett 2005). Therefore part of this research is conducted *with* the young people who are the authority on their everyday lives in residential care.

5.3.2 Regulation

There is currently no single regulatory authority for research ethics in Ireland (DCYA 2012). When contemplating the ethical considerations for this project, before submission to the ethics committee for approval, I first turned to Sociological Association of Ireland (SAI) ethical guidelines. There are debates about how ethical research with children differs from research with adults. The SAI ethical guidelines did not refer to children specifically. I therefore followed the Children's Research Centre (CRC) comprehensive guide to ethical research with children. These are based on: beneficence - of benefit to the participant, non-maleficence - causes no harm, autonomy - participation is based on informed and free decisions (Whyte 2006). After commencement of the fieldwork in February 2012 the Department of Children and Youth Affairs published guidelines for ethical research with children. The guidelines outline the core ethical concepts that additionally need to be addressed in relation to research with children: child protection principles, legal obligations and policy commitments and a child-centred inclusive approach (DCYA 2012a).

5.3.3 Ability and power

Hill (2005: 63) suggests that the main difference between children and adults is 'ability and power'. Children's ability to understand and express complex ideas varies greatly depending on age but one should be mindful that this also varies from one child to another: children are not a homogenous group but individuals. According to Gallagher (2008) throughout the literature on research with children power is seen as a commodity that is possessed by adults and not children. That power imbalance must be considered from an ethical perspective when conducting research with children and young people (Mayall 2000).

Foucault (2003: 14) viewed power as 'not something that is given, exchanged or given back, it is something that is exercised and that only exists in action'. For Foucault power is ubiquitous, it is found in all relationships and it only exists when there is resistance. Therefore power is not as simple as oppression of the powerless by the powerful. Gallagher (2008) draws on Foucault to argue that adults do not have complete control over children. If adults did have

complete power over children then children would always behave as the adults wished without arguments or discussions but, because children resist, ‘a whole series of power tactics become necessary: coaxing, cajoling, [...] behaviour contracts, rewards for obedience and so on’ (Gallagher 2008: 145). By positioning myself at the table I hoped that I would observe similar discussions and/or arguments that occurred between the young people and the workers around food rituals, rhythms and routines in the residential care centres.

5.3.4 Legal authority

Another consideration is that the adults do have legal authority over children and for that reason children ‘often find it difficult to dissent, disagree or say things that they fear may be unacceptable’ (Hill 2005: 63). This may be more pertinent for children within the care system. Emond (2003) suggests that many children within the state care system may have had a number of placements throughout their history of care and will have been asked many questions by adults, social workers, foster carers, residential staff, etc. Children within the care system may ‘associate being asked questions [by adults and often adult strangers] with a change in their circumstances (Emond 2003: 105). The research design did not require me to ask the young people direct questions but I did converse with them in a social manner.

The published literature on research with children suggests that the voices of children are interpreted by adults and therefore presented from an adult’s perspective (Hendrick 2000, Christensen and James 2000, Jenks 2005, Montgomery and Kellett 2009). This research aimed to ensure that the participation of the young people within the sample was valued for their unique insider perspective into their own lives. In keeping with Article 3 of the UNCRC this research being an action concerning children, the best interests of the child had primary consideration. In addition, the young people's views were taken into account as Article 12 of the Convention requires.

5.3.5 Confidentiality

There is broad agreement that the researcher should ensure confidentiality of information provided by the participants. In the case of research with people under the age of eighteen years, confidentiality may be a moveable feast - it may be breached if it is in the best interests of the child/young person. The DCYA (2012: 4) guidelines for research with children suggest that 'researchers must carry out their work in accordance with *Children First*'. The *National Guidelines for the Protection and Welfare of Children: Children First* (DCYA 2011) recommends that confidentiality should not be promised to parents or children because a child protection issue might be disclosed. I discussed child protection with the residential care managers and abided by their advice and policy on the matter. I ensured confidentiality in that the participant's name, place of residence and place of work would be given as pseudonyms.

5.3.6 Gatekeepers

Access to the residential care centres was arranged through the managers of the centres. The managers acted as gatekeepers. They in turn got permission to allow access from their line managers within the HSE. I was given access to the young people in residence after producing evidence of up-to-date Garda clearance. Access and initial agreement to partake in the research was discussed with the young people. In keeping with the *Children First Guidelines* and the CRC ethical guidelines, I did not spend time alone with an individual young person.

The use of gatekeepers in research can raise particular concerns. Dale and Watson (2010) suggest that because of the multifaceted organisation of residential care the researcher must rely on gatekeepers. In this case there was particular reliance on the residential care managers to be enthusiastic about the research project to first gain permission from their line managers and then to 'sell' the idea of the project to the participants: the residential care workers and the young people living in the centre. One of the concerns that Dale and Watson (2010) raise is that gatekeepers may choose participants that they believe are suitable for the project and this could influence the research

findings. This did not occur in any of the centres as I met all the young people living in all the centres I had access to. However, it may have been a deciding factor for the centre managers who declined to take part in the study.

5.3.7 Informed consent

All the participants were informed as to: what the research was about, how it would be conducted, how much time it would take and how the information would be disseminated (see Appendix 2 and 4). The CRC state, ‘written consent should be obtained from parents, in the case where children are under the age of eighteen’ (Whyte 2006: 4). This, however, depends on the legal status of the young persons in care. Either they are there on a voluntary or statutory basis. If they were there on a voluntary basis the parents still had legal rights. If they were there on a statutory basis the HSE had the legal right to make decisions about the young person. However, the Children Act 2001 section 268 states that while a child is in the care of the HSE it shall ‘have the like control over the child as if it were his or her parent’ (Irish Statute Book 2001). The Act does not specify if that care is voluntary or statutory.

Similarly, Emond (2000) found that under Scottish law the parents of the children in her study did have the legal right to be informed of the research she was conducting, but the issue of parental consent did not arise with the residential staff. In Emond's study the staff gave consent as they were acting in the role of *loco parentis*. This was also the case in this study - I discussed parental consent with the managers and was informed that it was not required. The centre manager from Hillgrove suggested that I only take written notes and not use the digital recorder as this would prevent the need to get parental consent. This manager may have been confusing Data Protection issues with consent issues. Therefore, there seems to be some confusion about parental consent and when and why it might be required. The DCYA guidelines for research with children may help to clarify this matter for future research. The guidelines state that:

Parental and /or guardian consent is required for children (defined in Ireland as a person below the age of 18) to participate in research. Where a child is in the care of the State additional requirements may be necessary' (DCYA 2012: 2).

The law and ethical guidance are generally linked but there is no law governing the requirement for parental consent in relation to the participation of young people in social research in Ireland (Keenan 2015: 90). The workers acting as guardians are legally, and according to the DCYA guidelines, entitled to give consent for the young people to partake in the research. Emond (2000) suggests that the lack of consultation with parents about consent gives insight into how the parents of children in state care are regarded.

The right to privacy is a fundamental human right and children and young people are explicitly protected under Article 16 of UNCRC. The right to privacy should be included but, according to Keenan (2015) is not, included in arguments on parental consent. According to Hammersley and Atkinson (2007:212) there is 'an assumption that children's private lives are legitimately open to scrutiny in ways that adults are not'. Graue and Walsh (1998: 56) point out that in everyday life people negotiate permissions with each other 'but adults seldom do it with children'.

In this study the young people were asked for their assent/consent and informed in appropriate language, verbally and in writing, what the research was about, what their role would be, why it was being done and how it would be disseminated. They were informed of their right to withdraw their consent at any time during the data collection and their attention was brought to my contact details if they wanted to withdraw at a later point. The CRC advise that one should 'obtain verbal consent from children in the presence, of a third party (adult) who is known to the child' (Whyte 2006). As the children in this study were adolescents they were asked to read and sign an informed consent form (Appendix 3) that was witnessed by a third party adult – one of the social care practitioners on duty.

5.3.8 Children's privacy

Young people living in residential care have been placed in the care of the state for various reasons. I decided for the purposes of this study that gaining knowledge of the young people's journey into state care was not relevant. I was, however, very aware that food may have been an emotive issue for some of the young people within the sample. I was mindful of this in any discussions I had with the young people. Asking a seemingly inoffensive question, about a favourite meal perhaps, could conjure up images that they would rather not be reminded of.

Another consideration of research with children living in residential care relates to entering their home. This is a private space, therefore my observational and surveilling gaze could be viewed as an intrusion:

This requires a degree of sensitivity and a tuning in to subtleties: the rhythms and routines of each unit, children's indications of discomfort, or our own intuitive feelings that we might be intruding (Kendrick et al. 2008: 85).

Also, when a researcher enters the private realm of a home, they are 'likely to learn a significant amount about the circumstances and everyday life over and above the stated purpose of the research' (Felzmann et al. 2009: 53). This proved challenging during data collection. Decisions had to be made as to what was and was not relevant to record. For example, discussions about a young person's background and reasons for being in care were not recorded. I also had to tune into the young people's feelings and know when it was appropriate for me to leave the room.

5.3.9 Data Protection

The Data Protection Act, 1988, amended 2003, is based on the fundamental right to privacy and regulates the collection, processing, keeping, use and disclosure of information relating to individuals. The CRC points out that the Act applies to adults and children similarly. It is imperative that the research data is stored correctly and safely. As already stated the data stored on my office computer and my laptop is password protected. Notebooks with

fieldwork notes, tape recordings and typed transcripts of fieldwork notes are labelled with ID codes rather than names and are stored in a locked filing cabinet in the research office. In addition, the signed informed consent forms are filed separately from the fieldwork notes and completed questionnaires

Honesty about the dissemination plans for the finished project is imperative to gaining informed consent. Emond (2005) found that a significant number of the young people in her research on residential care thought that their participation would 'change things' and 'make things better for the next lot of kids' (Emond 2005: 129). She suggests that honesty about the dissemination of the findings is imperative to prevent the participants assuming that their participation will make a difference. Like Emond (2000), this study is ultimately an examination that will result in a doctoral thesis. The participants were informed that the findings would be made available to: the young people in an appropriate form and the residential child care workers. The findings may also be presented to the CFA and HIQA. Also it was anticipated that papers would be prepared for academic journals and conferences.

5.3.10 Research relationship

Alderson and Morrow (2011) discuss the research relationship with disadvantaged children and raise the question, are fleeting friendships advantageous to the young people? 'How do children who may already feel rejected or betrayed react when the friendly researcher departs with the data and makes no further contact?' (Alderson and Morrow 2011: 24). While I intend to give feedback to the young people who participated the majority of participants were in their mid-to-late teens and they will have left the care system before this dissertation is complete.

According to Hesse-Biber (2010) the researcher should be aware of his/her own attitudes, values and biases because they may influence the questions we choose to ask or not ask and shape our perception of the research problem. Another consideration was that, as a chef, my own attitudes to food and eating practices are biased towards the use of fresh ingredients and against using processed foods. My being a chef could also have impacted on the workers. Past experience has shown that some people feel uncomfortable cooking in my

presence and felt that I was judging their cooking skills. This raised the question as to whether or not I should declare this information to the workers. I decided that if I was asked about my previous employment before becoming a student that I would answer honestly.

5.3.11 The workers

The managers also acted as gatekeepers to the workers for the focused ethnography and the questionnaires. The workers in the centres I visited were told why I was there and for how long. I introduced myself and restated why I was doing the research and reassured them that I was not carrying out an evaluation of their cooking skills. I also gave them the participant information and consent forms. I answered their questions on my role and the research. In retrospect I did not consider how, if on duty, they could withdraw their consent from the study. There was one worker in Woodlands who did not come into the kitchen while I was there. She may have been declining to take part or could have been busy elsewhere. There is also the possibility that some workers removed themselves from the rota to avoid being involved in the study. It should also be considered that the managers, in their role as gatekeepers, could have put workers on duty who they thought did 'good food' while the research was being done. The workers' participation in the qualitative strand was less problematic, as they could simply not complete the questionnaire.

To conclude: having explored the possible consequences of conducting research in the sensitive area of residential care, I was aware that ethical issues were present at all stages of the research process and due consideration was required when meeting the young people and the workers.

5.4 Pilot studies

5.4.1 Focused ethnography

At the outset of this project I was aware that gaining access to residential care centres could be difficult. I had a professional contact who managed the centre where the pilot was conducted. This manager had expressed an interest in the

research when it was in the proposal stage. After an initial meeting with the manager we arranged for me to conduct a 24-hour observation in the centre.

As discussed in the preamble the pilot, did not go as planned. There were two residents staying in the centre on the day but one was being moved to another location that day and did not want to go. I did not meet the second resident, there was no evening meal cooked and I did not stay in the centre for the 24 hours as it was not deemed appropriate at that time.

In the preamble, I express concern that the workers' planned food and eating activities - shopping and cooking with one of the residents - would not be a true representation of everyday life in the centre. This pilot study showed that everyday life in residential care is not easily stage-managed. After this pilot study I realised that I would have to have a flexible approach and be prepared to adapt my plans to situations in the centres that could change from one moment to the next. It also became obvious that asking to stay in the centres would further complicate access. I reconsidered the strengths and weaknesses in the chosen method. An advantage to conducting the fieldwork first was that it gave an insight into 'what the participants do as opposed to what they say they do' (Thomas 2005: 381). Another advantage, that supported my choice of method, is the data collected provides a description that is grounded because there is a direct link with the people and the place. Some disadvantages that were anticipated: my presence as a researcher could disrupt the *naturalness* of the situation, and gaining access was going to be difficult.

The decisions made, based on this pilot study, included continued search for fieldwork sites, as I believed this was the most appropriate method to gain first-hand knowledge of the food and eating practices in the centres. I decided that a focused ethnography would be the best suited qualitative method for this project. The pilot study gave me an insight into a day in the life of residential care that better informed my approach to the gatekeepers - the managers in the centres. In future communications with the centre managers I provided an opening for them to suggest how long I would be provided with access. I decided not to ask to be accommodated overnight as the centre would not only

have to have a vacant room but also workers on duty who would be prepared to look after a novice adult in the centre.

5.4.2 Questionnaire pilot study

The questionnaire pilot was conducted after the first phase was completed. Having analysed the fieldwork notes, I developed a pilot questionnaire based on the identified themes. The questions were designed using closed-ended questions or statements with a five point Likert scale to gauge the workers' level of agreement or disagreement. Some open-ended questions were included where it was thought further information might inform a deeper understanding of how food and eating practices were conducted in the individual centres and the workers' opinions of those practices.

I approached a centre I had been in contact with previously with regard to participation in the qualitative strand. The manager agreed to distribute the questionnaire to the workers and to give me feedback. I sent six questionnaires to him on the 16th of November 2012 and he returned five completed questionnaires on the 30th November 2012. Guided by Fink (1995), I then asked the workers for their opinions of the questionnaire. I asked how long it took to complete and if they thought it was too long. They agreed that it took about twenty minutes and that time was an appropriate length. I asked if the instructions were: clear, were any questions ambiguous or objectionable, was the layout clear and easy to follow, did they think I had omitted any topics. The feedback I received was positive so I fine-tuned the questionnaire.

The pilot study showed that the advantages of using a postal questionnaire included the potential to reach a large number of participants in a relatively short space of time. However, the 84% response rate and the two week turn around on the pilot questionnaire was never repeated. It could be argued that an electronic questionnaire could have served the same purpose. However, acquiring the work or personal e-mail addresses of the workers was not feasible. The postal questionnaire allowed me to send a number of questionnaires to the centre address and avoided the need to acquire personal contact details from the workers. Using a pre-structured format ensured getting standardized answers. On the other hand, a disadvantage to pre-

structured closed questions is that they restrict how the participant can respond. Denscombe (2007) suggests postal questionnaires, because they are completed at a distance and are anonymous, offering little opportunity to verify the answers given by participants. Another issue is the response rate for the pilot questionnaire was high, with five out of six returned. Expecting that to continue in the general survey would be unrealistic.

5.4.3 Photo-elicitation pilot study

The pilot study for the photo-elicitation was conducted with a group of twelve fourth year social care students who volunteered to stay behind after a tutorial. I introduced them briefly to my study and informed them of my plan to take this to a larger audience. I gave each student a photocopy of the photographed tables (Appendix 7) and asked the questions. I noted how long the exercise took and realised that I needed to write the instructions and the questions on the photocopy to avoid confusion.

Overall the pilot studies confirmed that the research design was fit for purpose. While the fieldwork would have to be approached with a degree of flexibility on my part, this was the most appropriate method to gain familiarity of the food and eating practices in residential care. The workers' questionnaire would assess the prevalence of those practices with a larger sample from a cross-section of social care practitioners working in residential care and provide a broader view of the issues of how food is done in residential care here in Ireland.

5.5 Recruitment and Samples

Having explored some of the broad methodological problems and ethical issues of research with vulnerable young people, I was aware that gaining access to residential care centres for young people would be complicated. Over a six month period I approached twenty eight residential care centres for young people, some HSE and some privately operated. The following table (Table 4) shows where the data was collected, the type of centre and the participants who were involved in the fieldwork data collection process.

TABLE 4 FIELDWORK

| Residential Care centres | | | | | |
|-------------------------------------|--------------------------|---------------------|----------------------------|--|----------------------------------|
| Approached to discuss participation | | 28 | Agreed to participate | | 5 |
| Participating Centres | | | | | |
| Pseudonym of centre | Type of centre | Young people | Ages | Gender | Number of workers on duty |
| Glenview | Short stay/Respite (HSE) | 4 | 17 15 13 11 | Female Male Male Male | 11 |
| Woodlands | Mainstream (HSE) | 1 | 17 | Female | 7 |
| Hillgrove | High Support (HSE) | 5 | 16 17 15 15 13 | Female Female Male Male Male | 30 |
| Hazelbrook | Mainstream (Private) | 3 | 16 16 15 | Female Female Female | 6 |
| Oaklands | Mainstream (Private) | 2 | 15 16 | Male Male | 9 |
| Total | | 15 | | | 63 |

The sample size required, Denscombe (2007) suggests, for small scale qualitative research, is difficult to estimate. Mason (2010), in his study of sample sizes for PhD studies using ethnographic methods, found, unlike quantitative researchers, many qualitative authors shy away from saying what a sufficient sample size might be. Out of Mason's 560 identified studies using qualitative approaches the most common sample sizes were 20 and 30. My sample would, by Mason's standard, be sufficient.

This research used a purposive sample of the young people living in residential care and the workers employed there. The sample criteria was based on both cohorts having specialised knowledge on the research issue and their willingness to participate. The samples for all phases are shown in Table 5 below. The sample for the qualitative strand consisted of 15 young people living in residential care and 63 residential child care workers in the field. The sample for the quantitative strand resulted in 92 workers who completed the questionnaire. The photo-elicitation consisted of 43 social care professionals.

TABLE 5 SAMPLE

| Sample | Young people | Workers | Social care professionals |
|---------------------|---------------------|----------------|----------------------------------|
| Focused ethnography | 15 | 63 | - |
| Questionnaire | - | 92 | - |
| Photo-elicitation | - | - | 43 |

The CFA's (2015) most recent report shows 6,403 children were in the care of the state, of whom 326 were living in various residential care situations: the majority in general care, but a small percentage receiving special care or high support. While the numbers of young people in the sample was relatively low in comparison to the number of workers, overall the sample was large for a qualitative study.

There are no current statistics for the number of workers employed in residential care for young people in Ireland. Lalor and Share (2013) provide a figure based on the Joint Committee on Social Care Professionals who, in early 2000, enumerated 1,214 social care practitioners were employed in children's residential care centres. Originally, the target group for my questionnaire was the 63 workers that I had met in the centres. I had discussed the questionnaire with the workers and informed them that it would be sent to them later in the year. I had hoped that having had personal contact with the workers would increase the response rate for the questionnaires. However, response from the first round of questionnaires with the workers I had met was low. Then contact was made with some of the managers who had originally declined to take part in the first stage but had expressed interest in the quantitative strand. The second round increased the response, but not sufficiently. Having exhausted my original contacts, I attended the Social Care Ireland Annual Conference to establish contact with potential research centres. The final analysable questionnaires returned was 92, a response rate of 50%, which, using Lalor and Share's (2013) figure of 1,214, is 7.6% of residential child care workers in Ireland.

5.6 Data collection methods

5.6.1 Focused ethnography

During the course of the first phase of data collection in the research sites, the fieldnotes were produced by digital-audio recording of the evening meal in two of the five centres, and at all other times noted manually. In addition to the informal conversations, notes were also taken as to what the meal consisted of, who was present, what was eaten and by whom, plus the atmosphere and topics of conversation. The audio recording of the evening meal began when the young people were told the meal would be ready and continued until they had left the table. All the other notes were jotted down contemporaneously and written in full at the end of each day. Photographs of the dining tables were taken in each centre. Three of the centres provided copies of weekly menu plans and one centre the weekly shopping list.

5.6.2 Questionnaire

The postal questionnaire for the workers was distributed to the 18 residential centres that had agreed to participate. After discussion with the managers in the centres an agreed number of questionnaires, participant information and consent forms were posted. Self-addressed and prepaid envelopes were supplied to the centres for the return of the data. The resulting returned data consisted of ninety four questionnaires, two of which were very incomplete and therefore discarded. Data from the ninety two usable questionnaires was coded manually and input to IBM SPSS software.

5.6.3 Photo-elicitation

The data collected for the photo-elicitation was originally generated as a visual record of the centres. As analysis of the fieldwork progressed, the symbolic significance of the photographs I had taken of the dining table in each centre became apparent. To interpret the photographs I used a form of photo-elicitation. Harper (2002: 13) defines photo-elicitation as simply inserting a photograph into a research interview. A photograph helps to stimulate conversation and discussing an image 'can prompt talk about different things, in different ways' (Rose 2012: 305). Due to the limited available time that

remained, conducting photo-elicitation interviews would not have been practical. I did have the opportunity to address two separate audiences comprised of social care professionals.

5.7 Fieldwork

5.7.1 Focused ethnography

In an attempt to ease access, I acquired contact details for the managers in residential care centres from the student placement coordinator in the Institute of Technology Sligo. I thought approaching centres that already had experience of student placement would be less disruptive to the residents and the workers. I sent out the first round of nine letters in December 2011. One centre manager responded over the holiday period and sounded very interested but informed me that I needed to contact the regional child care manager to gain approval. After the holidays I contacted the regional manager who told me that they had other research on-going and could not accommodate another project. This regional manager covered four of the centres contacted so almost half my proposed sample was not available. Out of the remaining five centres one agreed to take part.

I then widened my research site. I returned to the placement coordinator and obtained contact details for residential child care centre managers in the neighbouring counties. The second round of letters and follow-up calls resulted in just one centre agreeing to take part. I arranged meetings with these managers to discuss how they might accommodate the project. All the letters were followed up with telephone calls some weeks after the initial letters had been sent. There are several reasons why the letters did not produce a more positive response from the potential participants. The first round of letters was sent in late December and may have been overlooked because of the holiday period. Another reason was that some of the centres had social care undergraduate students on work placement at the time I was planning to conduct my research.

Notes from the follow-up calls to the centres show reasons for declining to take part included having research projects on-going. Having a young person

in residence that had an eating disorder was another reason and on this point I agreed with the manager that research into food and eating practices could heighten the issue for the young person concerned. In the telephone conversations with the managers, the majority did not leave an opening to ask why they did not wish to take part in the research.

The letters had not produced many potential participants so I decided to attend the Social Care Ireland annual conference (2012) to network and raise some interest in the project. At this conference I met the manager from Hazelbrook and the director of a residential care provider who operates multiple centres across Ireland. They both sounded very keen and gave me their contact details. I telephoned the manager from Hazelbrook and we arranged to conduct the research the following week. The director from the large organisation suggested that I attend the managers' meeting the following month and present the project to the managers. This was an excellent opportunity to meet the managers together and explain what the project was and how I hoped it could be accomplished. At this meeting three of the eleven managers were interested in taking part but as it turned out I could only visit one as the other two withdrew from the research because they felt that my being present in their centres would not be appropriate at that time.

I decided to position myself at the dining table in the centres to observe the food and eating practices. The kitchen/dining space in all the centres was a public area where the residents and workers drifted in and out. Situating myself in a public area went some way to addressing the child protection issue of spending time alone with the young people. From the table, in all but one of the centres, I could view the kitchen hotspots: the kettle, the fridge, the dish washer and the cooker to note the action occurring. In all the centres the workers sat at the table at mealtimes and in the majority of cases the young people joined them at the table. I took notes manually or used a digital recorder, dependent on agreement from the centre manager. The recordings were transcribed verbatim.

5.7.2 Questionnaire: Design and delivery

The aim of the questionnaire was to further develop and clarify issues and questions that were identified during the first stage. Marsh and Keating (2006) present the seven steps involved in designing a questionnaire: identify an issue, form a hypothesis, select a design to test the hypothesis, collect the data, interpret and analyse the data, form a theory based on the analysis and report the findings. Those seven steps can be applied to this study as follows:

1. The data collected during the fieldwork generated questions and issues.
2. My assumption was that those same issues would be apparent for the workers in the questionnaire centres.
3. The questionnaire was designed to elicit if workers' food and eating practices in the questionnaire sites were similar to those in the focused ethnography sites.
4. The questionnaires were distributed by post to the 18 residential care centres.
5. IBM SPSS 20 was used to code and analyse the collected data.
6. The questionnaire helped to further develop and clarify the findings of the qualitative strand.
7. The findings are presented in chapter seven.

One hundred and eighty four questionnaires were distributed after negotiations with the centre managers. The agreed quantity depended on the number of questionnaires the managers thought they could get completed. The quantity of questionnaires agreed on did not always correspond with the number of workers employed in the centre. A sample of all the workers would have been desirable but due to reliance on the managers as gatekeepers I agreed to send the quantity that they suggested.

Table 6 below shows the type of organisation and the quantity of questionnaires distributed and returned. In all one hundred and eighty four paper questionnaires were sent and the number returned was ninety four. Of the total returned questionnaires two were very incomplete and therefore it was decided to discard them. The number of useable questionnaires was ninety two which equates to a response rate of 50%. Denscombe (2007) estimates as a basic guide that a social researcher would be fortunate to get approximately 20% of postal questionnaires returned. Therefore the response rate was, by that standard, relatively high and justified the time spent in the field. The

response from the HSE centres was 52.5% and from the privately operated centres 49%.

Table 6 shows that within the total number of questionnaires there was a high proportion of respondents from privately managed centres. Further analysis shows that three private agencies operating on a nationwide basis employed 74% of the responding workers.

TABLE 6 TYPE OF CENTRE

| Centre | HSE/Private | Questionnaire Sent | Questionnaires Returned |
|--------|-------------|--------------------|-------------------------|
| 1 | Private ■ | 10 | 10 |
| 2 | HSE ■■ | 10 | 7 |
| 3 | HSE ■■ | 10 | 5 |
| 4 | Private ■■ | 10 | 6 |
| 5 | Private ■■ | 10 | 7 |
| 6 | HSE ■■ | 20 | 8 |
| 7 | Private ■ | 6 | 4 |
| 8 | Private | 10 | 3 |
| 9 | Private | 10 | 3 |
| 10 | Private | 10 | 5 |
| 11 | Private | 10 | 4 |
| 12 | Private | 10 | 3 |
| 13 | Private | 10 | 3 |
| 14 | Private | 10 | 3 |
| 15 | Private ■ | 10 | 7 |
| 16 | Private ■ | 10 | 6 |
| 17 | Private | 12 | 5 |
| 18 | Private ■ | 6 | 5 |
| | | Sent Total 184 | Returned Total 94 |

■ Focused ethnography centre

■ Direct contact with centre

■ Returns from more than one centre within organisation

The response rates from centres where I had direct contact with the managers yielded a higher return rate. In addition, the response rate from the centres where I visited was consistently higher than the centres where I had relied on a gatekeeper who was a head office figure to distribute the questionnaire. As for non-respondents, further contact was made by telephone calls or e-mail to the centres or the head offices after two weeks and again after four weeks from sending the questionnaires. Due to the anonymity of the questionnaires and the

use of pre-paid return envelopes, I did not know from which centre the questionnaires had been returned making it difficult to trace non-respondents.

5.7.3 Photo-elicitation

I presented a paper, 'The Dining Table in Residential Care', as part of the Centre for Research in Social Professions (CRiSP) seminars in IT Sligo and at the Social Care Ireland annual conference (2014). After presenting the main themes discussed in chapter one, I distributed photocopied photographs of the dining tables to the audience and asked them four questions shown in Figure 20 below. The questions were linked to the earlier discussion and used to focus the audience's attention.

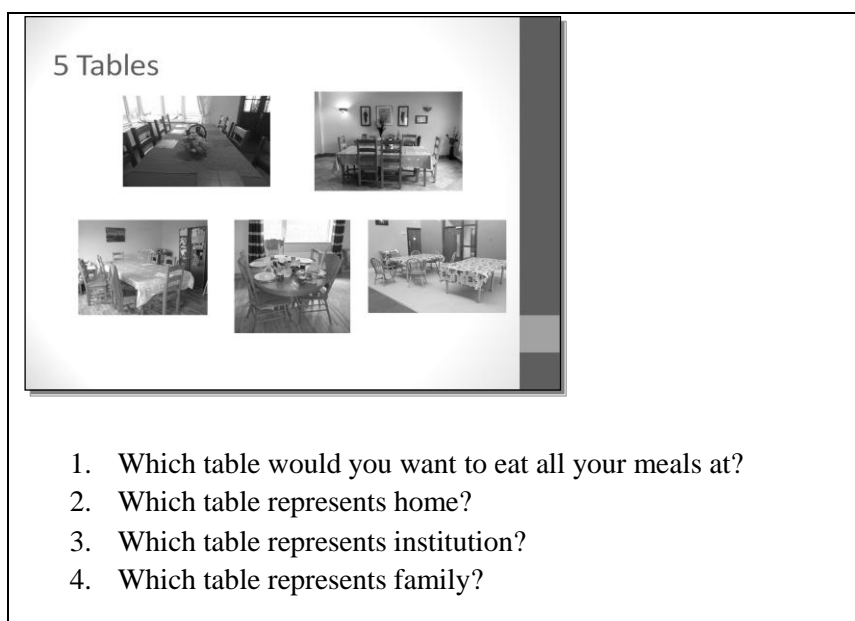


FIGURE 20 FIVE TABLES

The audience was asked to place the number 1 on the picture they would want to eat all their meals at, 2 on the table that represented home, 3 on the table that represented an institution and 4 on the table the represented family. They could place more than one number on the same table. The photocopies were collected and the numbers tallied. The results from the 43 respondents are discussed in chapter six.

5.8 Data analysis

In this mixed methods study the qualitative data is analysed using the qualitative method of thematic analysis and the quantitative data using the statistical analysis programme IBM-SPSS 20. As Figure 21 shows this is an exploratory sequential mixed methods design and the methods are connected during the interpretation stages.

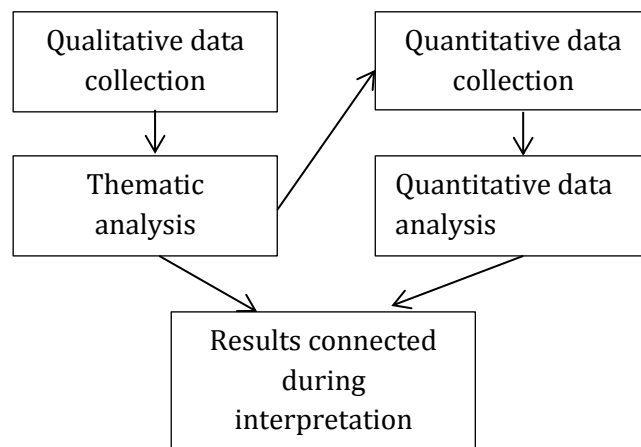


FIGURE 21 PROCEDURE OF DATA ANALYSIS

5.8.1 Thematic analysis

Approaches to qualitative data analysis are numerous and complex. For the purpose of this study I have chosen thematic analysis of the qualitative data collected during the focused ethnography. Thematic analysis is a commonly used analytic method (Braun and Clarke 2006; Boyatiz 1998). Braun and Clarke (2006: 78) propose that thematic analysis should be seen as the foundation for qualitative analysis. Thematic analysis is a method for finding, analysing and reporting patterns. It involves searching the data set to find repeated patterns of meaning. Thematic analysis requires immersion in the data by repeated reading and re-reading. I have chosen thematic analysis because it is a flexible approach that compliments the research question and provides a detailed account of the themes within the data.

Analysis of the data was concurrent with the fieldwork. The initial stage of analysis began during the transcription of fieldwork notes, which took place each evening, immediately after I had left the centres. Analysis began with

looking for the broad themes that had been identified during the literature review. According to Silverman (2014: 260) making fieldnotes is more complex than simply recording data because ‘the categories you use will inevitably be theoretically saturated’. The analysis therefore became part of the data collection process as I began interpretation of the fieldnotes while I was writing them. This initial stage was to gain an understanding of the setting and the participants. The analysis consisted of a combination of:

1. Listening and re-listening to the digital recordings and transcribing verbatim into hand written notes and transcribing fieldwork notes into comprehensive accounts of that day.
2. When I had concluded the fieldwork in each centre the transcripts were transferred into Microsoft Word documents and manually coded (for example see Appendix 8).
3. The transcripts were sorted into different category headings and files were constructed relating to each theme.
4. Finer analysis followed and new sub-themes were identified. These themes were then incorporated into the workers’ questionnaire.

Emerson et al. (2011) posit that fieldnotes are representations of just-observed events. They are inevitably selective because the researcher notes certain matters that seem significant and therefore leaves out other material. This could result in another researcher observing and recording different data as their interests may lie elsewhere. Researchers according to Miles and Huberman (1984: 27), ‘no matter how unstructured or inductive, comes to fieldwork with some orienting ideas, foci and tools’. The themes I was drawn to while collecting, recording and analysing the data, and an example is shown in Figure 22 below, relate to the significance of food and eating practices in and around the table in residential care

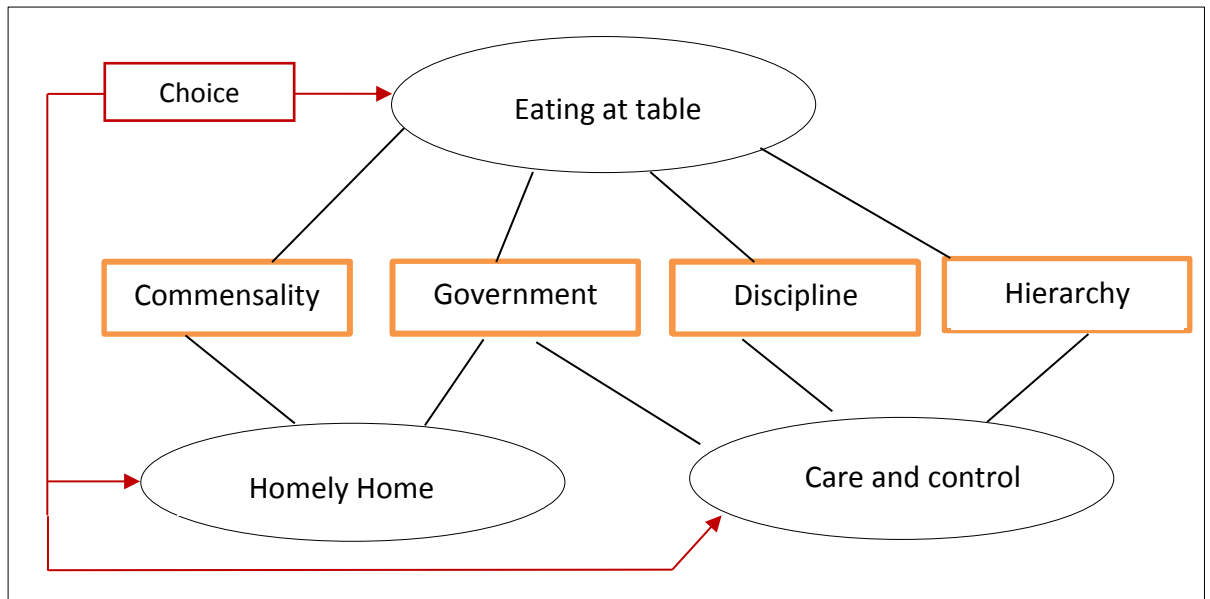


FIGURE 22 IDENTIFYING THEMES AND THE SUBTHEMES CHOICE

During analysis I noted references to the young people’s opportunities for expressing *choice* in what, when or where they ate. The diagram above (Figure 22) shows how the subtheme *choice* is connected to the key themes and theoretical concepts that underpin this study.

5.8.2 Quantitative analysis

For analysis of the workers’ questionnaires I used IBM-SPSS 20, a predictive analytics software package. The questionnaire was designed with appropriate data collection instruments using a Likert scale. When the study was conducted a code book was prepared and a data file was created in the SPSS programme. The data from the completed questionnaires was manually transferred into the SPSS programme. The data was screened and cleaned to check for errors. Preliminary analysis was conducted using descriptive statistics to describe the sample and to check if any of the variables challenged the research assumptions. Correlations were calculated to explore the relationship between variables.

According to Pallant (2013) significance levels should also be treated with caution when the sample is small. The sample in this study is $n=92$. A small sample (e.g. $n=30$) may have moderate correlations that do reach significance, while in a large sample ($n=100+$) small correlations may be statistically significant. Pallant (2013: 127) maintains that significance should be reported

but focus should be directed at how strong the linear relationship is between the two variables. Correlations were also calculated to explore the relationship between groups of variables. All significant correlations are presented and discussed in chapter seven.

5.8.3 Photo-elicitation analysis

As discussed in the final phase of the research design, I conducted a form of photo-elicitation with 43 social care professionals using photographs taken of the dining table in each centre. Photo-elicitation offers the visual researcher an opportunity to elicit how their audience might define the ideological messages associated with the images. Interpretations of images vary from one person to another and an image may communicate a message which was not intended by the person producing that image. Analysis of this visual data is presented with the photographs of the tables and discussed in chapter six.

The different phases of data collection and analysis of this exploratory sequential mixed methods design provides a fuller understanding of the fieldwork sites and the statistical analysis provides detailed assessment of the patterns and responses from the questionnaires. When all the data had been generated a final phase of synthesis was undertaken to create a deeper knowledge of the field. This phase required extensive discussion with my supervisors, re-analysis of data sets and refocus to define themes. The final mix is presented in chapter eight.

5.9 Limitations

A number of issues arose during the fieldwork that may be relevant to further studies in residential care. The first was gaining access to the centres. I did not have experience of working in residential care and as such did not have insider status. This was an independent study so did not have the authoritative backing of CFA or HIQA that would have eased access. In addition, the first stage requests to visit the centres coincided with undergraduate student placements.

Another consideration was the participant's motivations for agreeing to take part in the study. From the outset of the project I was concerned that only the

centres where the managers thought that their food and eating practices were positioned in the *good food* opposed to the *bad food* dichotomy were agreeing to take part in the study. The following fieldwork note from the managers meeting went some way to allaying that concern:

One of the managers from Oaklands suggested that I should come to her unit as they did 'great work' with food. The manager from The Meadows said that if I wanted to see the opposite I should come to his unit. (Fieldwork notes 3rd May 2012).

The opportunity to see what the manager from The Meadows was referring to did not transpire in the end as the arranged visit was cancelled on the day and attempts to rearrange did not work out. Another consideration is that the workers may have prepared and eaten food while I was present that differed from the usual meals. More time spent in the centres would have shown if this was the case.

Using a mixed methods approach has many benefits but it also raises challenges. Challenges in using mixed methods include the integration of the methodologies and methods. As stated, I am drawn to the qualitative paradigm. The quantitative strand of this study challenged and forced me out of that comfort zone.

5.10 Conclusion

This chapter has provided an insight into the processes deployed and the methods of data collection. I have paid particular attention to the ethical considerations of research in this sensitive area. I have identified some of the issues and limitations that arose during the fieldwork. The data collection and analysis of each phase of this sequential mixed methods design is presented in the following chapters. First, in chapter six, the qualitative phase of focused ethnography offers a view of everyday life in residential care from my position at the dining table.

Chapter Six: A table with a view

Presented here are the results from the data collected during the first stage of focused ethnography in the five residential care centres. This stage of the research was conducted to become orientated with residential care settings. The data includes the photographs taken in the field and used for the photo-elicitations. The chapter begins with how access was gained to the centres and describes where the research took place. A discussion follows on what makes a house a home. The Draft National Standards for residential care suggests that all children and young people should live in a ‘comfortable and homely environment’ (HIQA 2010) but what does homely mean? I present some of the issues that conflict with the aspiration to create a ‘homely’ residential care centre (Peace and Holland 2001; Dorrer et al. 2011; Clark 2014). I reflect briefly on my feelings about spending time in the centres. Then links are drawn with the everyday food and eating practices in residential care and the broader theories that were identified in the literature review. These include: what is the significance of food and eating practices in children’s residential care settings in Ireland? Do food and eating practices within residential care reflect similar eating practices in the general public? Is the sharing of meals at the table *commensality* an aspiration or reality in the residential care? Is enactment and enforcement of *hierarchical* behaviour and *discipline* embedded in the rituals, rhythms and routines of the table? How does the *government* of children’s residential services in and around the table affect food and eating practices? This chapter concludes with a discussion of how the food and eating practices, observed in the centres, can be deployed to illustrate this aspect of the complex and multifaceted nature of residential care for young people.

6.1 Getting my feet under the table

When writing the proposal for this project I described painting a broad picture of residential care by conducting observations in the centres. By observing ordinary activities, a researcher can gain an understanding of a social group. I hoped to achieve this by observing the food and eating practices in everyday

life in residential care from the dining table for a prolonged period of time. As discussed, gaining access to the centres was difficult and the time allotted by the managers in each centre was limited, but I believe the first-hand knowledge obtained was vital in developing a personal understanding of residential care to better inform the development and design of the workers' questionnaire.

When I started to analyse the data I felt that all I had was a Polaroid snapshot or a brief summary of everyday life in the five centres. Originally, Polaroid photography captured a moment because the images were 'developed instantly' (Polaroid 2014). There was no separate negative that one could produce a copy from at a later time. As I became more familiar with the raw data, using thematic analysis, I realised that I did, indeed, have the negatives that could develop into a view of residential care. Analysis of the collected data, together with the literature, has resulted in the identification of emerging themes, concepts, patterns and an understanding of the food and eating practices in the centres.

6.1.1 Getting a foot in the door

Having explored (as outlined in chapter five) some of the broad methodological problems and ethical issues of research with vulnerable young people, I was aware that gaining access to residential care centres for young people would be complicated. Over a period of nine months, twenty eight residential care centres for young people were approached to gauge their interest in taking part in the study. Ultimately, just five centres agreed to take part and allowed me access. The disparity between the two figures was significant but it should be kept in mind that I did not have an introduction to the managers, therefore I was cold calling to get permission to send them further information on the study. There is a degree of sensitivity around residential care for young people. The service has been at the centre of largely bad news stories over the past few decades resulting in an audit/regulatory environment. The managers' caution in such an environment is understandable.

6.1.2 Two and a half degrees of separation

The five centres were very different and located throughout Ireland. Three were operated by the HSE and the other two were operated by private residential care providers. Three of the centres were mainstream long stay centres, one HSE and the other two private. One was short stay/respice, operated by the HSE, and the other was a high support facility, also HSE. The centres, the workers and the young people have been given pseudonyms. Due to the relatively small community who live and work in residential care the locations of the centres also have been withheld in an attempt to aid anonymity. There is a theory that everyone in the world is separated by a chain of six people. An acquaintance of mine once suggested that in Ireland it is not six degrees of separation but merely two and a half. It is therefore feasible to assume the people involved in residential care could easily recognise the centres under discussion.

6.1.3 Every picture tells a story

A photograph was taken of the dining tables in the centres during the focused ethnography. These are presented to provide the reader with a representation of each centre. The visual material used in this chapter was originally captured as an *aide-memoire* but may be viewed as additional visual material from which to interpret the analysis. Spencer (2011) discusses the contribution visual methods can make to social research and suggests that there are two compelling reasons for the growing interest in the visual. First, the visual is central to humanity, affecting our ‘emotions, identities, memories and aspirations in a most profound way’ (Spencer 2011: 1). Second, social science has undervalued the visual, using it as a subsidiary to written text or ignoring it altogether.

Ocularcentrism is defined as the privileging of vision above all other senses in Western societies (Jay 1993 cited by Rose 2012; Banks 2007). Increased technology in the postmodern world has resulted in society being flooded with images and methods for capturing them. Despite this, social researchers, according to Wagner (2006) and Banks (2007), remain more comfortable with words and numbers. Words and numbers can seem

more manageable than images. Wagner (2006) suggests that researchers' neglect of visual aspects can distort how they portray the social life that they study. According to Spencer (2011) visual methods have the potential to provide a deeper and more subtle exploration of social worlds.

As already discussed dining tables hold significant symbolic and cultural meaning and they are the focal point of this thesis. Photographing the dining tables emerged from an idea of capturing and recording some material feature of residential care. The dining table is considered to be a site for the socialisation of children into competent and appropriate members of society (Ochs and Shohet 2006). It is also the site of power relationships that come into existence through food behaviours. These behaviours remain mostly unnoticed by the parties involved.

Maynard (2006: 137) suggests that a researcher should 'attempt to render intelligible those repetitions in social life which may be invisible or perceived in purely isolated and personal terms by the individual'. This brings to mind the distinction between the personal and the public that, according to C Wright Mills (1959), is essential to the sociological imagination and a feature of all work in the social sciences. By analysing and interpreting what was seen and heard in the everyday social situation of mealtimes at these dining tables in residential care, this study attempts to render that aspect of their everyday world more knowable.

Social research relies on the researcher to see and interpret on the basis of what is seen. Martin and Martin (2004) recognise that the old adage - every picture is worth a thousand words - may be true and that an image can have a more dramatic impact than text. However, they remind us to be cognisant as to which thousand words the picture is intended to replace. One person may interpret an image very differently to another and an image may be used to 'convey a message which was not intended by the photographer' (Martin and Martin 2004: 9).

According to Rose (2012) pictures, and in this case photographs, convey an enormous amount of information. Not only the image but how it was produced and interpreted needs to be considered within the frame of the research project.

There is an assumption that when presenting photo-documentation that the photographs are ‘an accurate record of what was in front of the camera when the shutter snapped’ (Rose 2012: 301). By contrast, Banks (2007) suggests that documentary photographs are not natural records but a representation of that particular event. Spencer (2011: 18) reminds us that photography has a long association with the potential for manipulation and propaganda. He suggests that ‘this has arguably reached a new peak with the so-called digital revolution’.

Banks (2007) discusses the frame and relates it to the frame within social research that indicates what will be included and excluded from the investigation. The frame in visual research can be physical, as in the actual edge of the photograph. However, for Banks (2007), the frame needs to be considered with regard to what is not shown beyond the edge and what influenced the selected frame. Spencer (2011: 16) argues that a visual representation is always political and that there is a risk in considering photographs as ‘authoritative evidence’. Rose (2012: 12) suggests that to look at images with awareness entails consideration for how visions of social stratification are offered such as ‘class, gender, race, sexuality, able bodiedness and so on’.

What can a photograph of a dining table say about class and gender? When thinking about class, consider the cost of a large solid wood table with eight chairs and the large kitchen needed to house it. When thinking about gender, consider if the choice of dining table is gender neutral or can the centres with a male manager be identified? Considering social stratification and age, are any of the tables child-friendly? In other words, a picture of a dining table is not as straightforward as it may appear.

To provide the reader with a view of the research sites the photographs of the dining tables are presented next. The tables may be viewed as synecdochical signs – a part of something that serves to represent the whole of the centre. The tables themselves and how the space is used in and around them can be reflective of the centres’ ethos. In an attempt to widen the frame I briefly describe the location of the photograph and introduce the young people who

were living in the centres. As discussed in chapter five, I conducted a form of photo-elicitation with 43 social care professionals to aid analysis of the photographs of the dining tables. They were asked to select which table they would want to eat all their meals at and which table represented home, institution and family. Their interpretations are presented with the photographs. Photo-elicitation offers the visual researcher an opportunity to elicit how his/her research audience might define the ideological messages associated with the images.

Glenview



FIGURE 23 GLENVIEW DINING TABLE
Photograph: Manager Glenview

Glenview was a short stay/respice centre a few miles outside a large town. It was a large detached house situated in a large garden with chickens running around. The house was typical of the neighbouring houses. The ground floor consisted of two sitting rooms, the staff office, the main bathroom and a large kitchen/diner. The house, as the photograph suggests, was tidy and there were very few pictures or ornaments. I conducted a pilot study here in October 2011 when there were two young women in residence. When I returned in February 2012 I spent three days at this table with 11 workers and four young people who were siblings: Darragh, 11, Connor, 13, Brian, 15 and Aisling, 17.

During the fieldwork in this centre there were discussions about the centre's future due to HSE cuts and the falling numbers of young people in the area requiring residential care. In the intervening period this centre has closed.

I did not take a photograph of this table because my ideal vantage point to capture the table and a little of its surroundings, as the other photographs show, would have included a large window that would have shown the

location of the centre. After taking pictures of the tables in the other centres I contacted the manager and asked him if he could take a picture and send it to me. This picture was taken in December. The Christmas tree and the red table cloth had not been there when I visited the previous February. The table mats, fruit bowl and the bottles of sauce were. This was a long table that fitted four chairs comfortably at each side. The table just fitted into the space and this is perhaps why there were no chairs at the short ends of the table.

Analysis of the photo-elicitation with the 43 social care professionals shows that the photograph of this table was selected by five people who would like to eat all their meals there and seven people thought it represented home and family. Five people said it represented an institution.

I felt quite comfortable at this table. This was the centre where I conducted my pilot study so it felt familiar. Also the young people eating with me at this table were siblings and some of their interactions at the table were also familiar due to coming from a large family. It was mid-term break and it felt like the young people were on holiday. One major contribution to the atmosphere in this centre was that the young people were there on a temporary basis and would be returning to the family home in the near future which added to the holiday feel.

Woodlands



FIGURE 24 WOODLANDS DINING TABLE
Photograph: Deirdre Byrne

Woodlands was a purpose-built long stay centre on the outskirts of a large town. There was just one resident - Fiona, 17. The centre provided accommodation for up to four young people. There was another resident - Gemma, 18 who had just moved into the independent living apartment on site. I spent four days at this table with Fiona and seven workers for breakfast and the evening meal. It was obvious from the exterior that this centre was not a regular house. The building was very large, one storey and set in a large garden. There are two reception rooms, a computer room, six bedrooms, manager's office, reception office, staff office and a large kitchen/diner. In the hall there was a basket for the resident cat that had been living in the centre for a few years.

Of all the centres this one has the most objects on display. On the side board there were photographs of Gemma the resident who was living in the independent living accommodation. The artwork on the wall and the sideboard consists of the same resident's original work and also generic prints. The flowers are artificial. The broken light bulb is waiting to be replaced by the

HSE maintenance department. Having a bulb-changing service is not usual in the average household and the workers or the young people not being 'allowed' to change the bulb themselves is indicative of institutionalisation in this centre.

The photo-elicitation shows, of the 43 respondents 13 chose this table as the one where they would want to eat their meals. Nine people thought it represented home and seven family. This table did not represent an institution for any of the respondents.

As discussed social research relies on the researcher to see and interpret on the basis of what is seen. One person's interpretation of an image may be very different to another and an image may be used to 'convey a message which was not intended by the photographer' (Martin and Martin 2004: 9). This may be the case for this photograph. This was a purpose-built centre. When entering this centre, for me, there was no question as to whether or not it was an institution. It smelled like an institution - a mix of cleaning fluids and food. The table was situated in a very large space and a stage set came to mind. The atmosphere at this table was uncomfortable. Fiona, the young person living here, did not want to be there.

Hillgrove



(There were just six chairs the others had been broken)

FIGURE 25 HILLGROVE DINING TABLE

Photograph: Deirdre Byrne

Hillgrove was a purpose-built, high support centre situated on the outskirts of a small town. This centre did not resemble a domestic home. The centre was designed to provide a high level of safety and security and is similar in design to special care units constructed in the same era. There were two houses on site one for boys and one for girls. In the interim period, between conducting the focused ethnography and the workers' questionnaires, one of the houses had closed. Each house was identical and had accommodation for five young people. Also on site were: a school, a gym, two apartments for visiting family and administration offices. I was shown around both the houses. On entry the first room was very large with a locked office that had a large glass window (I was reminded of the nurse's station in *One Flew over the Cuckoo's Nest*). The lounge area, with sofas and a television, was partitioned off by glass. There was a games room with a pool table to the left which also had a glass wall. The staff constantly record and monitor the young people's actions, behaviour and progress. The centre of the room was the dining area with two large tables but only one had chairs. The kitchen had a swinging fire door and it was well

equipped and stocked. The staff carried Pinpoint alarms for their safety and a master key that locked and opened all the doors. I spent four days in this centre and met 30 workers. There were three boys: Gavin, 15, Dylan, 15 and Richard, 13 in the boy's house. There were two girls in the girl's house but one was being taken into secure care that day. Lisa, 15, the young woman who remained, spent quite a lot of time in the boys' house. During my induction I was informed that there was a new resident group, the three boys Gavin, Dylan and Richard, who were described as unsettled. I was told that I could only be present in the centre between ten am and three pm.

This photograph was the least contested image in the photo-elicitation. Nobody wanted to eat there, or thought that it represented home or family. The majority of respondents recognised this image as an institution. The atmosphere at these tables was not comfortable. I did not sit at these tables unless I was accompanied by a worker.

(This centre has since been closed).

Hazelbrook



FIGURE 26 HAZELBROOK DINING TABLE
Photograph: Deirdre Byrne

Hazelbrook was a long stay centre situated in a semi-detached house in a city suburb. The house did not stand out in any way from the other houses in the area. This kitchen/diner pictured above had signs of everyday life with the residents' belongings strewn around and their clothes on the dryer. On the ground floor there was a sitting room, the staff office, kitchen/diner, utility room and a staff toilet. This centre provided accommodation for four young people and there were three young women in residence: Bridget, 16, Julia, 16 and Olivia, 15. Julia and Olivia were sisters. Olivia boarded at a special education school during the week so she was not there the first evening. Julia was away on a transition year school trip and was also absent. I spent two days at this table and met six workers.

To the left of the table there was a computer that Bridget used for the internet and to watch movies while the workers and I sat at the table. The fridge had lists with the young people's New Year resolutions and artwork. The kitchen/diner had recently been redecorated due to a recent incident when Bridget had wrecked it.

Analysis of the photo-elicitation shows that 6 of the 43 respondents would want to eat at this table, 11 thought that it represented home, 2 an institution and 6 family. As this photograph shows this is the only centre that looks messy and suggests that they are not putting on a show. The mess also suggests that people live in this space. The atmosphere at this table was comfortable.

Oaklands



(One chair missing here it too had been broken)

FIGURE 27 OAKLANDS DINING TABLE

Photograph: Deirdre Byrne

Oaklands was a long stay centre on the outskirts of a large town. It was situated in a rented semidetached house in a housing estate. This was the smallest house I visited and perhaps because of this it felt the most *homely* by which I mean a domestic space and I discuss this in greater detail below. On the ground floor there was a sitting room, a toilet and a large kitchen/diner. The staff office was upstairs and doubled as a staff bedroom. The centre accommodated two young people and there are two boys in residence: Robert 15 and James 16. I spent four days at this table for lunches and evening meals and met nine workers.

Just to the edge of this photo you can see an armchair. There was also a two-seater sofa and a television that was on during the evening meals. After dinner Robert watched television in this space and tuned in and out of the conversations at the table. On the wall to the left there were photographs of

Robert with his family and workers. At the last lunch here James brought his friend from school to eat. The friend looked very relaxed in the centre and I was told later that he spent quite a lot of time there.

This table was the most frequently selected picture in the photo-elicitation. The amount of people who would want to eat at this table was 13 (the same as Woodlands), 15 people thought it represented home and 20 thought it represented family. Nobody thought this image represented an institution. The workers and the young people talked together and appeared to have a good relationship. The atmosphere at this table was relaxed.

6.2 What makes a house a home?

‘Standard 17: The Living Environment’ in *The Draft National Standards for Residential and Foster Care for Children and Young People* requires – ‘that each child and young person lives in a comfortable and homely environment’ (HIQA 2010). However, the concept of ‘homeliness’ is, as Annison (2000) suggests, an elusive concept. Home, on the other hand, has received significant attention but, according to Mallett (2004: 62), it remains ‘a multidimensional concept’ that requires multidisciplinary research. She suggests home can be place(s), space(s), feeling(s) or practice(s). Home can also be as, the phenomenologists describe, ‘a state of being-in-the-world’ (Monza 2003: 43).

Home is difficult to define because it has many characteristics and levels of meaning. Home can be where you come from, where you currently live or where your family live. You can feel at home and make yourself at home. You can be living at home or in a home. Home may be located in a house, apartment or an institution but it is always more than this – it is a physical space that is lived (Mallett 2004: 80). Home is where the hearth is – welcome and warm or home is where the heart is – a loving secure and stable environment. Mallett suggests that ‘memories of home are often nostalgic and sentimental, home is not simply recalled in positive ways’ (ibid: 64) and not for people subject to violence and abuse who ‘are likely to feel homeless at home’ (ibid: 73).

A home can reflect something of the individual through the personalisation of space and by the familiar things that surround us. One way to consider our attachment to a space is reflected in those possessions. ‘Which eight things would you take with you’ is an activity found on an extract for an Open University Social Care course (2014). The activity is based on the radio programme *Desert Island Discs* that asks people to pick eight records that they would take if they were to be cast away on a desert island. The Open University version asks you to consider if you were to move to a place and could only take a few things with you to make it your own, what would you choose? Your list will say something about who you are because, as Miller

(2010) suggests, people express themselves through their possessions. For Miller the objects we choose to live with are not random collections but gradually accumulated and can make a statement about a person or a household because material objects are ‘infused with the underlying order that gives them their expectations of the world’ (Miller 2008: 287). Material culture, according to Miller, is central to our lives, our relationships and our wider relationship with society.

The stuff we surround ourselves with can speak volumes about who we are or how we would like to be perceived. In a study of women in prison Quinlan (2011) gathered data through photo-elicitation interviews with women prisoners using photographs of their rooms and cells. The women were permitted to decorate their personal spaces. ‘They take possession of the prison space and they personalise it and feminise it... [and]... their dressing tables, were in effect cultural shrines to home, family and friends’ (Quinlan 2011: 221). Quinlan maintains that the women’s personalisation of space assisted in reminding them of their relationships to others and their place in relation to the world. People living in a care setting may be permitted to personalise their own space, but often do not get the opportunity to do so. Older people moving into a care setting may have to leave a houseful of possessions behind. The literature from the Open University course suggests we assume that a young person will not have so much stuff accumulated but they also have to leave familiar objects behind.

The body of literature on home, for example Clark et al. 2014, O’Mahony (2012), Kaup (2011), Dorrer et al. (2011), Peace and Holland (2001), Christensen and James (2000) and Bowlby et al. (1997) identify the key meanings that represent home as a space for: privacy, family, security, control, personal-identity, self-expression and continuity. Annison (2000) adds comfort to that list. Henderson et al. (2007: 128) suggest that ‘memories, history and emotion’ are significant in young people’s perception of home. So a home is a private, familiar space, somewhere that you can be yourself, feel relaxed and comfortable. Young people living in residential care may have experienced living in several homes before moving into residential care therefore their

perception of what makes a 'homely home' may be very different from young people who have lived with just one family.

A residential care centre is a complex space where the spheres of private home and public work space overlap and, as Peace and Holland (2001) suggest, 'homely residential care' may be a contradiction in terms. According to Ormond (2014: 258) there is an 'inescapable artificiality' in residential care centres. One young person in his study put it succinctly, 'how would you like to live in a house where people work?' Clark et al. (2014: 6), who explored meanings of home from the perspective of young people and workers in residential care centres in England, suggest that a residential care centre can be 'an in-between space' for the young people that involves routines of 'doing home'.

Clark et al. (2014) suggest that the physical environment has received little attention in residential care theories. An exception being Maier (1987) who recognised the importance of the physical space as it contributes to a sense of emotional wellbeing and belonging for the young people and the workers:

Special effort has to be directed toward establishing that the children's beds and rooms are not only attractive, comfortable, and practical, but that they symbolize almost more than any segment of the residence the message 'we care' (Bettelheim, 1974: 153). Staff continuously need to search out whether attention given to furniture, room arrangements and decorations are really in the best interest of the children or whether these concerns reflect an adult conception of a spick and span and respectable place (Maier 1987: 22).

Dorrer et al. (2011) discuss the ambivalence felt by children and young people towards the 'institutional home' the young people they researched did not view the residential centre as their home but their natal home as home. Azzopardi (2011) also found that the young people in her study equated home with where their family lived. Some of the young people associated home with privacy and freedom to do what they liked when they liked. The participants in the Azzopardi (2011) study also referred to the appearance and physical structure of the centres and the stigma associated with being seen entering them. In

addition the young people in that study felt that home could also mean somewhere that they felt safe, secure and cared for.

My research also suggests that if the young person felt more secure in their placement there was less ambivalence felt towards the centre. Julia (16) from Hazelbrook, a long stay centre, was secure in her placement and boasted that she would be able to stay there until she was nineteen because she would be finishing her second level education. Fiona (17) from Woodlands, another long stay centre, had been in care for a short time and was counting the days until she was eighteen and could leave. Young people leaving care in Ireland do not fit neatly into the emerging adult or extended youth theories (Lalor et al. 2007) where young people leave or return to the family home at a later age. Recent European research shows that in some European countries up to 80% of young people aged 18-29 are still living with their parents – in Ireland about 45% (Eurofound 2014). Care leavers, in contrast, have an accelerated transition into adult life at 18. Fiona (17) had been in the care system for a short period so her entitlement to after care services was not guaranteed. She was therefore in a vulnerable situation and this went some way to explaining her negative feelings towards the care centre.

The workers in residential care are further challenged in their attempt to create a homely home by the language of residential care. A residential care centre is not called a 'home' in Ireland as they are in the UK. One possible reason for this naming is that a residential centre is always temporary and re-establishing the young person into a family home is rarely ruled out. A second reason for the naming may be the negative connotations that are associated with *children's homes* that have come to our attention over the past few decades here in Ireland. Another difference in the language of children's residential care is that in the UK children and young people are 'looked after rather than in care' (Smith 2009: 31). This links back to Lynch et al. (2009) who argue that care, because it is positioned in the affective domain, is treated as a private matter and not of sufficient political importance to be mainstreamed in theory or in this instance the language of residential care. Smith (2009) argues that the terminology changed to highlight rights and to reduce the stigma of being in care. Children in family settings are also *looked after*, therefore the

terminology could be described as neutral, but the stigma attached to the term *in care* may be, with time, equally applied to the term *looked after*. A further consideration is that removing the word *care* from residential care could be seen as downgrading the nature of care.

The care workers in the Dorrer et al.'s (2011) study were committed to creating a homely environment rather than being seen as creating an institution. Dorrer et al. (2011) also found, from the young people's perspective, that some of the workers' practices detracted from the feeling of home. An example given was eating at the dining table: while the workers saw this as a way to reproduce family/home, for the young people it was seen as constraining and therefore inhibited the feeling of homeliness. Discussions with the workers in this study show a similar commitment to making the centres they worked in homely and they too were of the opinion that eating together at the table helped towards that aim.

If we can get them to eat with us at the table then it is more homely (Bernie, Hazelbrook).

Interpretations of homeliness may be individual but they are not value free. They are informed by cultural norms and theory. With that in mind I noted my first impressions of the centres. On entering one centre I was struck by the smell of cleaning products. This, in my opinion, was not conducive to a homely atmosphere - for me it was more like a hospital. I also looked for the stated criteria in the communal rooms. In all the centres, furniture and decoration were domestic in nature. As the photographs of the dining tables (figures 23-27) show the domestic furnishings and decoration varied in the centres. Three of the five centres had pictures of the residents on display. Oaklands had photographs of one of the residents with his family and with workers on days out. The other resident had just recently moved in and his photographs had not yet been put up.

In Hazelbrook the fridge was covered with drawings and lists that the residents had produced. Crumpacker (2006: 103) suggests that the refrigerator door, covered with magnets or clear and sterile, may be viewed as a window to the heart of a household. In Woodlands there were pictures of Gemma who had

moved into the independent living apartment but not of Fiona the current resident. In all the centres (except Hazelbrook) the outside door could be opened from the outside but I would knock before entering. Some centres used the back door and others the front door. A piece of furniture present in all the centres was the large dining table.

In general I was welcomed into the centres with the offer of a cup of tea that would be taken at this table. Smyth (2007), in her study of the use of tea in the social care workplace, found that it was central to most social gatherings in Irish culture including social care settings. Referring back to the photographs of the dining tables as you can see all but one adhere to the hierarchical model of the rectangular table, discussed in chapter one, that allows distinction for the diners sitting at the short sides of the table.

To recap, the meaning of homeliness is shaped by individual values and preferences and what makes one person feel at home differs from what another would choose. The HIQA standards suggest that there may be a common criteria including the space being bright, clean, tidy, comfortable, and in good decorative repair. A residential care centre is a complex space where the spheres of private home and public work space overlap (Peace and Holland 2001). Young people living in residential care may feel ambivalent about the institutional home and the people employed there bring their own interpretations of home to the centres (Clark et al. 2014; Azzopardi 2011; Dorrer et al. 2011). Chapter seven presents analysis of the questionnaire for the workers and further explores how institutional regulations may conflict with the aim to provide a 'homely' home.

6.3 Look who's coming for dinner?

Young people living in residential care encounter many adults on a daily basis. The mainstream centres had, on average, ten workers and a manager employed. There were also people from outside the centre who visit and work with the young people. They had their own social worker and, depending on the individual situation, workers from: Garda Youth Diversion, Drug and Alcohol Education and Prevention, School Completion Programme, After

Care Services or outdoor-pursuits workers. Some young people also had regular contact with their parents and other family members.

During the course of the focused ethnography I met four centre managers and twenty-nine workers in the mainstream centres. In the high support centre I met at least thirty workers that included: receptionist, maintenance worker, chef, cleaner, teachers, psychiatrist, deputy director, house managers and social care practitioners. The majority of the workers I met worked a twenty-four hour shift so it was rare to meet the social care practitioners more than once. According to Furnivall (2011: 11) shift patterns in residential care can disrupt 'contacts between children and carers' but an advantage is that children have a choice of different adults to connect with and this makes it more likely that a child will make positive attachment relationships.

Due to the shift patterns I had to explain what the research was about daily. When unacquainted people meet they seek to find information about each other to help define the situation and learn what is expected of them. According to Goffman (1959) they can also assume that only a particular type of person will be found in a particular social setting. A residential care centre for young people is a hard-to-reach site. In this case my authorisation to be in the centre was: I had been approved by an ethics committee, I had been Garda vetted, the young people and the workers had been informed as to why I was there, the centre manager had informed me when and for how long I could stay. I was not just 'dropping in' for dinner.

6.3.1 Finding my feet

While the centres were accustomed to having social care students on work placement, my role was different. The perception I hoped to convey was that I was just hanging around trying to get a sense of the place. Visiting the centres was my first experience of residential care for young people. One of the first questions I was asked by the workers in all the centres was: had I worked in residential care? This may have been to gauge if I was one of them and/or how I might be judging them. My reply was 'No, but I believed that this might be advantageous to the project as I would be looking at residential care from a critical and open perspective'. However, on reflection, I was already

influenced by the reports and literature I had reviewed before entering the field.

According to Smith (2009) one can distinguish the *feel* of the centre very quickly. There will either be a feeling of tension or a feeling of calm. This could also be said of other institutions such as prisons, hospitals or schools. Describing the residential environment, Smith suggests that even in the best operating centres it can be stressful and likely to provoke anxiety. Workers frequently find themselves dealing with individual or group dynamics 'that appear to be simmering, or teetering, on the brink of a loss of control' (Smith 2009: 95). Emond (2000) found that there was a general preconception that residential care centres for young people were places to be feared. Emond suggests that this preconception could affect the young people being admitted because they felt that they had to *act up* to the image of an out of control child that could *kick off* at any minute. I entered the centres with some trepidation.

While I did not witness any direct violence there were signs that it had happened. In Hillgrove the office door was being repaired when I arrived as the wooden panel had been kicked in the previous evening. At lunch I enquired about the six missing chairs and was told they had been broken and not yet replaced. There was a charged feeling in this centre. It may have been in part because of the pinpoint alarms and the office remaining locked that added to the feeling that things could *kick off* at any time. On my second day in Hillgrove the young people and the workers were all exhausted as it had *kicked off* the previous evening. The young people were fighting amongst each other - they had been up all night and the Garda (Police) had been in attendance.

There was violent behaviour reported in Oaklands. One of the residents had broken bannisters on the stairs and broken the missing chair. This centre did not have the same charged feeling as Hillgrove. Unlike Hillgrove, that had a new resident group, this centre had been stable for some time. The resident who had caused the damage here had been informed that he had to move to a foster family and did not want to go. Woodlands was the centre where the most obvious verbal clash occurred between the workers and the young woman in residence (Fiona 17). However, I felt that there was no threat of

violence in this centre. One of Fiona's complaints about being in care was the food.

6.4 Three square meals: routines, rhythm and rituals of food practices

The significance of the rituals, rhythms and routines of food are commonly associated with the ordinary routines of everyday life. Bell and Valentine (1997) suggest that food and eating are associated with ordering or creating rhythms: the day with breakfast, lunch and dinner; the week with the Sunday lunch and the Friday night take-away or the year with birthday cake and Christmas dinner. The routine of a meal shared at the table is associated with kinship. According to Fischler (2011) the shared mealtimes or commensality are central to the creation and bonding of groups. The rituals, rhythms and routines of food in residential care are significant but, according to Emond et al. (2013), may be overlooked by the young people and the workers. Food and eating practices are entwined with care and control, not just for the young people, but also the workers. Smith et al. (2013) and Punch and McIntosh (2013) are in agreement that young people living in residential care need rituals, rhythms and routines to help ease their transition into care and to provide a sense of security and predictability.

All the centres provided three meals a day: breakfast, lunch and dinner. I was informed by the workers in all the centres that the young people had access to the kitchens and could help themselves to snacks or cook themselves a meal. The time of the evening meal was flexible and depended on who was doing the cooking. Woodlands appeared to have the least flexible attitude to mealtimes and it was in this centre that most conflict was recorded (as the quote below indicates).

It's horrible here - they cook dinner but I don't eat it (Fiona 17 Woodlands).

On reflection, the conflict may not have been about the workers routinely having the dinner ready on the table at the same time every night. It may have been that Fiona did not like what they were cooking. Taste is arguably the most significant feature of food. In addition, how food smells or looks can

prevent its being tasted in the first place. Trust, according to Milne (2013: 230), is essential when it comes to eating food prepared by others. Trust 'is individual and relational, rational and emotional'. The concept of trust can also be linked to Douglas (1972), who found food events ranged from intimate to distant. In her home meals were for sharing with family members not strangers. This suggests that for Fiona, eating what the workers cooked would not only mean that she trusted that their food would not poison her but eating their food would symbolise that she trusted them.

Breakfast and lunch in all the centres depended on the school timetable. I inquired from the workers what the young people had for breakfast and in all the centres was told that it was informal, with the young people helping themselves to cereal, toast, juice or tea. I was present for breakfast in Woodlands and Jackie (Worker) made pancakes for Fiona (17) on Shrove Tuesday morning as a treat. One morning Fiona (17) ate the berries from Special K Berries and on another she ate cake with Skooshy cream. In Glenview I was present during mid-term and the young people were getting up late and therefore breakfast was being eaten at what could normally be considered lunchtime by adults. They helped themselves to cereal.

Hillgrove had a school on site and the young people came back from the school building for a morning break and lunch. In Oaklands the young people were picked up from their schools and brought back for lunch. The manager in this centre thought this was important as it was an opportunity for her to spend quality time with the residents. The managers in residential care ordinarily work nine-to-five Monday to Friday so when the young people are attending school there is limited time to spend with them. In the other two centres the young people were given money to buy their lunch. I asked Fiona (17) from Woodlands what she did at lunchtime:

| | |
|-----------------|---------------------------------------|
| Fiona | I have a cigarette and start a fight. |
| Jackie (worker) | What? |
| Fiona | No I have a Chinese. |
| Jackie | The Chinese isn't open at lunchtime. |

Fiona Abracadabra has a noodle bar thing it is really nice.

Jackie I thought Abracadabra just did kebabs.
(Fieldnotes Woodlands).

This conversation suggests that Jackie is concerned about what Fiona may be doing at lunchtime. She joins the conversation at the point where Fiona says she smokes and fights in her lunch break. Fiona recognised the concern and said she did eat noodles from the fast food restaurant but Jackie again questions her honesty. The concern appears to be about Fiona's behaviour (smoking, fighting and lying) rather than her possibly not eating at lunchtime. This discussion shows, to some extent, that food and eating can be a catalyst for conflicts between young people and adults and the underlying issue is power and control. Fiona begins this discussion in control, stating that she is a powerful young woman who smokes and fights. She is a force to be reckoned with. Jackie appears to recognise this and quickly regains authoritative control.

In all the centres there was an evening meal at the dining table between five and seven o'clock and everyone present was encouraged to partake. The National Standards for Children's Residential Care state:

Staff and young people eat meals together and these are regarded as a positive social event (DoHC 2001).

The interpretation of a positive social event is subjective. How a young person regards a positive social event may or may not conflict with the workers or the HIQA inspectors' view. McIntosh et al. (2010) found conflict developed between the young people who were resistant to the set eating arrangements and the workers who felt that sitting at the table was an opportunity to produce a homely feel in the centre. I was not present at the evening meal in Hillgrove as I had to leave by 3pm but in all the other centres everyone in the centre was at the table for the evening meal except for one worker in Glenview who described herself as a picky eater. This worker discussed being questioned by the young people about what she ate and having to be careful with her answers as she did not want to influence their eating habits. This suggests that the workers' eating practices are also subject to surveillance and control:

If I told them why I don't eat minced beef they might not want to eat it either (Anne, Glenview).

Whether those at the table were eating or not was another matter. In Hillgrove when the young people had returned to school for the second day without eating lunch I broached the subject with the three workers who remained at the dining table:

When they have returned to school I ask if the boys often do not have lunch. The workers seem unconcerned and say 'Yes they would rather spend their free time playing on the Xbox than eating'. The workers talk about some young people not wanting to eat at the table or sit with the staff. They discuss young people not wanting to eat in front of other people. I ask if they are allowed to eat in their rooms and they say, 'Of course, they can eat were they like'. They discuss the fact that some young people are not used to eating proper meals but with time they do come to the table.

(Fieldnotes Hillgrove)

This extract from fieldnotes covers multiple themes and raises many questions. First, it appeared the young people in this centre would rather spend time in their own rooms than sit and eat with the staff but, of the lunchtimes when I was present in Hillgrove, the minimum number of adults sitting at the dining table was four. That left two seats at the table and there were three boys resident in the house. It may be that they did want to play on their Xboxes or it could be that Hillgrove is a high support centre and the residents are under surveillance most of the time, therefore spending time in their bedroom affords them some privacy. I was informed that the power in the bedrooms could be turned off to encourage the young people to come into the communal areas. The worker who informed me of this seemed unaware of how intrusive such a practice could be interpreted. If this had been a correctional facility this example of the power imbalance between the workers and the young people may have been expected. However, Hillgrove was a high support centre.

The second issue is eating with other people. Eating at the table for the young people, according to McIntosh et al. (2010), was often associated with being closely monitored and assessed. Punch et al. (2009: 8) found that the young people could feel vulnerable at the table 'because of the level of exposure to or

surveillance of the group and the need to eat'. Punch et al. (2009) suggest that the shifting of the composition of the residential group added to the complexity of mealtimes at the table. The resident group in Hillgrove were described as unsettled because they were all relatively-recent arrivals. This once again reflects back to trust and eating with strangers. It also points to the boys' levels of comfort: not only feeling comfortable eating in front of strangers, but their physical comfort – having enough chairs.

6.4.1 What's cooking?

While exploring the rituals, rhythms and routines of food and eating practices I recorded what the young people in care were eating. Collection of this data helped to establish if young people in care ate a similar diet to young people in the general public and how food choice was managed. It was evident from the centres I visited that 'traditional Irish dinners' or a *proper dinner*, as referred to by Charles and Kerr (1988) or Murcott (1982), were not being served.

In here some kids' idea of a Sunday dinner is pizza and chips (Sue, Woodlands).

The comment from this worker suggests that children coming into care are not familiar with the idealised *proper meal*. The top results on Google search suggests that traditional Irish dinners consist of Irish stew or potato with boiled bacon or corned beef. *The What Ireland Ate Last Night* study found that the *proper dinner*, meat and two veg, was Ireland's favourite style of dinner (Bord Bia 2011). However the report also shows that Spaghetti Bolognese was the favourite dinner for children. In the centres pasta was the most frequently served carbohydrate accompanied with a jar of sauce. Martin (2004: 156) found in his study of Irish student eating practices that the young people were 'enormous buyers of these processed sauces'. In this study meat was served at every dinner with chicken and minced beef being used most often.

From informal discussions with acquaintances who work in residential care I had made an assumption prior to commencing the fieldwork that oven chips and frozen pizza would feature heavily on the menu. Frozen oven chips were served once and twice homemade potato wedges were made as the healthy alternative to chips. Frozen pizza did get used once as an alternative to the

meatballs and that was by a vegetarian member of staff. Homemade pizza was served for lunch by the chef in Hillgrove. The two centres that provided lunch for the young people, Hillgrove and Oaklands, both provided salads but the staff rather than the young people generally ate these. The majority of the dinners were pasta sauces, curries or stews. Many of these meals did contain vegetables but only once did I see a vegetable being cooked on its own to be served as a vegetable. Fiona (Woodlands 17) ate several of the Brussels sprouts from the saucepan when the workers were out of the kitchen. All the centres had a fruit bowl on display showing that a healthy snack option was available. It was only in Glenview that the young people showed any interest in fruit, suggesting that the fruit bowl is a symbolic representation of healthy food choice. Clark et al. (2014: 13) suggests that the fruit bowl draws attention to the ‘institutionalised home’ that has responsibility to supply healthy food choices but also ‘it demonstrates the practices of *doing home* and also highlights an underlying narrative of *idealised home*’. The fruit bowl according to Orr (2011) says something about a household’s ‘sophisticated and healthy choices’, but in many households the fruit rots or shrivels before it is eaten.

In the past few decades the expert advice (Coveney 2014) given to parents is that children should be given choice and participate in the decision making about their diet. Generally, in the residential care centres, everyone ate the same dinner. The most significant conflict over food happened in Woodlands. The first morning I met Fiona and told her I was interested in how food was done in residential care she said:

Fiona It’s horrible, you’ll hate it.

Deirdre The place or the food.

Fiona Both.

(Woodlands fieldnotes)

In this centre the workers had the dinner ready at five pm. The first evening a chicken stir-fry had been made and Fiona did not eat it. She made herself some homemade soup using frozen vegetables and offered some to the workers and

me. The following evening there was a pasta bake prepared that Sue was putting into the oven when I got there. As she was setting the table I asked if they discussed with Fiona what she would like for dinner. The answer was that they discuss food preferences with the young people when they arrive in the centre. Fiona had arrived in the centre four months previously. So this would suggest that they had not discussed her food preferences since. Punch et al. (2009) found that some young people do not feel comfortable talking about their food preferences to people they did not know. This may have been the case here. The following extract is from the Woodlands fieldnotes. I was sitting at the dining table when Lorna (worker) and Fiona (17) came in from school. Lorna went through the kitchen to the office and Fiona to the cooker:

- Fiona Is this all there is for dinner? (*lifting the lid on the Brussels sprouts*)
- Deirdre No if you look in the oven there's fish and chips - (*Fiona pulls a face*) - it's Ash Wednesday.
- Fiona Oh my God, so just vegetables.
- Deirdre No - no meat.
- Fiona But fish is meat.
- Deirdre I know but it's an old tradition on a fast day you can eat fish - (*Fiona starts to look in the cupboards and fridge*).
- Fiona You're taken the hand out of me.
- Deirdre No, that's what's made.
- Fiona They know I hate fish.
- Deirdre Do they?
- Fiona That's why I hate this place - (*she has taken a jar of pasta sauce and some pasta from the cupboard and puts a pan of water on to boil*) - did you see those sheep out there - I'm afraid of sheep.
- Clare (*Clare and Lorna, the workers on duty, enter the kitchen*)
Hi Fiona - (*Fiona is eating Brussels sprouts from the pan*).
- Fiona Did you see the sheep I'm terrified of sheep.
- Lorna How could you be terrified of sheep? - (*She puts the pasta and sauce back into the cupboard*)
- Fiona I was attacked by them when I was small.

Clare Do you want some of this? (*Taking the fish from the oven*)

Fiona No I don't like fish.

Clare You don't eat fish? Well it's a fast day. Do you want a pizza? What are you going to eat?

Fiona Nothing.

Clare Well there's chips there.

Fiona I'm making myself spaghetti.

Clare What?

Fiona Pasta and ah... whatever you call it sauce.

Lorna Sorry, were you having this pasta? - (*Taking the jar of pasta sauce and spaghetti out of the cupboard again*).

(Woodlands fieldnotes).

This exchange highlights the cultural and religious tradition of eating fish on fast days here in Ireland. Fiona was from Eastern Europe and had moved to Ireland with her mother several years ago. I am not sure if she had a religion but she did tell me that her father was Muslim. This would have been Fiona's first Catholic fast day in the centre and there had obviously been no discussion with her about abstaining from warm-blooded meat for the day, or for that matter what she would like to eat any day. This conversation draws attention to the relationship between Fiona and the workers. 'They know I don't like fish' could be interpreted as - they do not care for me.

In contrast, the sibling group in Glenview challenged the workers' own preconceptions of the hungry child coming into care. These young people were described as *foodies*. When Anne (worker) returned with the shopping on my first day there she was delighted to have found a packet of mixed fresh chillies. The young people liked spicy food and complained that the workers never made anything hot enough. Darragh (11) the youngest was able to identify the different chillies. The menu choice was discussed with this group and they were given a choice of what they would have for dinner the following day. This gave the young people a sense of control over what they would be having for dinner.

In Hillgrove, the high support centre, the chef had complete control over the menu. The young people and the workers either ate or did not eat what was presented. In conversation with the chef, he was aware of the worker's likes and dislikes but not the young people's. He also said that the workers were not adventurous enough with their food and therefore did not set a good example for the young people. The following extract from Hillgrove fieldnotes shows that the chef did offer the young people and the workers a choice but not at the planning stage.

The chef works on a four-week menu and gave me a copy of this. I ask what input the young people have. He said that having young people in the kitchen when he was working was difficult. He was aware that they need to learn how to cook but it made his job more difficult and things took twice as long. He also said that health and safety was an issue, as he had to watch them with the knives and boiling water. I asked again if the young people had any choice in the menu plan. He said that there was always a choice at lunch - they can have soup or not. There is always food in the fridge and they can make themselves something. There are always noodles that he himself would not buy if he had the choice but some young people will not eat anything else (Chef Hillgrove).

Hazelbrook had a menu rota but it was subject to change. The shopping was done with the menu in mind but as Jason (worker) who did not want to make the burger and chips on the menu, pointed out, cottage pie uses the same ingredients. Bridget was given the choice burgers or cottage pie and said she would make the pie the same way her Granny did. Oaklands said that the residents each got to choose what to have two nights a week and yet the worker was able to give me the next four weeks' menus. This would suggest that the young people might have had an input into the menu plan at some stage but not for the following four weeks.

I also looked for signs of workers cooking different meals for the young people. I did not witness this but Kate from Glenview discussed how much easier it was to cook for the sibling group:

Kate went on to explain that the young people are asked the previous evening what they would like for dinner the following evening. I had witnessed this the evening before. Anne had asked all the young people what they fancied from the selection of mince or chicken pieces, suggesting fajitas or bolognaise. Connor suggested that they could

make meatballs with the mince but the general consensus was fajitas. Kate said that when a group was not a family group then sometimes no consensus is reached and the individual young people refuse to eat what the others would. When it is presented they sometimes refuse to eat it and help themselves to a sandwich or cereal (Kate worker Glenview).

This highlights the notion that a family's taste in food develops collectively. Family food preferences are often discussed in the first person plural – 'we don't eat much beef' (Haukanes 2007: 7). In my family home the collective 'we' did not like offal mainly because my mother did not like touching, cooking or eating it. The collective dislikes of food can spring from other members of the family as well. A dish receiving a poor reception can result in it never appearing on the household menu again. The collective development of taste raises a challenge for the workers in residential care as the collection of people at the table is constantly changing. Despite this, one manager was proud to use the collective 'we' when saying 'we do great work with food' (Manager Oaklands). It can be assumed that she was referring to the social aspect of food work rather than the culinary skill of the workers.

6.4.2 Who's cooking?

To establish participation in food related work I noted who cooked in the centres. In the mainstream centres there were usually two workers on duty in the evening. I did not witness any discussions as to who would cook. I asked Kate (Glenview) how they decided who would cook. She said it depended who was on duty and if they were *natural cooks*. By this she meant people who could make food without looking at a recipe. She went on to explain that if she was on duty with a worker who was less confident about cooking they would do it together but if it was a confident cook she would leave them to it.

It is recognised, for example by Stapleton and Keenan (2009), that the preparation of food is a highly gendered activity and tends to be viewed as a woman's responsibility. The gender division in residential care for young people is weighted heavily towards women. In the mainstream centres of the twenty-nine workers, four were men. I wanted to know if the men cooked. Sean, (worker) from Oaklands, had trained in social care in the 1990s and had

learned to cook as part of his course. He thought it was a good thing and said he did all the cooking at home but only cooked at work if he had to. Sean was the key worker for Robert (15) and had worked with him to encourage an improvement in his diet.

Robert's diet was very poor when he came to live here - he only ate junk (Sean worker Oaklands).

Sean and Robert worked together and came up with the idea of having themed weeks: one week a Chinese menu was devised and the next a Mexican menu. Robert was encouraged to do the research, find recipes and write up the shopping list. Robert decided himself that doing a budget week would be a good idea and useful for when he was living independently.

So it would appear that the decision as to who cooked depended on who was on duty. In Woodlands, one worker did the cooking and the other collected Fiona (17) from school. The dinner was served shortly after they returned. In Glenview, the evening meal was a little more flexible in the time it was ready and, as Kate (worker) said, it was either just one worker or both workers cooking. Oaklands shared the cooking duties and in Hazelbrook Kelly (worker) cooked the first night and Bridget (16) one of the residents cooked the second night. I was told that Bridget enjoyed cooking and would offer to cook breakfast for the manager:

Manager She'd ask if I'd had breakfast and offer me scrambled eggs if she wanted to get round me

Deirdre She only does it to get something from you

Manager Yeah, but it might just be to sit with her a while

(Fieldnotes Hazelbrook).

The manager's choice of words could indicate that spending time with the young people may conflict with her managerial role. Bridget, on the other hand, appears to be using food to engage in a relationship-building activity with the manager. Bridget cooked the second evening I was there. Jason (worker) gave her the choice of burgers or cottage pie. She decided on cottage pie and said she would make it. Jason offered to help and she said he could do

the potatoes. This is an example of the power imbalance shifting towards the young person with the adult doing the menial task of vegetable preparation while the young person cooks the meat. Apart from Hillgrove, where the chef was a man, I did not see the male workers in the other four centres taking an active role in cooking, suggesting that men avoid cooking at work. It is also possible that the women in these centres also avoid cooking if they can.

6.5 Kitchen Rules: Institutional regulations

Forero et al. (2009) present an argument that food provision in institutional settings can be understood as part of the wider governmentality agenda. In their study of food provision in non-domestic settings, such as schools and homeless shelters, they found that the institutional dining room was a contested space ‘with multiple social actors drawing on multiple discourses of nutrition, efficiency, choice and civility’ (Forero et al. 2009: 229). In the contested space of the kitchen/dining room in residential care I hoped to witness governmentality in action.

McIntosh et al. (2010: 294) found that ‘the kitchen was subject to a panoply of health and safety regulation and elevated levels of supervision and surveillance’. I assumed that the kitchen would be one area of the centre where institutional regulations would outweigh the aim to provide a homely home. I expected to see posters or signage on food hygiene, hand-washing or food storage, for example. However, looking around the kitchens in the mainstream centres there was very little evidence of health and safety regulations. The photograph below (Figure 28) shows signs above the sink of the utility room in Hillgrove. The dish washer was beside this sink and the young people must have been in the habit of scrapping their plates into the sink. The member of staff who put up these signs was obviously tired with cleaning up the mess. However, the worker appears to be trying to soften the message by scalloping the edges of the notices.



FIGURE 28 THE HEIGHT OF LAZINESS

Photograph: Deirdre Byrne

The shelves in the fridge in Glenview had labels to show that raw food was stored at the bottom. Hillgrove, the purpose built centre, that employed a chef, was equipped with a knee-operated, hand-washing sink. In conversation with the chef he explained that because a chef was employed there the centre was subject to inspections by the Environmental Health Department. The inspectors could not understand why he could not run the kitchen as any other industrial kitchen and keep records of temperature controls on the fridges. He described the young people coming into the kitchen opening the fridge and just staring into it or leaving the fridge door open while they make themselves a sandwich:

I have to keep reminding them [the Environmental Health Inspectors] that it is not a normal kitchen - it is the young people's home. You can't stop them from coming into their own kitchen (Chef Hillgrove).

The image of a young person staring into the fridge looking for divine inspiration is an example of the conflict between home and institution. The chef saying this is not a 'normal kitchen' refers to the difficulty of balancing the strict regulation of the institutional kitchen with the more *laissez-faire* activities of a domestic kitchen. While I did not witness the fridge staring incident, I assume that the chef would inform the young people that leaving the fridge open increases the temperature inside and wastes energy. On the other hand, it is possible that the same conversation takes place in many domestic kitchens.

One area of safety I was aware of before entering the field was where the cooking knives were kept. Figure 29 shows the Health and Safety Authority advice on the use of knives in high risk work areas. In Glenview, Oaklands and Woodlands they were kept locked in the office.

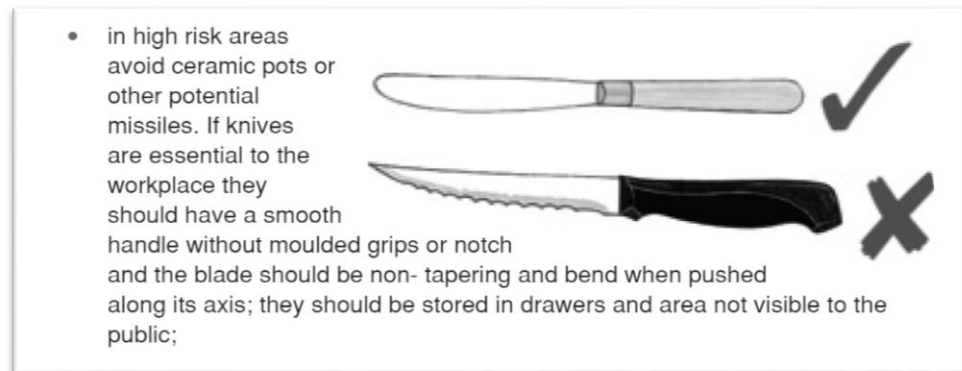


FIGURE 29 KNIFE SAFETY

Original source: Health and Safety Authority 2014

In Hazelbrook the knives were kept in a safe inside a locked cupboard in the kitchen. On my first day there Kelly was in the kitchen preparing bolognaise sauce for the dinner and I made reference to the safe and she said:

The joke is we don't even have a sharp knife
(Kelly worker Hazelbrook).

She went on to explain that it is really difficult to get the onions cut small enough without a sharp knife and Bridget would not eat the meal if she could see onions in it. Later that afternoon, when Kelly returned from doing the weekly shop, Bridget was in the kitchen and first thing she said to Kelly was, 'you put onions in the sauce' (Bridget 16 Hazelbrook). David (worker) said that he avoids getting the knives out. Kelly (worker) agreed and explained that you have to read the situation carefully because sometimes it is safer not to add knives to an unstable situation:

One place I worked in I got a knife out for one young person and another young person got it and had it at another worker's throat... I had to get the Guards [Police], it was horrible. (Kelly worker Hazelbrook).

On the first day in Glenview a pineapple was bought with the weekly shop and placed in the fruit bowl. Both the treat cupboard and the fruit bowl were replenished when the shop was done. The young people in this centre appeared to prefer fruit to the treat cupboard. The pineapple was still in the fruit bowl on my last day perhaps because it could not be eaten without a sharp knife.

6.5.1 Waste not, want not?

One evening in Woodlands Fiona (17) made soup and ate three bowls of it. When Jackie (worker) asked why she was eating so much she said that if she didn't eat it that they would throw it out just like the bolognaise she had made the other night. Jackie asked her if she had left it properly covered in the fridge. Fiona said that it had been too hot to go in the fridge when she was going to bed. This was one of the many examples of how ideas of food waste were being constructed by the young people and the workers. They were aware food was being wasted but they also tried to avoid waste. In Glenview awareness of food safety appeared to be *if in doubt throw it out*.

On my first day in Glenview (Monday) there was a chicken curry in a plastic container sitting beside the sink that was going to be thrown out. I asked why and they said it had been made on Saturday but the young people didn't want it then. I asked if it had been stored in the fridge and she said it had. The shift system worked in residential care centres may add to the waste of food as the worker coming on duty may not know how long something has been in the fridge. The growing literature on food waste is explored further in the following chapter.

6.6 Power and resistance

There is general consensus that mealtimes can be battle grounds and food scholars agree that power and resistance occurs at mealtimes between adults and children (Cook 2009; Coveney 2008; Wills et al. 2008; Bell and Valentine 1997; Grieshaber 1997). As discussed, power is not as simple as oppression of the powerless by the powerful. Adults do not have complete power over

children: if they did children would always behave as the adults wished without arguments or discussions but children resist and power tactics become necessary (Gallagher 2008). Power tactics at the table range from coaxing and cajoling to being ordered to leave the table. I assumed my position at the table would provide a ringside seat for the inevitable battles between the young people and the workers.

According to Forero et al. (2009: 229) in institutional dining rooms governmentality creates a space for the fluidity of power 'that travels and circulates through the social actors performing within it'. McIntosh et al. (2010: 290) found that 'relations of power and resistance [...] are routinely played out through food' in residential care settings for young people. In institutional and non-institutional settings adults, most frequently women, regulate the routine order of mealtimes. Through disciplinary power children's meals are eaten: in a specific place, at a specific time, a certain type of food is served and a sufficient quantity consumed whilst being monitored by adults. According to Grieshaber (1997) disciplinary power works:

[...] both on people and through them, via the processes of the hierarchical observation and normalising judgement (Foucault 1977). It is also in these instances that acts of child resistance are likely to occur (Grieshaber 1997: 653).

The dining table is a controlled and controlling space (Visser 1991; Ochs and Shohet 2006). It is here that children are disciplined by adults who train them in appropriate behaviour when eating. Rules such as: eat with your mouth closed, no elbows on the table, no playing with your food and asking to be excused from the table are common in many households. At the mealtimes in the centres, while I was present, there was little evidence of the workers checking the young people's manners at the table. An explanation for this could be the age of the young people resulting in their having already been disciplined in table manners. There was one incident of a young person's behaviour at the table in Glenview being admonished and that was by Aishling (17) who told her younger brother (11) to eat quietly.

Grieshaber (1997) discusses how young children contest and resist adult rules of food practices in the private home. Similarly, Punch and McIntosh (2013)

found that conflict between workers and young people in residential care was a regular feature of their interactions around daily food practices. The workers, because they are professionals and adults, have control over many food issues but the young people ‘use food to try and gain control or exercise power’ (Punch and McIntosh 2013: 11). Some of the examples given of young people exercising their power are: choosing to eat or not to eat, disrupt mealtimes, contaminate food, waste food or earn a change in food routine through positive behaviour.

For the young people in this study, resistance to mealtime regulation was demonstrated by choosing not to eat the prepared food. In some instances there was no discussion. For example, the three boys from Hillgrove did not eat the lunch provided and there was nothing said. In Oaklands Robert (15) did not eat one evening and he was asked if he was not feeling well as he usually liked the stew. Bridget (16) from Hazelbrook did not eat the bolognaise sauce because there were onions in it and helped herself to a crisp sandwich. In Glenview Fiona (17) ate just one of the prepared dinners. In all the centres if the young people did not eat the prepared food they could make an alternative for themselves.

McIntosh et al. (2010) have also explored residential care workers’ control of food and food spaces. They suggest that the workers’ control included that of the young people’s access to food spaces or specific food items within them.

Well, it is their home, but if they are getting too noisy or messing they get put out (Chef Hillgrove).

Dorrer et al. (2011) refer to workers restricting access to food spaces when group tensions are high because the kitchen can be a trigger point. The workers from that study describe the possibility of the young people barricading themselves into the kitchen and creating havoc. When I attended a managers’ meeting for a private residential care provider I was asked if I was going to investigate why some young people target the kitchen when they are being destructive. I found no specific literature on young people targeting the kitchen in residential care but an incident was described to me in Hazelbrook:

Bridget has wrecked the kitchen twice in the past five weeks. The second time the kitchen needed to be redecorated. Every cupboard, drawer and the fridges were pulled out and the contents smashed. You would be amazed how far a jar of mayonnaise can spread. Everything in the kitchen was destroyed, except the Easter eggs and a large bottle of coke (Manager Hazelbrook).

Just a few days later when I visited Hazelbrook I realised that the reason my original planned visit had been postponed and the allotted time for the fieldwork reduced was because of the incident described above. I asked if they had locked the kitchen and they said no, that their policy was not to lock rooms in the centre. The manager felt that due to the inconvenience caused by the kitchen being out of use that Bridget would be more aware of the consequences of her actions in the future.

In Oaklands, on the morning I arrived, there were four trays of meat defrosting and one of the residents was suspected of unplugging the freezer and turning up the thermostat on the fridge so the contents froze. The boys were asked at lunch if they knew anything about it and they denied knowing anything. It would appear that these five centres did not restrict the young people's access to food spaces and this theme will be further explored in the questionnaires.

Smith (2009) recognised the power differentials between young people and the workers in residential care. The workers can leave at the end of their shift and they are not dependent on the young people. However, the young people in this study did remind the workers that without them they would not have a job. The two extracts below are from Woodlands' fieldnotes. Fiona was arguing with Jackie in the first example about not being allowed to stay at her boyfriend's house. Jackie is attempting to convey to Fiona that she is not allowed to stay at her boyfriend's because they care. Fiona reminds Jackie that she gets paid to care:

- | | | |
|-----------|-----------------|--|
| Extract 1 | Jackie (worker) | Why do you think we chat to you? |
| | Fiona (17) | It's your job to chat to me. |
| Extract 2 | Sue (worker) | What - you'll be gone when you're eighteen – no one is asking you to stay. |
| | Fiona (17) | But you won't get paid, you'll have no work. |

In the second example Fiona said that she hated it there and did not want to be living in residential care. The comment from Sue appears on the surface to be uncaring but it was delivered in a light-hearted way and Fiona delivered her comment with a smile.

Lupton (1996) identified the power differential between children and adults around food practices. She suggests that the children who experience this lack of power can construct resistance through emotional reactions or physical actions and a child's most effective form of resistance to their subordinate position is refusing to eat. Punch et al. (2009: 13) suggests that food could be used as a safe way for workers and young people to test boundaries – ‘to show anger and distress, to reject care or relationships and to demonstrate power over another or oneself’. The following discussion takes place at the dining table in Woodlands after Fiona (17) has refused to eat what has been prepared. It demonstrates Fiona using her power of refusal resulting in the workers (in this case Lorna) feeling rejected and dejected because she would not eat the food they had prepared for her:

| | |
|----------------|--|
| Lorna (worker) | It wouldn't matter if you had roast chicken and lovely potatoes and garlic potatoes and five different veg. |
| Deirdre | Yes. |
| Lorna | There was a time you know when you'd get satisfaction making the dinner - the whole lot would be demolished. |
| Deirdre | Yes. |
| Lorna | You know, I might as well give it to them <i>- nodding to the sheep in the garden.</i> |

(Woodlands fieldnotes).

The young people from Hillgrove did not eat the lunch but the workers did not appear to be very concerned. I was only in this centre at lunch so there may have been more attention paid to what they were eating for their evening meal. Also, to be considered is that this centre employed a chef and the workers did

not prepare the food themselves, therefore they may have had more distance from it and did not take the refusal personally.

Visser (1991) maintains that children learn from an early age that food refusal is a guaranteed way of getting adult attention. While in the past it was common to deprive children of food (being sent to bed with no supper) for bad behaviour today it is more likely that children displaying resistance at the meal table will be offered an alternative meal or snack. The chef from Hillgrove complained that the workers would get the deep-fat fryer out when the young people didn't like the dinner and this happened too often (he did not specify what was being cooked in the fryer). The workers from Hillgrove discussed the frequency of young people refusing to eat in an attempt to get the extra attention from the workers. How food is used by the young people to gain attention will be explored further in the workers' questionnaire.

6.6.1 Who's watching?

Children's lives are observed, monitored and controlled by many types of surveillance technologies. According to Steeves and Jones (2010: 187) 'in a sense, to be a child is to be under surveillance':

[Young people living in residential care] are subject to monitoring and surveillance over and above children not in care; thus they are a doubly surveilled group (McIntosh et al. 2010: 294).

McIntosh et al. (2010) explored the relationship between care and surveillance in residential care for young people. They found that surveillance, or being 'watched over', is a crucial aspect of residential care that can be experienced as both negative and positive by the young people and the workers. The young people in this study are 'watched over' by a range of workers in the centres and externally by their social workers and HIQA inspectors.

McIntosh et al. also point out that being 'watched over' can be part of therapeutic practice, especially for young people who have experienced neglect and therefore an absence of being watched over. Knowing that you are 'watched over' can mean that you are noticed, which may be a positive experience for young people who are 'looked after' by the state. 'Watched over' and 'looked after' both imply a level of

visual surveillance that is considered necessary to protect and control children. Children and young people, on the other hand, may perceive being watched over as inhibiting and a source of intergenerational conflict.

At the end of my first day of fieldwork everyone was drifting in and out of the kitchen in Glenview. Darragh picked up some crisps and said:

- Darragh (11) If I eat this will you write it in your note book?
- Deirdre No. I only write things down when I have a quiet moment and it is just to help me remember things. (*Connor and Aisling had found some chopsticks and where attempting to stick them into a pineapple. Anne asked them to stop and they did. Darragh who was not involved with the pineapple, said*)
- Darragh I'm afraid to eat anything now

(Fieldnotes kitchen Glenview).

Darragh was aware that my role in the centre was to watch what the young people were eating and may have perceived my surveillance as unsettling. On the other hand, his comments may have been to gain my attention because I was not watching him at that time.

As discussed, there is a growing body of research on food practices that explores power relations between adults and children (Lupton 1996; Grieshaber 1997; Coveney 2006; Backett-Milburn et al. 2006; James et al. 2009; Jackson 2009; Punch et al. 2009). Adults' surveillance of children's food and eating practices is a central tenet within the literature. The surveillance of children's food is considered to be the responsibility of adults in families and in institutions such as schools. In residential care there is an onus on the workers to regulate the young people's food practices by monitoring what they eat. McIntosh et al. (2010: 301) found that there are often ambiguous relations between care and surveillance and 'how being part of a surveilled group can be an experience which is conflicting and ambivalent'.

The workers in residential care are also subject to surveillance. McIntosh et al. (2010) suggest that surveillance of the workers has increased in recent years due to the recent highly-publicized cases of abuse in care in the UK. This is also the case in Ireland. Another reason for the increase in surveillance is the move towards

managerialism that has put pressure on workers to show quantifiable outcomes. Surveillance in residential care is therefore multi-layered: the young people are closely monitored by the workers who are in turn watched by the young people while they live and work within the wider context of procedures and regulations (McIntosh et al. 2010).

My role as a researcher also added to the surveillance. As discussed, I was concerned about the reactive effect and the participants may be ‘performing food practices’ because they were being watched. As an illustration of this, when I accompanied a worker to do the weekly shop for one centre, she put a bottle of 7up in the trolley and said:

I don't want you to think we're putting on a good show

(Kelly worker Hazelbrook).

Originally I had hoped to spend enough time in the centres so that my presence would not be a novelty but in reality the data I have collected is based on that ‘getting to know you’ phase. I did not spend a long enough time in the centres to acquire insider status. Due to the working hours in residential care centres it was impractical to have met the workers prior to data collection. In addition, because I was travelling long distances, meeting the young people was also difficult. I therefore had to rely on the managers to explain why I was there. The following extracts from fieldnotes show that there were many incidents of the participants referring to their being watched. On my first day in Oaklands Robert (15) and James (16) had been collected from school and brought back to the centre for lunch. I was invited to sit at the table with the manager, the two workers on duty and the two boys. James asked where the milk was, or rather:

James (16) Oh, I'll just get the milk myself then.

Marie (worker) It's there in the jug.

(Fieldnotes Oaklands).

James and the others laugh: obviously the jug was being used because they had a visitor, or as Douglas (1972) would suggest, an ‘honoured guest’.

I was in Glenview on the day the weekly shopping had been done. The treat cupboard had been restocked but the young people were eating the fruit and yoghurts. The workers were more interested in the treat cupboard than the young people. I teased them that I was going to put a nanny camera in the cupboard at workers' height and that would become the study. On reflection, I was reminding the workers. in a roundabout way, that their food and eating practices were also under surveillance.

As already discussed, workers in residential care do not have meal breaks away from the centre and are often on duty for 24 hours. Punch et al. (2009) identified that the workers used food treats as a means to manage their own feelings. Making a cup of tea or having a biscuit provided an opportunity to nurture oneself. Smyth (2007) found that the ritual of making and drinking tea in social care workplaces was used as a remedy for many ills.

At the final lunch in Oaklands, Eileen, one of the workers, had made Pavlova. The conversation below illustrates that the resident group were conscious of 'performing food practices' for me:

- James (16) Are you here tomorrow?
- Deirdre No, I am finishing up today (*James looked very disappointed*). It's a shame you've been out the past two nights as I seen very little of you.
- James No, it's not that, we'll be back to dry bread tomorrow.
- Manager Don't worry, the inspectors will be coming soon.

(Fieldnotes Oaklands).

From the outset of the project I was concerned that only the managers from centres where they thought that their food and eating practices were positioned in the *good food* opposed to the *bad food* dichotomy were agreeing to take part. As discussed I met one manager at the managers' meeting who suggested that I visit his centre because the food and eating practices were not good. Unfortunately this was one of the centres that withdrew consent to take part.

During my time watching the food and eating practices, I saw little evidence of intergenerational power struggles at the table. The young people, when they were at the table, were sometimes friendly and talkative, while sometimes they were not. They did not appear to mind having an extra set of eyes watching them and as Brian (15) said in response to my thanking him for allowing me to do the research in Glenview: ‘sure it made no difference to us, there are so many people about’.

6.6.2 Who cares?

In residential care settings food can be used as a powerful symbolic instrument to demonstrate care (Punch et al. 2009; Emond et al. 2013). Food can be used to welcome and to build relationships. Food and eating practices can involve: caring, bonding, empathy, sharing everyday routines and special occasions. Lupton (1996) suggests that food is linked to care in several ways and the most significant is that of maternal nurturing:

...the smell and taste or even thought of certain foods, if connected to happy or idealized childhood memories, may elicit nostalgia to the extent that they shape preferences for food in adult life (Lupton 1996: 49).

Writers of food memoirs, such as Else (2013) and Slater (2003), suggest that food can signify love and security but it can also represent rejection and danger. Barton et al. (2012: 154) maintain that children who have been deprived, traumatised and abused are ‘normally very anxious in relation to food’. According to Barton et al. children’s concerns can range from not getting enough food to fears that the food on offer may have been contaminated. In addition, some young people feel that they have to be in control of what they eat by only eating specific foods, which can manifest as an eating disorder. They also suggest that children who have had to fend for themselves may find it difficult to accept food from someone else.

Food for some young people in residential care is an emotive issue. An example I encountered was in discussion with a worker from Woodlands who related the story of the workers attempting to recreate the perfect boiled egg for Gemma (18) who had lived in the centre for many years. Unlike Proust’s

madeleine, that transported him back thirty years to his childhood, no matter how they tried they could never get the egg just right. The original egg had been boiled by her mother many years before and was one of the few meals Gemma's mother had made for her. While the workers' attempts may not have been successful, their efforts to create that nostalgic egg may well be remembered.

6.7 Discussion

The overall aim of this project has been to use a mixed methods approach to elicit the significance of food and eating practices in children's residential care settings in Ireland? Using the main themes that emerged from the literature review and fieldwork data collected at the table I gained first-hand knowledge of this aspect of everyday life in the centres. My analysis thus far: shows that young people in residential care eat a similar diet to those in the general public. This research supports that of Punch et al. (2009) and Emond et al. (2013), who draw attention to food being used as a powerful symbolic instrument to both demonstrate care and reject care. In addition, I saw evidence that corresponds with McIntosh et al. (2010: 299) who found that by refusing to take part in mealtimes or to eat the food provided was one way that young people living in residential care could resist governance and 'gain control over their regulated lives'. During my time spent in the centres I realised that the rituals, rhythms and routines of food in residential care may impact on the workers' personal experience of food and eating practices.

Having presented those initial findings, I will continue with discussing the analysis of the fieldwork data and connect these with the conceptual themes introduced in the first chapter: Is the sharing of meals at the table *commensality* an aspiration or reality in the residential care? Is enactment and enforcement of *hierarchical* behaviour and *discipline* embedded in the rituals, rhythms and routines of the table? How does the *government* of children's residential services in and around the table affect food and eating practices? First, though, a few thoughts on the spaces I encountered.

6.8 The physical tables

Positioning this research at the dining table has provided a view of everyday life in residential care. The photographs showed that there were similarities between the tables, two even had the same wipe-clean tablecloth, and apart from Oaklands (see Figure 26), they were all the hierarchical rectangular shape. Taking the photographs and discussing them with other social care professionals helped to highlight the complexity and individuality of impressions of home. As discussed, home and homeliness are concepts that are hard to pin down. The meaning of homeliness is shaped by individual values and preferences. What makes one person feel ‘at home’ will differ from what another would choose but they are not completely idiosyncratic there are commonalities and patterns in the construction of ‘homes’. The meaning of home has attracted significant attention across the disciplines, and a study by Henderson et al. (2007: 125), found that young people associated home with: ‘safety, security, comfort, contentment, privacy and stability’. Young people living in residential care may have different associations with their family homes. This suggests that providing a ‘comfortable and homely environment’ (HIQA 2010) is a challenge for the workers and the young people - as Clark et al. (2014: 15) contend regulations may state ‘but do not make explicit how to “do” home’.

When I enter a new space I look for familiar furniture and objects that help to give me cues as to how I should behave. According to Painter (2013) human behaviour and the design of spaces are intricately linked and our response to different environments are deep-seated. She suggests that people unconsciously adapt their behaviour to different environments and illustrates this with a person unconsciously dropping their voice when they enter a formal space. Residential centres for young people are complex spaces where the concepts of home and institution collide. The service has moved away from the large institutional buildings of the past and many of the centres are in ordinary houses. The purpose-built centres I encountered did portray an air of formality. Hillgrove did not feel, or look, like a space in which people and, in particular, children could relax and be comfortable. I am arguing that there was a contradiction in terms between what Hillgrove was supposed to be

providing - *high support* - and what the space looked and felt like. This space was a correctional facility designed to provide high levels of safety and security (O'Connor et al. 2014). The space was not child-centred, child-focused or child-orientated. Hillgrove was the antithesis of a 'homely home'. This highlights the struggle to (re)create a 'home' in a 'home'.

6.9 The metaphorical table

The metaphorical table introduced in chapter one conceptualises food in residential care as a table. The metaphorical table is supported by four legs or themes: commensality, hierarchy, discipline and government, which have been developing throughout the thesis and will be discussed next. First though, the photo-elicitations are reviewed. It became apparent during supervision that the photographs of the tables were conceptually important. They provided an opportunity for movement from the metaphorical table to the actual table in residential care that, according to Clark et al. (2014: 12) symbolises, 'doing home'. Therefore, the actual tables also held a degree of metaphor as they raise issues of people's ideals and understandings of institution, family and home.

The photo elicitations with the social care professionals highlight the symbolic significance and cultural meaning of the dining tables in the five centres. According to Rose (2012) photographs convey an enormous amount of information and how they are interpreted needs to be considered within the frame of the research project. The photographs were initially taken as an *aide-memoire* but on reflection I realised they had the potential to be used as an instrument to collect additional qualitative data that could help to develop a contemporary view of residential care.

As discussed Banks and Zeitlyn (2015) suggest images have both an internal and external narrative. The internal narrative is what the image communicates and the external narrative is the social context in which the image was produced. The photographs depict tables (internal narrative) in residential care (external narrative). The photo elicitations consisted of four questions asked of 43 participants. The questions were designed to elicit how the readers of this thesis might define the images. The participants were not young people but they were people who provide services for young people. My first question -

which of these tables would you want to eat all your meals at? - was asked to gain an empathetic response. This was the question that most people took time to answer, perhaps because they were aware that young people living in the centres do not get to choose the table at which they eat. The other three questions were based on which table represented home, family and institution. It was evident from the responses that what was captured in the images did not truly represent what I had experienced in the centres. This prompted me to provide a more detailed word picture of my view of the tables.

6.9.1 Commensality

In all five centres commensality was practised. The young people were encouraged, and sometimes chose themselves, to eat with the workers at the table. In conversation with the workers, similar to the workers in Dorrer et al. (2011) study, they made references to the group eating together at the table is an opportunity to create a 'homely' feel in the centre. The shared meal at the table is predictable it can create a sense of normality (Punch et al. 2009) - that is just the way things are done. The findings thus far suggest the shared meal with the resident group is a time when the workers and the young people can be on more of an equal footing – satisfying their hunger. Sharing the same food at the table can create a sense of belonging in the centres for the workers and the young people.

The dining table in all the centres was in a communal space. This study has found that in a domestic setting the family meal table is a site where the inequities of power can be played out. By contrast, the table in residential care can be used as a neutral space. Unlike the workers' office, or the young person's bedroom, the dining table can provide an arena where the imbalance of power may be set aside. The mealtimes, to me, were reminiscent of the regular ebb and flow of family life. I am not so naive to think that this is always the case and as the pilot study showed, meals, depending on what is happening in the centre, sometimes do not get cooked. I am also aware that my presence at the table altered the regular ebb and flow of normal everyday life in the centres.

The table played an important role in the rituals, rhythms and routines of everyday life in the centres just as in homes in general, as illustrated (Figure 2 page 11) by Arnold et al. (2012). Commensality, or sharing meals at the table, is a highly regarded aspiration by the workers and the regulators in residential care. However where do the young people feature in the aspirational use of the table? In chapter one I identified that the dining table is a morally superior space, the shared meal at the table is regarded as better than any other eating arrangement. The table is a space where children are supervised and trained in appropriate behaviour. So why would young people choose to eat there? During my time in the centres the young people, except those in Hillgrove, not only chose to be at the table but often lingered there when they had finished eating and sometimes when they had not eaten. This suggests that there is much more going on at the table than sharing food.

The table in the residential care setting, as in other homes, is centre for household activities. It is the site where homework is done with or without the assistance of workers. Arnold et al. (2012) found that children spent as much time doing homework at the kitchen table as they do eating. It is a site where plans are made for the future: for example, in Glenview, where to go during mid-term break. It is also the site where significant decisions are made. When I left Woodlands, Fiona (17) and Jackie (worker) were sitting at the table completing a CAO form and discussing what courses she would like to do in third level education.

6.9.2 Hierarchy

The enactment and enforcement of hierarchical behaviour occurs at tables where children and adults eat together. The behaviour can involve very subtle forms of power such as a disapproving glance for inappropriate manners or being removed from the table for unacceptable behaviour. The hierarchy of the table goes far beyond the shape of the table or the traditional seating plan where a man sat at the top of the table, children at the long sides and a woman served.

According to Smith et al. (2013: 96) food work can offer an opportunity to challenge gender stereotypes. Positive role models could be portrayed by men and women taking an active role in food work. The provision and preparation of food remains a highly gendered activity and is strongly associated with maternal nurturing (Stapleton and Keenan 2009; Lupton 1996). The young people in this study were generally being served by women who make up the majority of workers in residential care. I took note of male social care workers taking an active role in food work. Jason (Hazelbrook) assisted Bridget (16) in preparing the evening meal and Sean (Oaklands) and Adam (Glenview) both said they only cooked if they had to. This suggests that men avoid food work. However, I am proposing that women workers may also avoid the kitchen if they can. This is a point that I explore further in the workers' questionnaire.

The Bord Bia (2011: 54) survey shows that 49% of children in households ate different meals to the adults and the reason given was that the children had different tastes. The workers in residential care are required by the National Standards to provide a healthy and nutritious diet and to consult the young people on menu choice. The fieldwork data indicates a hierarchy in relation to food choice was evident in two centres and the workers were in the dominant position. Without consultation with the young people the workers in Woodlands and the chef in Hillgrove decided what and when to cook. The workers in Oaklands said that the young people decided what to have for dinner but, as mentioned previously, I was given the following four weeks' menu. Hazelbrook also had a written menu plan but Bridget was consulted before they started cooking on the second evening. In Glenview the young people were asked what they would like for dinner for the following evening. This shows that while consultation with the young people about food choice happened it was limited. Reasons given for this included not being able to accommodate all the different young people's likes and dislikes.

In the case where just one young person lives in the centre, one would assume their food preferences would have precedence. This was clearly not the case in Woodlands where Fiona (17) was the only resident and the workers did not consult her when deciding what to cook. The workers are also part of the resident group and their food choices do have a means of expression. The

workers have control over the shopping and the cooking so therefore can cook dishes how they like. This was observed in Hazelbrook when Kate (worker) made a bolognese sauce. Bridget (16), the only young person having dinner that evening, did not eat onions but onions had been added to the sauce and she did not eat it. The following evening when Bridget cooked a cottage pie she did not add onions. This finding indicates that there is fluidity in how food choice is determined and negotiated within a regime of power and control in the centres. It also shows that there are practical, nutritional and food waste issues in not consulting with the young people over food choice.

When considering the hierarchy of food, a proper meal is considered to be cooked using fresh ingredients 'from scratch'. In Ireland and the UK meat, vegetables and potatoes are strongly associated with being a proper dinner (Charles and Kerr 1988, Murcott 1982). The majority of meals cooked in the centres were pasta with sauce, curry and stews. The young people, in all the centres, had the option to eat what had been prepared or to make themselves an alternative. The alternative to the cooked meals, according to the workers, was usually noodles, cereal or a sandwich. This corresponds with Martin (2004) who found that the staple diet of third-level students in Ireland was noodles and sandwiches. Fiona (17) ate just one of the prepared meals. Jackie, when serving it, said 'Fiona would eat spaghetti bolognese 24/7'. On the other evenings Fiona made herself a vegetable soup, pasta with readymade sauce and pancakes. I got the impression watching Fiona in the kitchen that she enjoyed cooking and by many people's standards the food she cooked for herself was proper food.

Fiona's rejection of the prepared meals did have an impact on Lorna who said it wouldn't matter what they made, Fiona would not eat it. This suggests that Lorna was interpreting Fiona's rejection of food as a symbolic rejection of the care offered by the workers. Food may be offered to show care but 'paradoxically it is experienced as invasive, intrusive and contaminating' (Bell and Valentine (1997: 48). By rejecting the food on offer Fiona may have been 'reclaiming [her] dominion over [her] body' (Earle and Philips 2012:144) that was in a place not of her choice. A challenge for the workers in residential care, as Emond et al. (2013) suggest, is that food is central to the construction

of children's identities - 'they are what they eat'. Conflict arises between the workers' responsibility to provide a healthy and nutritious diet for the young people, on one hand, and recognising and encouraging their growing sense of autonomy when it comes to food choice.

6.9.3 Discipline

The table is the site where children are trained in appropriate behaviour while eating. There was no evidence of the workers' controlling the young people's manners at the table. I witnessed just one incident of a young person's behaviour at the table being reprimanded and that was by his older sister. It can be assumed that the young people had already been disciplined in the rules of the table before coming to the centres or they were on their best behaviour because I was researching their eating practices. However, the food and eating routines at the table provide regular opportunities for the resident groups to influence each other, modelling behaviour and instilling normative standards of the expected behaviour whilst eating.

McIntosh et al. (2010) explored residential care workers' control of food and food spaces and found the workers could control the young people's access to food spaces or specific food items within them. Punch et al. (2009) found that supply and restriction of access to treats was a contentious issue between the workers and the young people in their study. Hillgrove did not provide treats because there had been arguments in the past between the workers and the young people about the workers' control and distribution of them. All the other centres provided treats and all restricted access to them. The regime in each centre seemed quite relaxed and I did not witness young people being excluded from the kitchen/dining areas or contention about access to treats. In all the centres access to knives was restricted, even if, as Kate (worker Hazelbrook) pointed out, the knives are not sharp.

The workers showed a willingness to obey the rules of how food is done in their centre. The closest I came to seeing a worker disobeying the rules was Jason not cooking the burger and chips on the menu and allowing/encouraging Bridget (16) to make cottage pie. The workers were not aware of, in a reflective or detected sense, how the ritual, rhythm and routine of food practice

had been developed and incorporated into everyday life in the centres. Suggesting the discipline of everyday food and eating practices had become uncritically accepted by the workers and the young people living there and linked to habitus. The concept of habitus, according Bourdieu (1996: 16), is ‘the structured structures, generative principles of distinct and distinctive practices’ or the deeply engrained habits and dispositions that provide an implied sense of how our world works and what our place is in it.

6.9.4 Government: who governs the table in residential care?

The table in residential care centres is governed on multiple levels by external and internal authority and regulation. The term governance, according to Lemke (2007), generally signifies the various strategies, procedures and processes that control, regulate or manage problems from global to organisational levels. The governance of everyday food and eating practices in residential care is multifaceted. The kitchen/dining room in residential care is a space where the discourses of domestic home and public institution are evident. This results in a space that is difficult to govern. McIntosh et al. (2010: 294) found that the kitchen in the residential centre was subject to elevated levels of supervision and surveillance. By contrast, I found no physical evidence of this in the centres that I studied. The kitchens in the centres had very little evidence of food safety or health and safety regulations on display. While the display of signs may be only one aspect of governance, this went some way to dispelling my assumption that the kitchen would be one area of the centre where institutional regulations would outweigh the aim to provide a homely home.

All children’s residential care centres are subject to inspection by HIQA who, amongst other things, evaluate food practices. The HIQA reports do not specify how they do this. Under the provision of food and cooking facilities many of the reports tick the box - *practice met required standard*. The workers and the young people are aware the centre is governed by inspections that can be announced or unannounced. This was illustrated by the conversation in Oaklands when the manager joked with James (16) that they would not have to eat dry bread because the inspectors would be visiting soon. The majority of

kitchens in residential care in Ireland are graded as domestic - this is a direct contrast with the Scottish experience (McIntosh et al. 2010). The kitchens in this study, except for Hillgrove the high support centre, are graded as domestic and therefore not subject to inspection by the Food Safety Authority (FSA). A non-domestic kitchen is subject to inspection and Hillgrove was the only centre inspected by the FSA. Non-domestic kitchens are obliged to have a food safety management system in place or a HACCP (Hazard Analysis Critical Control Point). This system requires food workers to control, monitor, record and demonstrate compliance to safe food practices. If food work in residential care was controlled to this level, I believe it would increase the institutional aspect of the centres.

Forero et al. (2009) suggest that food in institutional settings can be better understood by applying governmentality theory. My time spent in the centres indicates that it is through governmentality that everyday food and eating practices are a problem to be addressed by self-regulation. The workers must regulate their own eating habits and steer the young people in the direction of developing good eating practices so they can in turn become healthy socially skilled citizens. A significant instrument in the successful completion of this task is the dining table where both the social role of adulthood and children's positions are reinforced.

6.10 Conclusion

The results from this first strand of fieldwork signals the following themes are evident in residential care in Ireland: the significance of the rituals, rhythms and routines of food in residential care are entwined with care and control for both the young people and the workers; food is a symbolic instrument to demonstrate care; policy and regulations of food practices have an impact on the food spaces in the centres, conflicting with the aim to provide a 'homely' home and workers' personal food and eating practices are placed under scrutiny of the public gaze (Emond et al. 2013a; 2013b; Punch et al. 2009a; 2009b; 2011a; 2011b; 2013; McIntosh et al. 2010, Dorrer et al. 2011).

The centres varied in their daily food practices and in some cases those differences could depend on who was on duty. The workers' culinary skill also

determined what went on the menu. One common denominator was the dining table. In all the centres commensality was practised and all the young people were encouraged to eat with the workers at the table. The hierarchy of food choice was evident and the workers, with or without consultation with the young people, decided what and when to cook. The young people, on the other hand, had the option to eat what had been prepared or to make themselves an alternative.

The order or discipline of everyday food and eating practices have become uncritically accepted cultural norms for the workers. Moran (2011) suggests that there should be a distinction drawn between habitual and routine behaviour. Habit can be located between automatic and deliberate action. Habits can be good or bad - 'there is a historical evolution of habits (e.g. eating habits), and there is a great fixity and resistance to change so a habit can be said to be intensely conservative' (Moran 2011: 55). The reflexive food and eating habits of the workers demonstrate institutional discipline in the centres. The discipline of everyday food and eating practices, I have shown, may or may not be resisted by the young people. They may accept the discipline surrounding eating habits because they aid to strengthen the experience of homeliness – 'habits' often characterise what is distinctive about a 'home'.

The table in residential care is governed on multiple levels by external and internal authority and regulation. Food rules and regulations are advised by state bodies such as HIQA or FSA. However, this research has shown that food is not high on the agenda in many HIQA inspections. Coveney (2006) argues that there is no need for state inspection of our food and eating practices because discourses on nutritional knowledge are internalised and increase our individual ethical concern so we self-regulate our diet. The internalisation of food governance: the rules and regulations for controlling and managing food and eating practices, controlled by surveillance rather than force, results in governmentality being evident in the everyday food and eating practices of the workers and the young people in residential care. These themes are further explored through the design and analysis of the quantitative strand of the questionnaire for the workers. The results are presented in the following chapter.

Chapter Seven: More tables

7.1 Introduction

This chapter presents analysis of the second stage of this mixed methods study that explores the complexities of food and eating practices around the table in residential settings from the workers' perspective. This study asks what is the significance of food and eating practices in children's residential care settings in Ireland? The fieldwork commenced with focused ethnography in the five residential care centres, followed by a postal questionnaire with 92 social care practitioners working in the field. Analysis of the data collected during the first stage, discussed in chapter six, indicates that food in residential care is a symbolic instrument to demonstrate care (Emond et al. 2013; Punch et al. 2009). The everyday rituals, rhythms and routines of food are entwined with care and control for the young people and the workers (McIntosh et al. 2010). Those same rituals, rhythms and routines can impact and conflict with the aim to provide a 'homely' home in the centres (Dorrer et al. 2011). The aim of the questionnaire was to further explore the significance of food and residential care for young people from the workers' perspective and to develop and clarify the questions and issues raised during the focused ethnography.











The research has focused on the dining table. As stated at the outset, this study uses the four legs of the table as a conceptual metaphor. The hypotheses and design of the questionnaires for the workers are intertwined with those four main themes: commensality is a widespread practice within residential care, the dining table in residential care is a site for the enactment and enforcement of hierarchical behaviour, the dining table is a controlled and controlling space where young people are disciplined and finally, through government, the young people and the workers learn how, when, where and what to eat in accordance with the regulations of the everyday practices in residential care for young people.





Thematic analysis of the data collected during the focused ethnography contributed to the formation of the following questions that would be examined in the questionnaire:

1. Are the workers aware of the significance of the rituals, rhythms and routines of food in residential care that are entwined with care and control for both the young people and the workers?
2. Is food a symbolic instrument to demonstrate care?
3. How do institutional regulations, for example eating together at the table, conflict with the aim to provide a 'homely' home?
4. How do workers feel about their personal food and eating practices being placed under scrutiny of the public gaze?

The questionnaire (Appendix 1) was designed to gain greater understanding of the identified issues and answer the questions above. The questionnaire is organised into six sections that further explore the everyday food and eating practices in the centres. The table below (Table 7) shows the questions that guided the construction of the questionnaire, how the sections of the questionnaire link to the questions and how commensality, discipline, hierarchy and government are interwoven throughout.

TABLE 7 HOW QUESTIONS, THEMES AND QUESTIONNAIRE SECTIONS LINK

| | Section 1 Ritual Rhythm Routines  | Section 2 Food choices  | Section 3 Feelings and emotions  | Section 4 Power and resistance  | Section 5 Rules and regulations  | Section 6 Workers role  |
|--|--|---|--|---|--|---|
|  Are the workers aware of the significance of the rituals, rhythms and routines of food in residential care that are entwined with care and control for both the young people and the workers | CHDG | CHDG | CHDG | CHDG | CHDG | CHD G |
|  Is food a powerful symbolic instrument to demonstrate care | CG | C | CG | HDG | CHDG | CG |
|  How do institutional regulations, for example eating together at the table, conflict with the aim to provide a 'homely' home | CHDG | HDG | CHDG | HDG | CHDG | CHD G |
|  How do workers feel about their personal food and eating practices being placed under scrutiny of the public gaze | CHDG | HDG | HDG | CHDG | HDG | CHD G |

The coloured shapes     represent the links between the questions and the section of the questionnaire.

C - commensality, H - hierarchy, D - discipline, G – government.

7.2 Who is sitting at the table? *Population profile*

To provide a profile of the population and to set the scene, the sample is introduced. The data presented was compiled from the completed questionnaires from (n=92) workers employed in 18 children's residential care centres. The five demographic categories used in the questionnaire are as follows: what gender they belonged to, what age group (Table 8), how long they had been employed in the centre, how long they had worked in residential care (Table 9) and what was their position in the organisation (Table 10).

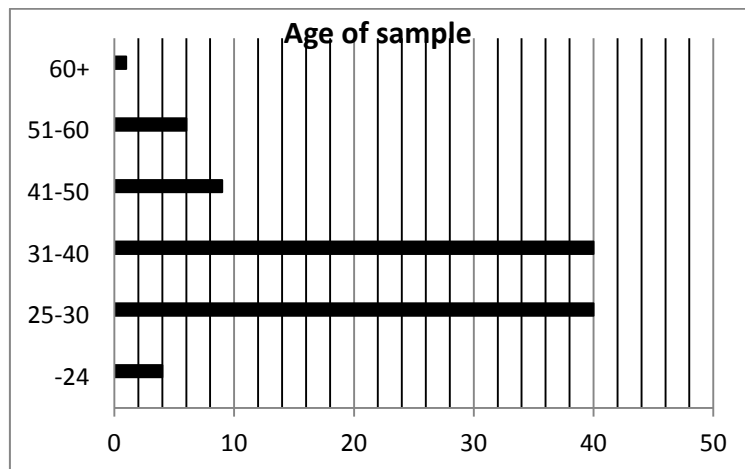
The majority of the respondents, 84%, were women and the rest, 16%, were men. There are no current figures for the breakdown of male and female social care practitioners in Ireland. Doyle (2009) presented a figure of 1,284 social care students training to be social care practitioners in Institutes of Technology across Ireland between 2003 and 2007. Of that figure (n=86) were men, equating to 6.7%. The percentage of men responding here is 16%. This percentage indicates the proportion of men working in residential child care may be relatively high in comparison to other social care services.

Residential care, according to Smith (2013: 144), remains 'an obvious gendered site of practice'. There is a dearth of research into residential care for young people as gendered site (O'Neill 2008). Care, either in the home or the workplace, is considered 'women's work' and care work in general as a non-traditional occupation for men (Smith 2003; Doyle 2009; Lynch et al. 2009). There is extensive literature on the gendered nature of care within other human service professions, including nursing (McLaughlin et al. 2010; Keogh and O'Flynn 2007), services for older people (Barry and Conlon 2010) and early childhood care and education (Madden 2012). Smith et al. (2013: 145) suggest that gender issues in residential care are 'generally considered with the equal opportunities framework' that overlook the different needs of boys and girls living in care settings.

O'Toole (2013) recognises that gender is a complex concept that has been neglected within social care settings in Ireland. One area that has received attention is men who enter the non-traditional occupation of social care may

benefit as their masculine qualities may be held in high regard (Fagan and Norman 2013; O’Toole 2013; O’Neill 2008; McPhail 2004; McLean 2003; Cree 2001). This was evident when discussing access to the centres with management. Two of the HSE centres had men in the top management positions. The three large privately operated services also had men in prominent management positions. However, of the fifteen male respondents here just one was above the position of key worker.

TABLE 8 AGE OF SAMPLE



As table 8 illustrates 80% of the workers were between the ages of 25 and 40. Only one worker was over 60 and four were less than 24 years old. One of the under 24-year-olds was a student, one was a worker and the other two were key workers. This table shows that the workforce in residential care is quite young and 44% of the workers were under 30 and therefore not old enough to be parents of young people in their late teens. Employing a young workforce could be advantageous to minimising the risk of young people placing a worker into a parental role and becoming confused about their relationships with the workers. It could, on the other hand, place young workers in the vulnerable position where the young people confuse the professional relationship as a friendship (Cooper 2012).

Table 9 shows that 28% of the respondents had been employed in residential care for more than five years and a further 33% for more than ten years. These figures suggest that the often quoted high turnover of staff in residential care,

(for example Williams and Lalor 2001; Colton and Roberts 2007), may be either inaccurate or that staff turnover in Ireland has improved. This finding may be a consequence of the current financial crisis.

TABLE 9 TIME WORKED IN RESIDENTIAL CARE

| The number of years worked in residential care | HSE | Private | All |
|---|------------|----------------|------------|
| | % | % | % |
| Less than 1 year | 13 | 12 | 12 |
| 1 - 2 years | - | 17 | 13 |
| 3 - 5 years | 4 | 17 | 14 |
| 5 - 10 years | 26 | 29 | 28 |
| More than 10 years | 57 | 25 | 33 |

Analysis of the data collected here shows accumulatively 83% of workers employed in HSE centres and 54% employed in private centres had worked in residential care for more than five years. This could be due to employment in a state agency providing more security for the workers. Another consideration is that a level 7 Bachelor's degree is now required to work in residential child care and social care practitioners will have invested time and finances acquiring that qualification. The workers were also asked how long they had worked in the current centre. In response, 50% of the workers employed by private organisations had worked in the current centre for less than five years. That could suggest that the private organisations do not have an equivalent retention rate to the HSE centres. However many of these centres are new to the field and therefore may have been in operation for less than five years. All the respondents in management positions had worked in residential care for five years or more. Table 10 illustrates that the majority, 74% of the respondents were frontline workers/key workers. Ten managers and seven assistant managers responded. The respondents who ticked the other option included students, agency and relief staff. There were some management titles specified that I will not report as they may be identifiable to a particular centre.

TABLE 10 JOB TITLE

| Job title of workers | n | % |
|-----------------------------|-----------|------------|
| Worker | 33 | 36 |
| Key Worker | 35 | 38 |
| Assistant Manager | 7 | 8 |
| Manager | 10 | 12 |
| Other job title | 7 | 8 |
| Total | 92 | 100 |

To sum up, the majority of workers are aged between 25 and 40, and 60% have worked in the sector for more than five years. Results from the questionnaires show that while residential care remains a gendered site of practice, a relatively high proportion of male social care practitioners are employed in residential care in Ireland. It is also evident that despite the unequal balance of male and female workers in frontline positions men are well represented in the management of residential care.

7.3 Three square meals: rituals, rhythms and routines from the workers' point of view

Examined now is the significance of the rituals, rhythms and routines of food in residential care. Food and eating are commonly associated with the ordinary routines of everyday life. Food practices such as shopping, cooking and cleaning up afterwards are activities that we are all involved with but most notably we all need to eat every day. Smith et al. (2013) and Punch and McIntosh (2013) are in agreement that young people living in residential care need rituals, rhythms and routines:

[Young people in care] need to experience a sense of order and organisation in their lives that restores some coherence to the chaotic and disintegrated circumstances in which they have often been living (Smith et al. 2013: 20).

Punch and McIntosh (2013) suggest that sharing food rituals, rhythms and routines provides a stage and a script for young people and the workers to interact. In the centres I saw the young people returning from school and their first question for the worker in the kitchen was ‘What’s for dinner?’

In the five centres I visited breakfast, lunch and dinner depended on the school timetable during the week. In general, the evening meal was served between 5pm and 7pm. To ascertain if this was the case in all the centres the survey began with the statement: *mealtimes in the centre you work are at set times*. The responses were 51 workers said yes and 41 no. In 14 of the 18 centres the workers in that centre did not agree that they had set mealtimes where they worked. This raises the question, what is a set time? If dinnertime is supposed to be at 6pm, for one person 6.15 would be late but for another any time before 7pm would not, because time itself is potentially an elastic concept. If the question had been - what time do you have meals at? - it is probable that the answers would also have varied within the individual centres.

The workers in just one centre were in agreement that they did not have a set mealtime in that centre. For respondents who said they did have set mealtimes 90% agreed that set mealtimes created a rhythm, routine and a sense of security in the centre. Looking back, there may have been some problems with this question and the workers may have interpreted it as meals being served at the same time every day. This raises a further question – what exactly is a ‘routine’? In domestic life, as in residential care, routines are constructed collaboratively and depend on who is present.

It is generally acknowledged within the fields of sociology and anthropology that sharing food is central to displaying and experiencing family (for example Murcott 1982; Charles and Kerr 1988; DeVault 1994; Jackson et al. 2009; Ralph 2013). Eating together at the table, or commensality, is encouraged by the workers and is stipulated in the DoHC (2001) standards for children’s residential care. The routine, rhythm and ritual of the workers and young people sharing food at the table offers a point of consistency. Through repetition, using the dining table becomes a cultural norm that the workers and the young people become accustomed to. Eating together at a dining table may

be unfamiliar for some young people entering care and they may resist joining the group at the table. Notes from the focused ethnography show that, after the young people have settled into the centre, that they 'do come to the table' (Hillgrove 16th April). Workers, because of their hierarchical elevated position, both as adults and professionals, can find ways to avoid eating with the residential group at the table. Due to the young people's position in the hierarchy they may not have the same freedom.

Analysis of the data shows that 96% of respondents agreed with the statement: *young people should be encouraged to eat at the dining table*. They were also asked what their level of agreement was with: *young people should be able to eat where and when they like*. Only 11%, of the respondents, agreed with this statement. Therefore, it can be assumed, through subtle or overt disciplinary codes that the young people are directed towards the table. Another reason for sharing meals at the table is to monitor what the young people are eating. 88% of the respondents agreed that monitoring the food young people eat leads to improving their dietary intake. A further 72% agreed that young people eating at the table consume more nutritious meals.

The relationship between the institutional regulation requiring the resident group to eat together and the aim to provide a homely home was investigated. The relationships between questions 1.4 through to 1.8 were tested, resulting in the following correlations being identified, they are accompanied by a significance test, as Table 11 shows. The strength of the relationship between young people consuming more nutritious meals (question 1.6) and encouraging them to eat at the table (question 1.4) is shown. The correlation was significant at the level of 0.01 (2-tailed), shown on Table 11 as 0.306**. This suggests a belief that sitting at the table leads to eating more nutritious meals.

TABLE 11 CORRELATIONS FOR EATING AT THE TABLE

| | Encouraged | Where/when | Nutritious |
|------------|------------|------------|------------|
| Encouraged | 1.00 | | |
| Where/when | -.205 | | |
| Nutritious | .306** | .010 | |
| Monitoring | .199 | -.213* | .164 |

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed). Encouraged = Young people should be encouraged to eat at the table; Where/when = Young people should be able to eat where and when they like; Nutritious = Young people eating at the dining table consume more nutritious meals; Monitoring = Monitoring the food the young people eat leads to improved diets; Flexibility = Flexibility of mealtime and situation (e.g. pizza while watching TV) creates a homely feel in the centre. *N* = 92 for each correlation.

Table 11 shows another significant correlation, though this time a negative one was $-.213^*$ the relationship between young people being able to eat where and when they like (question 1.5) and that monitoring what they eat improves their diets (question 1.7). This suggests a belief that if young people are not seen while eating, their diet will not be healthy. The third significant correlation $.232^*$ shows the relationship between the young people being able to eat where and when they like (question 1.7) and flexibility at mealtimes creating a homely feel in the centres (question 1.8). This correlation suggests the workers are also aware that not eating at the table leads itself to a more relaxed and ‘homely’ atmosphere.

Pallant (2013) suggests that significance levels should be treated with caution and that a third variable may confound the results. The questions selected for correlation analysis shown in Table 11 were designed to elicit how food worked in the centres. The results show the workers believe that young people should eat at the table and monitoring what they eat will lead to their having an improved diet. The correlations also show that the workers believe the young people being allowed to eat where and when they like would lead to unhealthy choices in what they would eat. The workers appear to be aware that a more relaxed attitude to eating arrangements could lead to a more

‘homely’ feel in the centre. This indicates a conflict between the regulation for eating at the table and the desire to create a ‘homely’ feel. This conflict is further complicated, and discussed in greater detail later, by 93% of the workers agreeing that the shared mealtime at the table (question 6.2) also produces a ‘homely’ feel in the centre.

7.3.1 TV dinners

Within the sociology of food it is generally accepted that participation in the routine, rhythm and ritual of meals is considered a key way of displaying and experiencing family, both in residential care and in the general population (for example Punch et al. 2009; Ralph 2013; Jackson et al. 2009; Murcott 1997). The family meal at the table, Lupton (1996) suggests, is a metonym for the family but what family are the workers and HIQA inspectors attempting to emulate? Outside of residential care mealtimes vary considerably from one household to another and eating at a table may not have been the norm for the young people in their past or in the workers’ own homes.

A ‘proper family meal’ in Westernised societies conjures the image of all the family gathered around the table enjoying the same food and having convivial conversations. That image remains a constant symbol of ideal family life. Wilk (2010) suggests that assuming that image is the norm renders other eating arrangements deviant. McIntosh et al. (2010), Dorrer et al. (2011), Punch et al. (2011) and McManus and Morrison (2009) raise the question of flexible and alternative eating arrangements in residential care centres. The children and young people in those studies thought that they should not always have to eat at the dining table and that if they were at home they could eat where, when and what they like. Dorrer et al. (2011: 24) found that the workers in their study believed that eating a take-away in front of the TV with the young people at the weekend was an opportunity to experience what might be happening in other ‘normal homely’ homes. According to Dorrer et al. (2011) rigid and inflexible food practices may contribute to the institutionalisation of the centres.

The workers were asked for their level of agreement as to whether or not: *flexibility on the situation and time of meals, for example having a pizza in*

front of the television, created a homely feel in the centre. Just 10 workers disagreed with this statement, as Table 12 shows.

TABLE 12 FLEXIBILITY LEADS TO A MORE HOMELY FEEL

| Flexibility on the situation and time of the meals, for example having a pizza in front of the TV, can create a homely feel in the centre. | | |
|--|----|-----|
| | n | % |
| Strongly agree | 15 | 16 |
| Agree | 50 | 54 |
| Undecided | 17 | 19 |
| Disagree | 10 | 11 |
| Strongly disagree | - | - |
| Total | 92 | 100 |

This result shows that there is conflict between the rules that govern eating at the table and the wish to create a homely feel in the centre. Dorrer et al. (2011) found, and also considered here, that a break in the normal routine of eating at the table may be a treat to be given or taken away and therefore can be used as a form of discipline and dependent on the behaviour of the young people. This highlights some of the complex ideas and contradictory beliefs that people working in residential care hold about how food works, as demonstrated by the workers in this study believing that eating at the table and not eating at the table both contribute to creating a homely feel in the centres. Though it may well be that contradictory thoughts and beliefs about aspects of everyday life are normal and widely distributed because life is not always rational (Hindess 2015). The workers' interpretations of food and eating practices are complex and consequently difficult to measure or quantify.

7.3.2 Social dining

The National Standards for Children's Residential Care (DoHC 2001) require staff and young people to eat together and that these meals should be regarded as positive social events. At the same time the encounters between the workers and the young people are shaped within the framework of unequal power relations and the dining table is a setting where the inequities of power based on gender and age can be played out. Initially, I doubted that I would encounter the National Standards idealised image of the positive social group sitting around the table, eating the same food and having interesting conversations. This was due to my preconceived idea of the residential environment that was 'teetering on the brink of a loss of control' (Smith 2009: 95). Conversely Emond et al. (2013: 7) suggest that the ritual of the shared meal can provide 'an order out of disorder'. I did observe several mealtimes in the field not dissimilar to the idealised image. There were also other mealtimes where another image of family life was evident: that of complaints, about the food from the young people or by the workers about not coming to the table when the food was ready. These mealtimes were not fraught with tension, rather they were reminiscent of regular ebb and flow of family life.

Workers in residential children's care do not have food breaks away from the job or clients as is the case for the majority of workplaces for example nurses or social workers. While workers eat their meals they are on duty and they manage the young people's behaviour at the table. Mealtimes at the table, according to the National Standards, are to be regarded as social events. Punch et al. (2009) found that mealtimes could be considered work time by the adults and the young people in their study. The mealtime may be the only time in the day when everyone in the group sit together and is therefore an opportunity to discuss and make plans for the evening or days ahead. The workers in this study were asked for their level of agreement to the statement: *mealtimes are working times not social times* and they did not agree with the statement, unlike the workers and children in the Punch et al. (2009) study. However, once again there may be a problem with the statement - I had hoped it would be interpreted as descriptive. The workers, on the other hand, may have understood it as normative or prescriptive - how things should be, not how

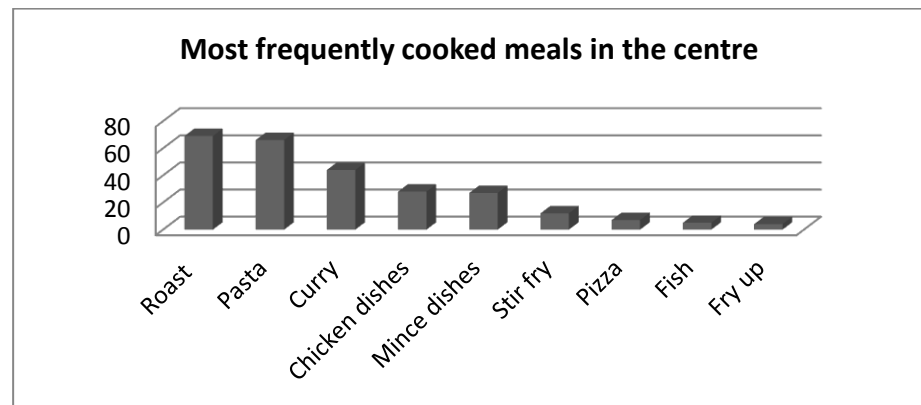
they actually are. The social care workers' role at the table is discussed in greater detail later in this chapter.

7.3.3 On today's menu

Section 6.9 of the National Standards also requires that the young people should have an input into menu planning. Question 2.1 asked how often the young people are consulted about menu choice. The majority, 54 respondents, said weekly and 31 said daily. Of the remaining seven respondents six were from the centre that employed a chef and their responses ranged from 'rarely' to 'never consulted'. The chef in this centre prepared set meals from a four-week rolling menu. The menu may have been well balanced but the majority of the workers, including the chef, had been employed in this centre for more than 10 years so it was likely to have become monotonous. In my experience, working as a chef, cooking the same food over and over again resulted in the work becoming an automated task that required little thought or attention. The workers, after 10 years, may be able to tell the date by what is on the menu but the predictability may also be comforting and familiar. The turnover of young people in this centre was frequent so they may have found the menu was sufficiently varied. Punch et al. (2009: 17) found that the workers and young people disliked the repetitive menu and that the cook may represent 'the institutional dimension of the home'. The chef in this centre did not consult with the young people on the menu. The food practices in this centre harked back to the eating arrangements from the large institutions of the past, when children's food choice was not considered.

In chapter three the history of food and residential care in Ireland was explored and it was evident that the food eaten inside the institutions was not dissimilar to that eaten outside the institutions, therefore I hoped to elicit if that trend had continued. The workers were asked to list the three most frequently cooked meals in the centre and Table 13 shows their response.

TABLE 13 MOST FREQUENTLY COOKED MEAL



Meat, vegetables and potatoes are strongly associated with being a traditional or proper dinner (Charles and Kerr 1988; Murcott 1982). For the purpose of coding I used 'roast' for this meal type. As table 13 shows a 'roast' was the most frequent first choice. The roast is revered as an institution in its own right and may be the highpoint of the weekly menu and therefore easily recalled to memory. The second most frequently recalled meal was described as varying types of pasta. During the focused ethnography, which took place midweek, the most frequently cooked meals were pasta dishes.

What should be stressed, at this point, is that the meals may have been cooked but they were not necessarily consumed by the young people. The workers were asked was an alternative meal provided if a young person did not want to eat the prepared meal. Eighty respondents said yes and the majority of examples given were that the young person could make something for themselves. Depending on the age of the young person, or the situation, the worker occasionally would make an alternative. Fieldwork notes show that the most often referred to alternatives were sandwich, noodles or cereal.

The provision and management of treats (sweets, chocolate, crisps, and fizzy drinks) was identified by Punch et al. (2009) as potential site of conflict between the workers and the young people. The term 'treat' is recognised as problematic for health promotion and nutrition education professionals because it has a positive connotation and, according to Petrunoff et al. (2014), a more appropriate term would be 'extra food'. That positive connotation is often linked with luxury and pleasure. Safefood (2014) define treats as foods

that are high in sugar, fat or salt. Food that is associated with treats has little nutritional value and considered as unhealthy. Treats are often offered by parents after healthy 'good' food has been consumed. Lupton (1996: 150) maintains that it is food morality that dictates which foods are considered nutritious and good, as opposed to those that are bad and guilt producing. Positioning food as bad 'renders it more desirable', therefore treats are associated with reward. A treat, according to Foley-Nolan, the director of Human Health and Nutrition at Safefood, should have an occasional quality to it and a treat is not a treat if you have it every day (O'Callaghan 2014).

The management and provision of treats varied in the five centres that I visited. In some centres treats were controlled by the workers and they were rationed over the week. In Hillgrove, I was informed that there were no treats provided because they were considered as a flashpoint for conflict. Punch et al. (2009) found that young people felt that they should not have to ask for their treats and the workers used treats to barter for desired behaviours. In contrast they also found that the control of treats could be considered by the workers and the young people as a positive form of control or care for the children's diet.

In this study treats were provided by all the responding questionnaire centres and 66 respondents said they were controlled. This was another area where there was disagreement within the individual centres as to whether or not treats were provided and/or controlled. The control of treats varied from: keeping them in a locked cupboard or the office, rationing the amount available to the young people, or distributed as a reward for good behaviour. From discussions with the workers in the five focused ethnography sites the main reason for controlling the young people's access to treats was that the treats would last longer under the workers' control.

The Caroline Walker Trust (CWT) advises, that when workers are taking young people out for treats, they should consider an alternative to fast food. Fast food is very popular in Ireland and a recent Euromonitor International report shows that Irish people spend more on fast food than 19 other European countries (Healy 2014). According to Share (2008: 18) all new surveys on

young people’s dietary practices in Ireland ‘re-establish that they eat too much junk food’. In my experience of working with young people in other social care services when a day out occurred, it seemed obligatory to visit a fast food restaurant. As table 14 shows, the most frequently visited restaurant in this study was described as Burger/Fast food.

TABLE 14 MOST FREQUENTLY VISITED RESTAURANT

| When eating food other than that cooked in the centre what is the most frequently used restaurant? | n |
|--|----|
| Burger/fast food | 49 |
| Take away | 10 |
| Chinese | 10 |
| Do not eat out | 6 |
| Pub/restaurant | 4 |
| Pizza | 3 |
| Café | 3 |
| Varies | 3 |
| Not answered | 4 |
| Total | 92 |

Many respondents added that this restaurant choice was decided by the young people. This was the only area where the respondents added additional unrequested information. This may be an example of the workers relinquishing their authority to ensure that the young people eat nutritious food.

7.3.4 How many cooks...?

Smith et al. (2013) suggests that food activities can offer an opportunity to challenge gender or cultural stereotypes. With that in mind, we return to the image of the hierarchical family dinner table where a man sits at the head of the table, children sit at the sides and a woman serves. The dining tables did not have an adult sitting in the hierarchical position at the head of the table but they did have children sitting being served, generally, by women. I was

interested in how the food work was organised in the centres. While in Glenview I asked Kate (worker) how the decision was made as to who would cook. I was told that it depended on who she was on duty with. If the other worker was a confident cook she would not get involved. If the other worker was a less confident cook they would do it together. The fieldnotes from Oaklands recorded a conversation with Sean (worker) who told me that he avoided cooking when there was someone else on duty who would cook.

In the questionnaire I followed this issue by asking respondents to reply yes or no to the statement: *I avoid cooking at work*. Just two respondents answered yes and both worked in the centre that employed a chef. From the conversations recorded above there was an assumption that more workers would have answered in the positive. A possible explanation for this could be that the word *avoid* used in a questionnaire, while not intended, was construed as negative. However, continuing in this vein, they were also asked if cooking at work was similar to other domestic duties and 70% agreed with the statement. Food work being viewed as equal to basic physical care provision rather than with the more professional aspects of the job may mean that the symbolic significance of food is being overlooked. On the other hand food work being viewed as everyday and ordinary may allow for a more relaxed attitude from the workers and less interest from the regulators.

The literature on food practices in residential care (Punch et al. 2011) highlight young people's involvement in food related chores in two main areas: resistance to doing chores and by helping to cook and clean they have the opportunity to learn independent living skills. When conducting the focused ethnography I noted the young people's involvement with food related chores. Some young people like Bridget (16 Hazelbrook) cooked the evening meal for the group while others such as Connor (13 Glenview) had to be cajoled into putting his plate into the dishwasher. In all the centres I was informed that young people set the table and clear away their dishes. However, I did not see any young people setting the table, but they all cleared their dishes from it after eating.

To ascertain if the young people were involved in food related chores in the 18 questionnaire centres, the workers were asked to select: *daily, occasionally or never*. Just over 20% selected daily. The most common response was occasionally with, 75%. The majority, 94%, agreed that young people should be encouraged to take part in food related chores and 60% of the respondents disagreed that young people’s involvement in food related chores caused tension in the centres. They were also asked for their level of agreement as to whether or not the young people doing food related chores should be voluntary. As Table 15 shows accumulatively more workers were undecided, disagreed and strongly disagreed than agreed. This analysis shows that the young people in the focused ethnography sites were involved in everyday food chores -specifically clearing their plates from the table.

TABLE 15 SHOULD CHORES BE VOLUNTARY

| The young people’s involvement in food related chores should be voluntary. | n |
|--|----|
| Strongly agree | 3 |
| Agree | 36 |
| Undecided | 28 |
| Disagree | 21 |
| Strongly disagree | 4 |
| Total | 92 |

Devine et al. (2004), citing both Whyte (1995) and Brennan (2001), suggest that children’s involvement in household chores in Ireland show patterns of decline. Analysis from the workers’ questionnaire indicates that a small amount of young people are expected to complete food related chores daily. This would suggest that the majority of young people do little or no food work in the centres.

To conclude it is evident that commensality is highly regarded in children’s residential care. The resident group at the dining table share the same food

which is central to displaying and experiencing family. According to Punch et al. (2009: 154) the social aspect of the mealtime in residential care is ‘a taken for granted cultural norm’ that is often ‘uncritically accepted and acted out’. In most of the centres meals were at set times. The majority of workers believed that the young people should be encouraged to eat at the table and that by so doing they would consume more nutritious meals. On the other hand they are also aware that flexibility on eating at the table may create a more relaxed atmosphere in the centres.

The meals provided inside the centres are not dissimilar to those eaten within the general public . The workers are responsible for providing what appears on the table and none of the workers here avoided that chore. Food work is viewed in the same light as basic physical care work so its significance may be overlooked. The young people do have input into what goes on the menu but ultimately their choice is to eat the prepared food or not. If not, in the majority of centres, they could make themselves an alternative.

7.4 Who cares? Food is a symbolic instrument to demonstrate care

Punch et al. (2009) and Emond et al. (2013), who studied the food and eating practices in children’s residential centres in Scotland, found that food practices could encompass:

[M]any positive elements: connecting, caring, bonding, empathy and sharing special occasions but they also can invoke notions of power, hierarchy, punishment and control (Punch et al. 2009: 40).

The analysis of the questionnaires continues with how food is used to demonstrate care in children’s residential centres for both the workers and the young people. The workers in the Punch et al. (2009) study viewed food as an important way to show that they cared about the young people. Food is linked to care in several ways, perhaps most significantly in maternal nurturing. The workers in residential care are, to a certain extent, positioned in the maternal nurturing role. They have a duty to prepare food for the young people and oversee its consumption. According to Smith et al. (2013) food is central to

the development of nurturing relationships between adults and children. Lupton (1996) suggests that the emotion most often linked to food is love. According to Smith et al. (2013: 42) residential care in recent years has been 'risk averse and child protection dominated'. Talk of such a strong emotion as love has not been a good idea and 'fear rather than love has been the dominant emotion'.

Smith et al. (2013) argue that due to the shift towards managerialism residential care has moved towards measurable outcomes and away from a relationship-based job where 'love is deemed unprofessional' (Smith 2009: 124). Within residential care food work can be used as a safe way to show a young person or a worker that they are cared for or even 'loved'. Examples of how food is used to demonstrate care include: the workers attempting to replicate the remembered perfect boiled egg for Gemma (Woodlands 18) or Martina (Glenview 16) making a cup of tea for Anne (worker) because she looked stressed.

Lupton (1996: 66) suggests that childhood memories of food can be an emotive issue and associated with emotions such as 'disappointment, anger, resentment and frustration juxtaposed with security, delight and happiness'. Food for young people in residential care can also be an emotive issue and may be dependent on their past food experiences. Food can also be used to resist or reject care and to express negative feelings and emotions. It may be easier for a young person to say 'I do not want your food', rather than 'I do not want your care' (Emond 2011 personal communication 23 November). Punch et al. (2009) found that food was a safe way to express emotions for the young people and the workers. An illustration of this was Fiona (17 Woodlands) saying she hated the food in the centre, and this was often a precursor to 'that's why I hate this place'. In addition, Lorna (worker Woodlands) indicated that Fiona refusing the prepared meals was a symbolic rejection of care offered by the workers.

Food is not only used as a 'safe' way to reject care, as food spaces are often the target of destructive behaviour. The manager from Hazelbrook informed me that Bridget (16) had wrecked the kitchen twice in the previous five weeks.

At the managers' meeting I had also been asked if I was going to investigate why young people targeted the kitchen when they were acting out. Emond (2000: 369) found the young people in her study considered 'screwing the system a means of gaining power or control not only over the adults but over their lives'. She reports that such thinking 'led to acts of vandalism or wastage of food'. I found no extensive literature on young people targeting the kitchen in residential care. However within the prison system food is considered a potential flashpoint for violent behaviour. According Earle and Phillips (2012) communal dining rooms have been phased out in the UK prisons since the 1970s following a four day prison riot in HMP Albany that was triggered by food. Poor food provision was also cited as a contributory factor in the Strangeways riot in 1990. Food has also been a site of conflict in migrant centres in Australia in the 1950s (Postiglione 2010). Here in Ireland poor food quality has become a focus of protest for asylum seekers living in Direct Provision centres (O'Shea 2014). To gain insight into this matter in residential care I asked the workers if there had been any incidents of food related physical conflict. They were also asked to give examples of that conflict and Table 16 below shows the results.

TABLE 16 INCIDENTS OF FOOD RELATED CONFLICT

| Have there been any incidents of food related conflict in the past twelve months in the centre where you work? | | |
|--|----------------|---------------|
| | Yes=46% | No=54% |
| <i>Examples given</i> | | n |
| Throwing food | | 22 |
| Contaminating food | | 10 |
| Disrupting meals | | 1 |
| To gain control | | 1 |
| Wasting food | | 3 |
| Breaking dishes | | 4 |

As illustrated in Table 16, throwing food was the most frequent example given. The food was thrown around the kitchen, at the walls and sometimes at the workers. Food being contaminated was also referred to in varying ways from spitting in pots or pans of prepared food to putting salt in the sugar bowl as a prank. The examples given were sometimes accompanied with reasons for the behaviour, such as – ‘when the young person was stressed or emotional’. This demonstrates the workers are aware that food is used as an outlet for emotions.

Correlation analysis was used to test the hypothesis that food is a symbolic instrument to demonstrate care. The following table (Table 17) shows the correlations calculated on workers’ views on food being used to show care, express emotions and gain individual attention. These questions were initially grouped in the questionnaire under food, feelings and emotions. The data is based on the responses to a Likert scale. To gauge the workers’ awareness of the significance of food and care they were asked if they thought that they could show they cared through food. The majority of workers agreed with the statement: *knowing what the young people like or dislike to eat can show that I care*. There was also agreement with: *a young person knowing what food you like or dislike can be a sign that they care for you*.

By running correlation analysis on questions 3.1 through to 3.4 the following significant correlations were identified. Table 17 shows a significant correlation (.530**) between the statements *I can show I care through food* (question 3.1) and *a young person can use food to show a worker that they care* (question 3.2). This illustrates that the workers were conscious that food is used in the centres to demonstrate care both for the young people and themselves. Table 17 also shows that there is a significant correlation (.455**) between the workers using food to show they care (question 3.1) and food being used to express emotions (question 3.3).

TABLE 17 FOOD USED TO EXPRESS CARE AND EMOTIONS

| | Show Care (W) | Show care (YP) | Express emotions |
|------------------|---------------|----------------|------------------|
| Show care (W) | 1.00 | | |
| Show care (YP) | .530** | | |
| Express emotions | .455** | .349** | |
| Gain attention | .049 | .032 | .351** |

Note. ** Correlation is significant at the 0.01 level (2-tailed). Show care (W) = I can use food to show that I care; Show care (YP) = A young person can use food to show a worker that they care; Express emotions = Food can be used to express emotions for workers and young people; Gain attention = Young people use food to gain attention. *N* = 91 for each correlation.

The other significant correlation (.349**) is between the young people using food to show that they care (question 3.2) and food being used to express emotions (question 3.3). The final significant correlation (.351**) is between young people using food to gain attention (question 3.4) and young people expressing their emotions through food (question 3.3). These results suggest that the workers recognise the significance of food being used to show the young people and the workers that they are cared for. They are also aware that food is used by the young people and the workers to express emotions.

Table 17 also shows that there is no significant correlation between the young people using food to gain attention and the workers or the young people using food to show that they care. The SPSS analysis programme may not have found those correlations statistically significant but the workers, as illustrated by Table 17, did not hold positive associations with young people using food to gain attention. The relationship between those variables may not be significant from a quantitative perspective but they are significant from a qualitative perspective and supports my decision to use a mixed methods approach. This finding suggests that the young people using food to gain attention is perceived as negative behaviour that needs to be controlled and bears little relationship to the more positive behaviours associated with care. This finding is linked to McIntosh et al. (2010: 301) who found that workers

having to exercise control over young people can be a ‘deeply ambivalent experience’ because workers would prefer to emphasise their caring role.

7.4.1 I’m not eating that

Children learn from an early age that food refusal and displaying resistance at the meal table may result in being offered an alternative meal or snack but, as Visser (1991) suggests, it is a guaranteed way of getting adult attention. Young people saying they are hungry and children not eating, overeating or messing with food are certain ways of gaining adult attention at the majority of tables. The workers were asked for the level of agreement to the statement: *young people use food to gain attention*, 60 workers agreed and 24 were undecided. They were also asked to give an example. The majority agreed with the statement and 71 workers gave examples. The examples were coded as shown in Table 18. Rejection of food was the most common example and only eating what they cook themselves could be included. Destruction of food, throwing it on the floor, around the kitchen or at the workers was a close second. Using food to get one-to-one attention was stated by 18 workers. This question did not generate many positive examples, as Table 18 illustrates, of how food was used to gain the workers’ attention.

TABLE 18 HOW IS FOOD USED TO GAIN ATTENTION

| Can you give an example of how food has been used by a young person to gain your attention recently? | % |
|--|----|
| Food refusal | 24 |
| Destroy food | 23 |
| To get one-to-one attention | 18 |
| Bingeing | 11 |
| To gain control | 9 |
| To start an argument | 6 |
| Cook to gain praise | 4 |
| Only eat what they cook | 4 |
| To apologise | 1 |
| Hoarding | 1 |

Emond et al. (2013: 10) found that workers used food to defuse situations when tension was high. It was used as a 'means of reaching out to a young person in distress in a non-threatening way'. Examples from their study include: offering to make a drink or something to eat for someone who is upset or using the promise of popcorn to get the young people to settle in front of the television. In this study, 64% of the workers agreed that food could be used to defuse tension in the centres they worked in.

Food related conflict is referred to within the literature on residential care (Dorrer et al. 2011; Punch et al. 2009) with regard to control of access to food spaces. Dorrer et al. (2011) discuss kitchens in residential care being locked 'at a time of difficult group dynamics' due to concerns for safety. As already discussed in chapter six, there were instances of the kitchen being the target of destructive behaviour in Hazelbrook and the policy in that centre was not to lock doors. To explore if this was a general policy the workers in this study were asked *if food spaces in the centre were ever locked* and 30% of respondents said yes. However, this did not always refer to access to the kitchen. In some instances, they referred to knives being locked in cupboards. Once again this may reflect some lack of clarity in this question.

Emond et al. (2013: 12) found that workers can experience rejection of the food they have prepared as a rejection of themselves and the care they are offering. The workers in this study were asked to use one word to describe how they felt when a meal they had prepared was rejected by a young person. Table 19 shows the twenty three words used by seventy five of the respondents.

TABLE 19 DESCRIBE HOW YOU FEEL WHEN YOUR PREPARED FOOD IS REJECTED

| <i>Word</i> | <i>Frequency</i> | <i>Word</i> | <i>Frequency</i> |
|---------------|------------------|-------------|------------------|
| Disappointed | 13 | Understand | 2 |
| Indifferent | 8 | Apathetic | 1 |
| Annoyed | 6 | Angry | 1 |
| Fine | 6 | Frustrated | 1 |
| Nothing | 6 | Tense | 1 |
| Concerned | 5 | Hurt | 1 |
| Their choice | 5 | Challenged | 1 |
| Unappreciated | 4 | Insulted | 1 |
| Rejected | 3 | Demotivated | 1 |
| Normal | 3 | Snubbed | 1 |
| Disheartened | 2 | Saddened | 1 |
| Question why | 2 | | |

As you can see the words are almost universally negative. Table 19 shows the most frequently used word was disappointed, indicating that the workers were affected by the young people's rejection of their food. Most of the other words indicated to varying degrees that the workers felt rejected, even angry that their efforts had been rebuffed. The young people's rejection of the food prepared by the workers can trigger negative emotions similar to Keenan (2006), who also found that feelings of rejection can be evoked in workers by children refusing to eat what they have worked hard to create. As discussed in chapter six rejection of food can be symbolic of rejection of care. This raises a challenge for the workers, who have to contain their negative emotions while continuing to demonstrate care.

To conclude, analysis of the data shows that food is used by the workers to demonstrate to a young person that they are cared for. Food can also be used by the young people and the workers to express feeling and emotions. Food can be used to gain individual attention and to defuse tension in the centres. Overall the workers in this study are aware that food can be used to demonstrate and reject care.

7.5 Creating a 'home' in a 'home'

As discussed, young people and the workers sitting at the dining table to share food is an assumed cultural norm that is often performed unquestioningly by the workers. The workers are of the opinion that eating as a group at the table is an opportunity to create a 'homely' feel in the centre. However, other advantages of eating at the table may outweigh that desire. Those advantages include: surveillance of what the young people are eating and encouraging social skills and appropriate behaviour at the table. In addition, I suggest, food mess is confined to the kitchen/dining room, everyone eats the same food at the same time, the group can be together in the one space and their interactions can be observed. Table 20 shows the responses to the questions on the workers determining where, when and what the young people will eat.

TABLE 20 WORKERS DETERMINE WHAT, WHERE AND WHEN YOUNG PEOPLE EAT

| Do the workers determine what, where and when the young people will eat? | <i>What</i> | <i>Where</i> | <i>When</i> |
|--|-------------|--------------|-------------|
| Strongly agree | 3 | 5 | 2 |
| Agree | 15 | 41 | 29 |
| Undecided | 11 | 9 | 10 |
| Disagree | 52 | 33 | 43 |
| Strongly disagree | 11 | 3 | 5 |
| Total (n) | 92 | 91 | 89 |

As Table 20 illustrates, the workers mostly disagree that they determine *what* will be eaten. Half of the workers agreed that they decide *where* the young people will eat and they mostly disagreed that they determine *when* the young people will eat. As already discussed at the beginning of this chapter 96% of the workers agreed that the young people should be encouraged to eat at the table and 11% did not agree that the young people should be able to eat when and where they would like. This highlights that the workers and regulations can determine where the young people can eat, but not to such an extent when or what they will eat.

The kitchen is potentially the most highly regulated space within residential care centres. McIntosh et al. (2010: 294) found that ‘the kitchen was subject to panoply of health and safety regulation and elevated levels of supervision and surveillance’. The kitchen in any household is a potentially dangerous place. The possible hazards include: burns and scalds from cookers and kettle, cuts from sharp objects, slipping on spills or the ingestion of hazardous chemicals. The kitchen is also the possible site for the contamination of food by bacteria, hence the heightened regulation of the kitchen in children’s residential care centres. Once again I looked to the National Standards for Children’s Residential Care to establish what the regulatory advice was. The following statement is not specific to the kitchens:

§10.14 The centre has an up to date Health and Safety statement which has been developed in consultation with relevant Health and Safety authorities, and a member of staff is a designated Health and Safety Officer (DoHC 2001: 31).

The workers overwhelmingly agreed that health and safety regulations kept the young people and the workers safe. They also agreed with the statement: *I am confident in my knowledge of health and safety regulations*. The workers were asked if they thought that health and safety regulations could restrict the young people’s cooking activities and 25 agreed while 5 strongly agreed. In addition, 75 respondents said they did not have experience of health and safety regulations restricting young people’s access to food spaces.

Of the fifteen workers who had experienced restricted access six gave knives as an example, with reasons such as: ‘not allowed in the kitchen when sharp knives are being used’ (Worker 85), ‘they can’t be up-skilled because they cannot use the knives’ (Worker 72) and ‘if there is a young person who is self-harming we have to keep them away from knives’ (Worker 37).

In one centre, one of the five responding workers said the kitchen was locked at night. Of interest here is that other workers from that centre did not recognise that the kitchen being locked at night restricted the young people’s access. I found this significant on many levels, not least that the young people’s access to a glass of water was restricted. There were two examples

given of how food safety rules restricted access: ‘they get annoyed by food rules – having to use coloured boards’ (Worker 21) and ‘if they don’t wash their hands’ (Worker 79). One worker said that young people were not allowed in the kitchen if they were ill - ‘if they have a bug’ (Worker 20) and another said ‘they were not asked to help prepare the meal if tension was high in the centre’ (Worker 48).

7.5.1 What a waste

As discussed in chapter six, during the qualitative data collection, I saw a great deal of food waste. On my first day in Glenview a chicken curry was being thrown out because it had been made two days earlier and the young people had not eaten it. The curry was in a covered plastic container and had been stored in the fridge. This alerted me to food waste in the centres. In all the centres I visited meals were prepared but they were not always eaten and there was no evidence that they were being saved for another day. The National Standard 6.9 (DoHC 2001) that requires the centres to offer adequate quantities of nutritious and appetising food may account for food being wasted because in practice the food is not being consumed by the young people.

There is growing concern regarding household food waste. Evans (2012: 53) suggests that the current levels of household waste are problematic and: ‘the passage of food into waste occurs as a consequence of households enacting ordinary domestic practices and negotiating the contingencies of everyday life’. Evans (2012) found that the established institution of the family meal can contribute to increased household food waste. He illustrates this by parents buying food that they think the family should eat, plus the food they know will be eaten. This may also be the case in residential care.

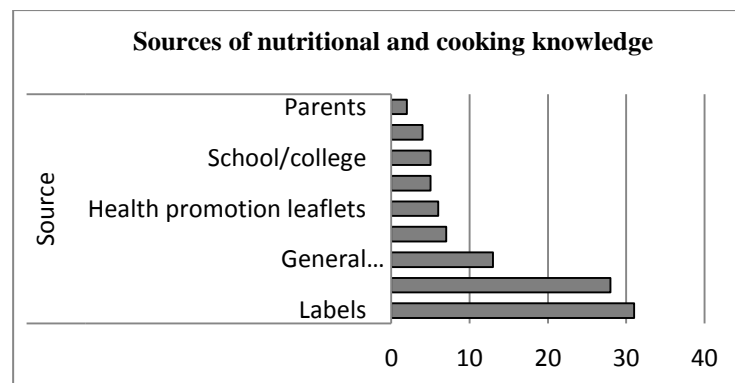
The balance between the efforts to ensure the resident group and, in particular, the young people, are offered a healthy meal and having to provide a back-up in case, or when, the young people (or the workers) refuse to eat the prepared meal results in food waste. In an attempt to clarify if there was a connection between the workers’ knowledge of food safety and waste, I asked for the workers’ level of agreement with the statement the *knowledge of food safety*

can reduce food waste and 80% of the workers agreed. Arguably, food safety knowledge, for instance the chicken curry being safe to eat, has no connection to the food wasted in the centres. A relevant factor in food waste, I believe, is who pays for it. If the workers or the young people had to pay for the food themselves they might be less inclined to waste it. Food waste in residential care settings warrants further exploration as my question on food waste did not produce sufficient data to bring clarity to the issue.

7.5.2 You know what's good for you

The onus is placed on the workers in residential care to offer the young people a healthy and nutritious diet. The National Standard 6.9 requires young people to have ‘adequate quantities of nutritious and appetising food’ (DoHC 2001: 22). I was interested in how the workers acquired the nutritional knowledge to fulfil this requirement. According to Coveney (2006) discourses on nutritional knowledge heighten ethical interest in our individual diets and through self-regulation and self-reflection healthy or unhealthy citizens are produced. Coveney (2006: 121) suggests that within the family there is no need for State inspection of our daily food habits because ‘in the government of food choice, individuals *want* to be healthy [and] experts instruct them how to be so’. The following table (Table 21) shows the workers’ source of food knowledge supports Coveney’s theory on the penetration of nutritionist knowledge.

TABLE 21 TOP 3 SOURCES OF FOOD KNOWLEDGE



Within children’s residential care daily food practices are inspected by an external State body and the eating habits of the young people assessed. Punch et al. (2009) propose that food can be viewed as a quantifiable indicator of

care work such as: What is their input into menu choice? Have they tried new foods? Do they sit at the table? Have they gained or lost weight? I wanted to examine where the workers in this study gained their food knowledge. The results in Table 21 show food labels were the most frequently stated source of food knowledge, followed by the internet/media. Pollan and Kalman (2011) argue that food that carries a label needs a package and is therefore more likely to be processed. This suggests that workers' reliance on labels means that they also rely on processed food. This could mean that the workers have knowledge of the attributes of specific foods, rather than food knowledge in general. However, closer inspection of the workers' questionnaire shows that food labels were given as an example and therefore this result may be due to the power of suggestion rather than a reliance on processed foods.

The responses indicate that 5% of the workers had completed a food training course. Sean (worker) was the only worker who had trained in social care in the 1990s when learning to cook was on the curriculum. Therefore the construction of food knowledge appears at present to be an individual activity in residential care as it is within the general public. The workers do not receive training in food knowledge as part of their social care qualification and the sample here mainly rely on the information provided by food producers and discourses in the media to inform their food practices. Conversely, according to Safefood (2012: 94), within the general public television, newspapers and the radio were the leading sources of information on healthy eating - food packaging was the least.

CORU the body responsible for the regulation of health and social care professions is currently in the process of establishing a registration board for social care workers. Under the Health and Social care Profession Act 2005, workers will be required to register and engage in continuing professional development (CPD) (Social Care Ireland 2015). The absence of any food training for residential care workers at present provides an opportunity for it to be introduced as part of a CPD programme.

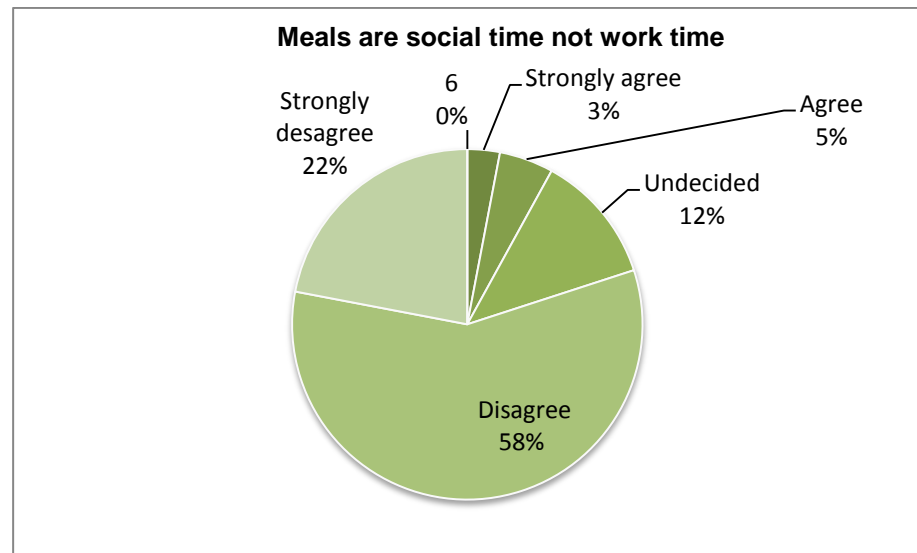
Rules and regulations can determine that the young people will eat at the table but not when or what they will eat. The workers agree that health and safety

regulations are important in keeping the resident group safe. Over 90% were confident in their knowledge of food hygiene and health and safety regulations. The majority did not have experience of regulations restricting the young people’s access to food spaces or gaining cooking skills.

7.6 Who’s watching?

The CWT (2001) suggests that workers, while sharing the same food as the young people, should be encouraging: healthy eating choices, appropriate social skills and be aiming to make the atmosphere pleasant. As already discussed, workers in residential care do not get meal breaks away from the job, as is the norm in the majority of work places. When on duty they eat in the centre with the resident group. As shown in Table 22 below, 80% of the workers disagreed with the statement: *mealtimes are work time not social time*. The workers disagreement with the statement could be interpreted in two ways. The workers disagreed with the statement because they view mealtimes are social time or they disagreed because they are both work and social time.

TABLE 22 MEALS ARE WORK TIME NOT SOCIAL TIME?



The workers are unlikely to switch off their worker or adult roles at the dining table. There are expectations of the workers during mealtimes. The expectations come from within and outside the centre. During the focused ethnography in the five centres I noted that at least one worker would be responsible for cooking/serving the food and workers would get up from the

table to get something for the young people if requested. Arguably this is an expected duty for the workers during mealtimes. There is also an expectation that they should set good examples in their food choices and social skills at the table. The majority of respondents agreed that sharing mealtimes and eating the same food as the young people was an opportunity to produce a homely feel in the centre. I am arguing that while mealtimes may be one of the more pleasant aspects of the workers' day, it is nevertheless part of their working day. Therefore mealtimes in residential care are both work and social time.

One of the key ideas within social pedagogy is the lifespace approach where 'close and effective personal/professional relationships emerge in the course of everyday encounters' and 'naturalistic situations' (Smith 2012: 51). Deploying the lifespace approach, a social pedagogue creates opportunities to promote social inclusion, growth and learning and the shared meal at the table creates one such opportunity. Mealtimes, according to Storø (2013: 129), are 'important to the social pedagogue precisely because it is *not* about his [sic] profession' (emphasis in original). The resident group eating together provides an opportunity for workers to spend time with the young people in a less formal professional way and Storø (2013: 130) warns against 'turning the meal into a meeting'.

The National Standard 6.9 states that the young people should have an input in menu planning. It could be contended that if there is a hierarchy of food choice in residential care then the workers' choice should be lower on the scale because the service is provided for the young people not the workers. However the workers are not only expected to eat with the young people but they are also expected to eat the same meal.

I wanted to ascertain if the workers believed that they should have a say in what that meal might be. The next table (Table 23) shows the workers' level of agreement on their personal food choice being taken into consideration when menu planning.

TABLE 23 WORKERS' FOOD CHOICE SHOULD BE TAKEN INTO CONSIDERATION

| Workers food preferences should be taken into consideration when menu planning. | n | % |
|---|----|-----|
| Strongly agree | 4 | 4 |
| Agree | 54 | 59 |
| Undecided | 18 | 20 |
| Disagree | 16 | 17 |
| Strongly disagree | - | - |
| Total | 92 | 100 |

People working in children's residential care regularly work 24 hour shifts and generally do not have an alternative but to eat in the centre. Workers in residential care do not have access to alternative food choices as many other workers do in their meal breaks. They do have some choices, as the data collected during the focused ethnography showed: workers can bring in their own food from home, eat different food from the group or have special food bought for them. Table 23 shows the workers mostly agreed that their food choice should also be considered when menu planning.

The fieldwork notes from Glenview recorded Anne (worker) after she had returned from doing the weekly shop. She discussed the difficulty in trying to cater for everyone's likes and dislikes and that it is often the workers who are most vociferous if their preferences are overlooked. Nevertheless, there is an expectation for the workers to eat the same meals as the young people so they were asked if they thought their food choice should be taken into account when menu planning. Table 23 shows that 4% of the workers strongly agreed that their choices should be considered, 59% agreed, 20% were undecided and 17% disagreed. This indicates that the workers feel that they should have a say in what will be cooked and eaten in the centres.

Punch et al. (2009) found that workers' food and eating practices differed between work and their homes. One area was treats: because they had the keys they could help themselves to treats and they would graze more at work than

at home. An extract from Glenview fieldwork notes recorded two of the workers discussing grazing when at work:

Mary said that she eats all the time when she's here, "Stuff that I would never eat at home, it's like when I'm at home I'm not constantly thinking what can I eat now" (Mary worker Glenview).

The workers, responding to the questionnaires (shown in Table 24), were asked to consider if their eating practices at work differed from when they were not on duty.

TABLE 24 FOOD PRACTICES AT WORK AND HOME

| Do the workers cook and/or eat different food when at work in the centre? | Cooking similar at work to cooking at home % | Eat different food at work % |
|---|---|---------------------------------|
| Strongly agree | 17 | 5 |
| Agree | 62 | 19 |
| Undecided | 7 | 8 |
| Disagree | 13.5 | 57 |
| Strongly disagree | 2.5 | 13 |
| Total | 100 | 100 |

They were asked for their level of agreement to the statements as shown in Table 24: *The food I eat at work is different to what I eat outside of work* – 57% disagreed, 13% strongly and, *the food I cook at work is similar to the food I cook outside of work* – 62% agreed, 17% strongly. These results suggest that the majority of workers believe that their eating and cooking practices are similar in and outside work. I wanted to determine if the worker ate different food inside work to encourage the young people to try new things and Table 25 below shows their response.

TABLE 25 DO YOU EAT DIFFERENT FOOD AT WORK TO ENCOURAGE THE YOUNG PEOPLE TO TRY NEW THINGS?

| Do you eat different food at work to encourage the young people to try new things? | % |
|--|----|
| Yes | 47 |
| No | 53 |

As already discussed, the CWT suggests that workers should lead by example with their personal eating habits. Taste, according to Lupton (1996), is generally accepted to be a personal and individual disposition on what a person likes and dislikes. On the other hand, Haukanes (2007) maintains that food preferences can develop collectively within familial or social groups. Bell and Valentine (1997) suggest the taste, texture, smell or appearance of certain foods can evoke disgust and revulsion, as was the case with offal in my family home. When discussing the food and eating practices with the chef from Hillgrove he stated that the workers were resistant to eating different foods and that they did not set a good example for the young people. The workers were asked to answer yes or no to the statement: *I eat food at work that I would not normally eat outside of work to encourage the young people to try new foods.* As Table 24 shows the workers are divided on this matter. Perhaps requiring workers to eat food that they dislike or are unfamiliar with is a step too far.

7.7 One word to sum up food and residential care

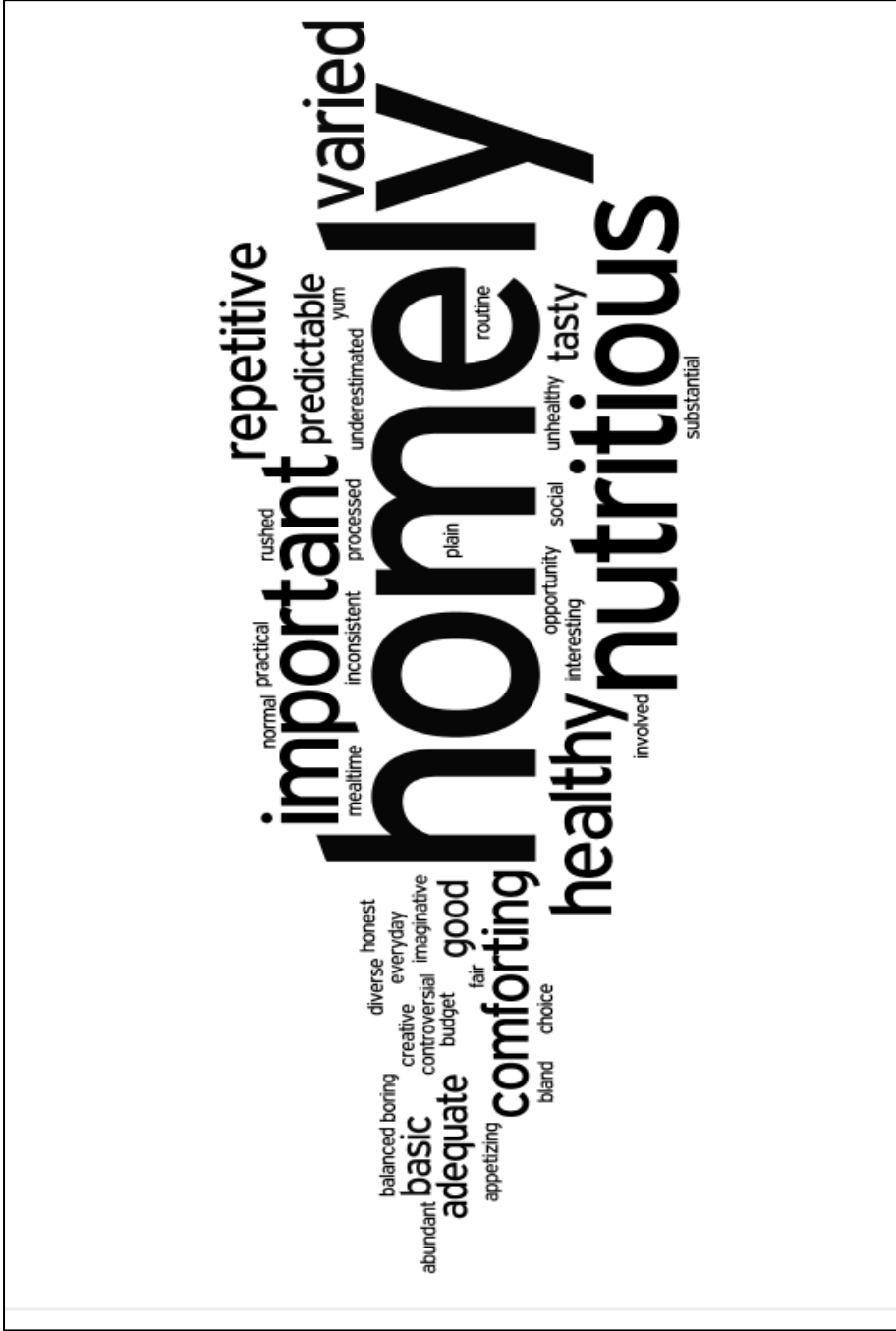
At the end of the questionnaire the workers were asked to write one word that sums up food and residential care for them. The words range from:

| | | |
|------------|---|-------------|
| boring | ↔ | interesting |
| healthy | ↔ | unhealthy |
| repetitive | ↔ | varied |
| important | ↔ | everyday |
| nutritious | ↔ | processed |
| bland | ↔ | tasty |

The words highlight that food and eating practices are both subjective and objective. The workers in residential care interpret food and eating practices into complex ideas and they hold contradictory beliefs about how food works in the centres they work in. The words used also demonstrate that food and eating practices in residential care reflect, as Punch et al. (2011) suggest, that food and eating practices in residential care are highlighted by the good food/bad food dichotomy.

The words were uploaded to a Wordle™ and Figure 30 shows a ‘word cloud’ of the chosen words. Word clouds give greater prominence to words that appear most frequently in the source text. There were 44 words used by 82 workers. As you can see, homely was the most frequently used word. This further supports Dorrer et al. (2010) and Clark et al. (2014), who found that workers in residential care associate food and eating practices with ‘doing home’.

FIGURE 30 ONE WORD TO SUM UP RESIDENTIAL CARE



7.8 Discussion

The aim of this exploratory, sequential mixed methods study was to elicit the significance of food and eating practices in children's residential care settings. The fieldwork began in the five residential centres where first-hand knowledge was gained of everyday life from my position at the dining table. Thematic analysis of the data collected during the first stage generated questions and issues and those insights contributed to the construction of the hypotheses for the workers' questionnaire. The theoretical concept of the metaphorical tables standing on commensality, hierarchy, discipline and government continued to be developed throughout this chapter and is discussed in detail in chapter eight. The quantitative strand of this research set out to answer four main questions identified at the beginning of this chapter. Those questions will now be discussed and answered.

1. Are the workers aware that the significance of the rituals, rhythms and routines of food is entwined with care and control for both the young people and the workers?

Punch et al. (2009) and Smith et al. (2013) found that within residential care for young people that food is a symbolic instrument to demonstrate care. The findings of this study suggest that the workers are aware that they can use food to show that they care for the young people and themselves. The workers further agreed that the young people use food to show that they care for them. The results show the workers believe the young people should be encouraged to eat at the table and eating at the table resulted in the consumption of a more nutritious diet. The workers were aware that they had control over where the young people should eat but not when and what they would eat. These results emphasise the complexities of the care and control of food practices in residential care. In a similar way to McIntosh et al. (2010) it demonstrates that workers are less at ease discussing their control rather than their caring role for young people.

2. How is food used as a symbolic instrument to demonstrate care?

Emond et al. (2013) found that food can be used by the workers to connect with the young people. A young person living in residential care, according to Stanley (2011), can feel nurtured in an environment where they know their needs will be provided for. Therefore, with regard to food needs, a worker, like a parent, should know when a young person might need feeding and what food will satisfy a particular need at a particular time (Stanley 2011: 37). During the focused ethnography, there were several times when a worker listed the likes and dislikes of a young person. Remembering what a young person likes or dislikes eating, as the workers in Punch et al. (2009) study state, conveys the message that you cared enough to remember. The results in this study show that 84% of the workers agreed that they could show they cared through food. In addition, 76% of the workers agreed that a young person remembering what the worker liked to eat showed that they cared. These results show the workers are aware that they use food as a symbolic instrument to demonstrate care.

The workers were asked if the young people often used food to gain attention and 66% of the workers agreed that they did. Space was provided to give examples and these are shown in Table 18. The examples given were mostly associated with negative food practices, for instance refusing or destroying food. I had assumed or hoped the workers would give positive examples of young people using their agency in relation to food. Vanderbeck (2008: 398) suggests institutions involved in child protection 'operate with ambiguous understandings of children's agency'. Dorrer et al. (2011) demonstrate this further by arguing that the ambiguity extends to the workers and the residential establishment. Ambiguity regarding young people's agency and status can be exposed and lead to conflict when decisions are being made about food (Dorrer et al. 2011: 32). The mainly negative examples given by the workers in this study show young people using food to gain attention also illustrates that conflict. There is ambiguity and tension felt by the workers towards the young people who use food to disrupt the established rhythm and routine of the centres.

3. How do institutional regulations, for example eating together at the table, conflict with the aim to provide a 'homely' home?

This study confirms that a residential care centre for young people is a space where private home and public institution overlap. It is both a home and a work space (McIntosh et al. 2010; Dorrer et al. 2011; Punch et al. 2011; McManus and Morrison 2009). The majority of workers in this study agreed that sharing mealtimes and eating the same food as the young people was an opportunity to produce a homely feel in the centre. I have presented the argument that the shared meal at the table is not necessarily 'normal' and not all households eat together at a table. The young people in previous studies (see McIntosh et al. 2010; Dorrer et al. 2011; Punch et al. 2011) thought that they should not always have to eat at the dining table and that if they were at home they could eat where, when and what they like – including, of course, at the table.

The workers in this study were asked about flexibility in eating arrangements and just 11% of the workers agreed that the young people should be able to eat where or when they like. At the same time 70% agreed that flexibility of eating location creates a homely feel in the centre. This shows a contradiction between the young people choosing to eat somewhere other than the table and the workers allowing deviance from the established rules of the centre – it is only acceptable to sit and eat in front of the television if the workers say so. This corresponds with Dorrer et al. (2011), who also found that deviance from the set routine of eating at the table is an opportunity for the resident group to experience what may be happening in a 'normal homely' home. This suggests that the workers are aware that the institutional regulation of eating at the table takes precedence while, at the same time, knowing that a more relaxed regulation of eating arrangements would enhance the feeling of homeliness in the centres.

4. How do workers feel about their personal food and eating practices being placed under scrutiny of the public gaze?

The fieldwork data pointed to the complexity of food in the centres, for the workers as well as the young people. I realised that the rituals, rhythms and

routines of food in residential care may impact on the workers' personal experience of food. The questionnaire was designed to gain insight into the respondents' personal experience of food at work. The workers in residential care do not get meal breaks away from their work. When on duty, the workers cook for and eat with the young people. The regulations state that mealtimes should be social events and the HIQA inspectors report on the atmosphere at mealtimes. There is an expectation on the workers to lead by example while at the table: to make healthy food choices, to teach the young people the social skills of the dining table while maintaining a pleasant atmosphere (CWT 2001). All this must be accomplished at the same time as the workers take care of their personal need for food.

Punch et al. (2009) found that the workers and the children in their study sometimes regarded mealtimes as a work time and not a social time and I assumed the workers in this study would feel the same. The workers were asked for their level of agreement with the statement, *mealtimes are work time not social time*, and 80% disagreed. This result surprised me as I had identified that the everyday routine of food practices in the centres had an impact on the workers' personal experiences and attitudes to food while conducting the focused ethnography. A reason for this may be, as Lalor and Share (2013) suggest, the social aspect of social care work is an important, and for some social care practitioners, a key element of their work. Through the ordinary, informal and intimate activities of everyday life, relationships are developed and workers get to know the young people.

Another reason for the workers not regarding mealtimes as work time could be that they interpret this aspect of their work as 'less professional' and therefore more social. Smith et al. (2013) and Punch et al. (2009) identified that within social work discourse there is little attention granted to the significance of food. Workers, they suggest, find it difficult to appreciate the significance of the everyday activities of food 'given the demands and responsibilities that you are required to meet' (Punch et al. 2009: 1). Smith et al. (2013: 47) suggests those demands include care planning and paperwork and may be viewed as 'the "professional" aspects of the job'. There is a similar lack of attention paid to the significance of food within the social care discourse in

Ireland. In the four years spent completing a social care degree, the only discussion on food was during a health lecture in the first year and the lecturer told the class ‘to learn how to cook’.

That, however, did not answer the question why the workers in this study believed mealtimes were social and not work. Analysis of the workers’ responses showed that they are eating and cooking the same kind of food as they eat and cook outside of the centres and 63% agreed that their food preferences should be taken into consideration when menu planning. This indicates that the workers are having their personal needs met with regards to food. This result also shows the workers believe that their cooking and eating preferences are not only appropriate for production of nutritious and appetising food that is suitable for the resident group, but it is one area in their working day where they can confidently exercise personal authority.

In addition, I believe that the workers’ response to the statement: *mealtimes are social times not work times*, is strongly associated with commensality. According to Sobal (2000: 119) a meal is a social event as much as a food event. For Sobal commensal units are groups of people who gather to share meals, snacks or beverages. According to Sobal and Nelson (2003: 181) the fundamental commensal unit is the family but they also identify work groups on lunch breaks as commensal units. Mealtimes in residential care have been identified by the workers as an opportunity to create a family feel in the centres. At the same time, I am arguing, the group gathered at the table is a work group. It is possible that some of the workers would choose to eat together socially outside of the centre. It is unlikely that the workers or the young people would choose to eat together socially away from work. The shared meal in the centres highlights the complexity of residential care as a shared space where, as Dorrer et al. (2011) and Clark et al. (2014) suggest: work and social and public and private life overlaps.

7.9 Conclusion

Analysis of the data collected from the questionnaires has shown that the food and eating practices vary between the 18 responding centres and according to the responses they also vary within the centres. Results show the majority of the respondents (n=92) were aged between 25 and 40, and 60% had worked in the sector for more than five years. Residential care is a gendered site of practice but, despite the unequal balance of male and female workers in frontline positions, men are well represented in the management of residential care.

It was evident that commensality is highly regarded and practised in children's residential care. The resident group regularly sit at the dining table and share the same food. The workers felt that this social aspect of the mealtime was an opportunity to create a homely feel in the centre and the majority of workers believed the young people should be encouraged to eat at the table and, that by so doing, they would consume more nutritious meals. On the other hand, there was awareness that flexibility on eating at the table could create a more relaxed atmosphere in the centres. The regulations, together with encouragement from the workers, can determine that the young people will eat at the table, but not when or what they will eat.

The food provided in the centres was not dissimilar to what is eaten within the general public. Just one centre employed a chef, so the workers were responsible for providing the cooked food and none of the responding workers avoided that aspect of their duty. Food work is viewed as similar to other basic care work. The young people's input on the menu was sporadic and ultimately their choice was to eat the prepared food or not. If they choose not to eat the prepared food, in the majority of centres, they could make themselves an alternative.

With regard to how food is used in the centres to express feelings and emotions analysis of the data shows that food is used symbolically by the workers and the young people. Food can be used symbolically to show a young person or a worker that they are cared for or even 'loved'. The workers

are aware that food is also used by young people and the workers as an outlet to express feeling and emotions. Food can also be used to gain individual attention with behaviour ranging from cooking to gain praise to throwing food at the workers. They also agreed that food is used to defuse tension in the centres.

The workers agree that health and safety regulations and food safety are important in keeping the resident group safe. The workers were of the opinion the food safety knowledge helped to reduce waste but there is no evidence to back this up. The majority of the workers had no experience of regulations restricting the young people's access to food spaces or gaining cooking skills. As for the workers' food knowledge, they mainly rely on food producers and discourses in the media to inform their food practices. The workers agreed that sharing mealtimes and eating the same food as the young people was an opportunity to produce a homely feel in the centre. They are attuned to the social aspects of mealtimes. The workers mostly agreed that they should have a say in their centre's menu choice and that their eating and cooking practices are similar in and outside work.

The variety in the words used to describe food in residential care highlights that food and eating practices are open to the workers' individual interpretation. Words such as 'homely' can be construed as commensality. 'Good', 'important' or 'nutritious' suggest that there is a discourse on the hierarchy of food. 'Predictable' and 'repetitive' infer the order or discipline of everyday food and eating practices become accepted norms within the centres. The final consideration is that the diverse, complex and contradictory interpretations of food in residential care reflects the diverse ways that food conduct is governed both for the workers and the young people in their care.

This chapter presented analysis of the second stage of this mixed methods study and further developed and clarified the questions and issues that were identified in the first stage. Analysis of the quantitative data further supports the work of Punch et al. (2009); McIntosh et al. (2010); Dorrer et al. (2011) and Emond et al. (2013) who found: food in residential care is a symbolic

instrument to demonstrate care, everyday rituals, rhythms and routines of food are entwined with care and control for the young people and the workers and those same rituals, rhythms and routines can impact and conflict with the aim to provide a 'homely' home in residential care centres. The research in all stages of this sequential mixed methods study has focused on the table. Throughout the study the four legs of the table have represented: commensality, hierarchy, discipline and government. In bringing this thesis to its conclusion, the subsequent and final chapter presents a discussion of those themes.

Chapter Eight: The final mix

8.1 Introduction

This study set out to use food and eating practices around the table to elicit the significance of food and eating practices in children's residential care settings in Ireland. In so doing it has generated data for the exploration of broader theoretical concepts of: commensality, hierarchy, discipline and government. In addition, it has provided relevant links to the development of knowledge to inform social care practitioners, in order to enhance the quality of care in residential settings for young people in Ireland. I have identified that focusing on the complexities of food and eating practices in care settings offers an enriched understanding of residential care in general. This thesis makes a significant contribution to the knowledge of aspects of everyday life in residential care for young people in Ireland

In drawing this study to its conclusion, the main themes that underpin the chapters are revisited. As stated at the outset: the focused ethnography was positioned at the dining table in residential care centres. The decision to situate the research at the table, both physically and metaphorically, stemmed from the regulatory standard that requires workers and young people in residential care to eat together. In addition using the table confined the research to the dining area, the most public area of the centre. The central position of the table to the food and eating practices in residential care and to this thesis, led to the construction of the metaphorical table. A table standing on the four themes of commensality, hierarchy, discipline and government. These themes provided coherence to the literature review and research design.

The theoretical perspective underpinning this thesis drew on Coveney's theory: 'the government of the table', which itself uses the Foucauldian perspective of governmentality to examine nutritional expertise and the social organisation of family food habits. In that context the study further examined how food and eating practices are governed and who governs the table in residential care. An unanticipated but significant theme that developed throughout the thesis relates to the complex notion of creating a 'homely

home' in residential care centres for young people: food and eating practices play a significant role in that process (Punch et al. 2009; McIntosh et al. 2010; Emond et al. 2013).

It is therefore upon the theoretical concepts of commensality, hierarchy, discipline and government and the aspiration to create a homely home in residential care that this chapter focuses. It will also provide an overall conclusion to the thesis. The original purpose of the research will be restated. Discussion on the links between the identified themes and the main research findings that make a significant contribution to the research field will be established. The limitations of the study will be identified and critiqued. Finally, presented are some thoughts on the future - *menu du demain* - what's on tomorrow's menu in residential care for young people?

8.2 Original purpose

The overall aim of this study was to elicit the significance of food and eating practices in children's residential care settings in Ireland. By focusing on food and eating practices around the table, it explored the complexities of everyday life in residential care settings. This study has advanced the understanding of this aspect of everyday life in residential care for young people in Ireland. It sought to show how food and eating practices in residential care had changed over time and if they reflected similar eating practices in the general public. The findings show that food in residential care has kept pace with societal change in food and eating practices. This is not necessarily a positive finding as there are recent government reports and research which have raised concerns about the quality of young people's diets.

In addition this study explored, from the workers' perspective, how food could be used to demonstrate care. As discussed, in chapter three, care is something that is difficult to define and for the people who give and receive care it can be confused and contested. This study shows, and in agreement with Punch et al. (2009) and Emond et al. (2013), that food is used as a symbolic instrument to demonstrate care. Furthermore this study sought to know if power and resistance were played out through food and eating practices. The results from

the workers' questionnaire show that the power differential between workers and the young people is evident. For the young people resistance is manifest in their refusal to eat the prepared meals. Finally, I explored the workers' personal food and eating practices, which are also placed under scrutiny of the public gaze.

The study originally was guided by these themes, but other questions were raised during the process of data collection. In the first chapter, to introduce some of the theories concerned with food and eating, the four legged table metaphor was introduced as the focus for inquiry. The four legs, or themes of commensality, hierarchy, discipline and government, were used to bring more clarity and coherence to this complex situation. The second chapter reviewed where children feature in the sociology of food and suggests that there has been a hierarchical shift and children today may be sitting at the top of the table, when it comes to food choice within families. While children may have gained some ground with their rights being recognised, they are still in a subordinate position in society (Corsaro 2005; Mayall 2000; Beardsworth and Keil 1997; Qvortrup 1994) and there is growing concern about what they choose to eat (Lupton 2013; Gard 2011; Robb 2007; Coveney 2006; Trew et al. 2006; DoHC 2005; Gard and Wright 2005).

Chapter three presented a historical overview of residential care for young people in Ireland with particular reference to food. That research showed that commensality is a relatively new aspiration in this institutional field and the discipline and government of food practices of the young people have shifted over time, from strict control within the institutions to an approach that is based on children's rights. This chapter also included discussions on the contemporary landscape of residential care in Ireland, on the significance of routine, rhythm and ritual in the centres and a definition of care.

In chapter four previous research studies that closely linked food and residential care for young people were discussed in relation to methodological perspectives and the selection of research design for this project. I also present an exploration of mixed methods, the paradigm of pragmatism, and my rationale for applying mixed methods to this study. The selected design is an

exploratory sequential mixed methods design, therefore the qualitative and quantitative data and analysis are presented sequentially. Chapter six discusses the data and analysis from the focused ethnography and the photo-elicitations. Chapter seven reports the findings from workers' questionnaires. This final chapter presents the mix in this mixed methods study by merging the main research findings.

8.3 Research findings

The main fieldwork commenced with data collection at the table in the centres and focused on the young people and the workers' food and eating practices. The subsequent quantitative postal survey of the workers was then administered. Given the complexities of research with vulnerable populations, gaining access to a closed community and the private matter of food and eating, a degree of flexibility was required. I decided that the best approach was to use mixed methods. The chosen design for this research was weighted towards the qualitative method and analysis was mixed during the interpretation. Each method was distinctive but had a common aim: to develop a broad picture of food and eating practices in residential care. Using the selected methods and despite considerable barriers I was able to recruit a cross-section of participants. The data collected represents 18 centres from across Ireland. The services included: mainstream residential, respite care and high support. The centres varied in the daily food practices but one common denominator was their use of the dining table. The overall sample consists of: 15 young people and 63 workers for the focused ethnography; 92 workers for the questionnaires and 43 social care professionals for the photo-elicitations.

This research began with the question: what do young people in residential care actually eat? This question was guided by my interest in the sociology of food and, not least, by my being a chef. The literature reviewed showed that the food available to children and young people living in the care of the state has, over time, been reflective of the food available to children in general. In the current climate there is a concern that children's health is at risk because of the food choices being made by them and on their behalf. It could be argued

that children in the care of the state should be eating the diet recommended by the state authorities.

The ideal diet, according to Safefood (2014), is: enough starchy wholegrain foods to meet your energy needs, lots of fruit and vegetables, some dairy, some protein and little or no energy-dense and salted foods. The diet I viewed being eaten contained no wholegrain and very little fruit and vegetables. The meals being offered were similar to the diet reported by Bord Bia (2011) and the alternatives eaten by the young people were similar to the diet described by Martin (2004) of third-level students in Ireland that consisted mainly of sandwiches and noodles. Children living in residential care in the past were strongly encouraged and in some instances, as the reports from the CICA show, forced to eat food they disliked. I am not advocating that we return to that attitude, nor did I find the answer to the crucial question - how do you get children and young people to eat a healthy diet? Smith et al. (2013: 46) suggests that workers having to struggle to get young people to eat a healthy diet can lose sight of the bigger picture: where eating is 'a pleasurable experience and food consumption an enjoyable social ritual'. This points to one of the key policy/practice issues - a centre may have a healthy eating policy but what are the workers to do in practice when a young person will only eat pot noodle? A young person not going hungry is most likely to determine the outcome.

8.4 Care

Care, as discussed in chapter three, is a word that is used widely but it is difficult to define and discussions of the ideal of care are mainly absent from critical social care literature. Steckley and Smith (2011) suggest care is largely unexplored despite its centrality of the title residential care. In the recommended text for social care students in Ireland, O'Toole (2013: 114) suggests that some of the debates on professionalism insist 'a critical and emotional distance is necessary for social care as a profession'. Smith (2009: 124) suggests that because residential care has become 'risk averse and child protection dominated', there has been a shift away from a relationship-based job where care is considered unprofessional. Care, in the emotional sense, has

become something to be careful about. McHugh and Meenan (2013: 252) contend that 'the caring relationship' remains 'central to good and effective professional care'.

Holland (2010) found that the young people in her study defined care as: an enduring relationship with a fair and reliable carer that manifests in everyday acts. The survey conducted with social care practitioners and social care students in Byrne (2013) highlight that doing care is something that is difficult to define because for the people who give and receive care it can be confused and contested. That could also apply to those teaching care. The social care students used words such as empowerment, advocate, helping and enabling suggesting that care is an action rather than a feeling. This raises a necessary question, can social care students be taught how to care? Costello and Haggart (2008), discussing student nurse training, suggest that it is not *if* but by what means students can learn to care more effectively. Lynch et al. (2009: 47) argue that 'paid care work is definitively emotional work', but it can be carried out 'with varying degrees of emotional involvement'.

Foster care is the preferred option for children and young people in need of alternative care today. As the Kennedy Report (1970) recommended residential child care is used as a last resort. As a result, residential care has become more specialised, and as Gilligan (2009) suggests, provides care for young people who have a diversity of needs and often challenging behaviours. Working with often traumatised young people, according to Fox (2002), is not for the faint-hearted and, as McHugh and Meenan (2013) recognise, social care practitioners need specific skills for this kind of work. It is recognised that it is the everyday little things that help to build relationships in the centres and through the development of caring relationships with workers that some young people living in residential care learn how to accept care. The everyday activities surrounding food is an often quoted method to connect with the young people in care (Smith et al. 2013; Clark et 2014; Emond et al. 2013a; 2013b; Punch et al. 2009a; 2009b; 2011a; 2011b; 2013; Dorrer et al. 2011;

McIntosh et al. 2010). This study supports the idea that food is regularly used by workers as a symbolic gesture to reach out to young people in care.

8.5 Commensality

Commensality, or sharing meals, is strongly encouraged by the workers and stipulated by the regulators. The HIQA (2014) inspection reports show that the inspectors take note, under the provision of food and cooking facilities, if they observed the young people and workers sharing meals. They do not specify, but I assume, those meals were at a table. This study showed that 96% of the workers believed that the young people should be encouraged to eat at the table and I presume during a HIQA inspection that encouragement would be heightened

The table was used as the focus of this thesis and this choice stemmed from the standard 6.11 (DoHC 2001) that requires the young people living in residential centres and the workers employed there to eat meals together and that those mealtimes be positive social events. Commensality is a highly regarded aspiration in residential care, as it is more broadly in society. The table plays an important role in the routines, rhythm and rituals of everyday life in the centres (Smith et al. 2013). The workers in this study, in agreement with those in Dorrer et al. (2011), believe that the group eating together at the table is an opportunity to create a 'homely' feel in the centre. The shared meal at the table is predictable - it can create a sense of ritual and normality. According to Storø (2013: 130) rituals can represent 'the security of the constant recurring'. The shared meal with the resident group creates a point of consistency - it requires little reflection - it is just the way things are done. As Punch and McIntosh (2013) suggest, the table is a stage with a script where young people and the workers know how to interact. According to Sobal (2000) a meal is a social event as well as a food event. A significant, and I believe a positive, finding in this research is that workers regard mealtimes as social time and not work time.

Notwithstanding the hierarchical nature of many meal events, it is possible that during mealtimes in residential care the workers and the young people are on a more equal footing. The dining table in residential care can be used as a

neutral space and can provide an arena where the imbalance of power may be set aside. Workers and the young people are at the table to satisfy their common need - to eat. On the other hand, the table is an inequitable space, where children eat under the surveillance of adults who monitor what they eat, their behaviour and their relationships within the resident group. Despite this, young people choose to eat at the table with the workers. It may be the subtle or overt disciplinary codes that directs them towards the table, or the driving force could be, simply, that they are provided with a cooked meal.

Smith et al. (2013: 47) discuss mealtimes as having the potential to be at the heart of nurture in residential care, but they can also be fraught affairs 'to get over and done with as quickly as possible'. This study has found that, at the majority of observed mealtimes, the young people lingered in and around the table after the meal had ended, they were not fraught affairs. The workers regarding mealtimes as social time indicates that mealtimes are more often positive events. This research found that there is a lot more going on at the table in residential care, as in other living spaces, than sharing food. It is a space where homework is done and plans are made for the future. A study into how much time the resident group spend at the table would further illuminate the intricacies of group dynamics in residential care.

It is broadly acknowledged within sociology and anthropology that sharing food is central to kinship in many cultures (Simmel 1910; Douglas 1972; Lupton 1996; Murcott 1997; Jackson et al. 2009; Wilk 2010; Fischler 2011; Ralph 2013). Who shares the meal, where and when it is eaten 'helps to create the boundaries of the household, of friendship, of kinships' (Sobal and Nelson 2003: 181). Participation in the ritual, rhythm and routine of meals is considered a key way of displaying and experiencing family. The family dinner table is a potent symbol for proper family life (Lupton 1996). A proper family meal is considered to be when all family members gather around the table enjoy the same food and have pleasant conversations. While there is concern for the alleged decline in the family meal (Murcott 1997; Jackson 2009; Wilk 2010) it would appear that in residential care sharing a 'proper meal' is considered central to group cohesion or the constitution of a type of

familial relationship in the care setting. In other words, it is viewed as – ‘the proper way to eat in a proper home’.

8.6 Hierarchy

Children in this society are marginalised: they have little in the way of institutional power, status or rights. Children in residential care, who may have been neglected or abused, are further marginalised. The current provision of care for children in Ireland is ‘child centred’, according to HIQA (2012), but in residential care there is a generational hierarchical structure. As in other social service provision there is a power imbalance between middle class professionals and mainly working class clients. Workers in residential care have to balance the acknowledgement of children’s agency, competence and participatory rights at the same time as acknowledging children are often more vulnerable, dependent and inexperienced. On the other hand, Qvortrup et al. (2009: 57) remind us, in some circumstances these children ‘may be more competent, resourceful and resilient than those who formally care for them’. It is possible that some young people in residential care will have had more experience of cooking and feeding themselves than some of the workers.

As the fieldwork data has shown Martina (16 Glenview pilot), Fiona (17 Woodlands) and Bridget (16 Hazelbrook) were all competent in the kitchen and appeared to enjoy cooking. These young women may have come from situations where they had to learn how to feed and fend for themselves. However, many young people of that age living in ‘normal’ homes, where both parents work, for example, also have had to learn to feed themselves. Punch and McIntosh (2013) and Smith et al. (2013) are in agreement that young people living in care often need rituals, rhythms and routines to help restore a sense of order into their disordered and often chaotic lives. Strier and Binyamin (2010) argue that interventions that ignore positive strengths impose middle class values on social service clients. For children in care workers need to be aware of the balance between following the rituals, rhythms and routines of the centre and recognising that their actions could lead to the deskilling the young people in their care.

Another significant finding in this study was the hierarchy of food choice. I assumed that the young people's preferences would be taken into account when menus were being planned, as the regulators require. I also assumed that the young people's choices would take precedence over that of the workers. The results show that the consultation in relation to food choice is sporadic. As Punch et al. (2009) found consultation on menu choice is viewed as a measurable indicator of care and HIQA inspectors quantify consultation on menu choice in the course of their inspections. During the focused ethnography, on two separate occasions I noted an interesting tension - I was told that the young people were consulted weekly but the workers showed me copies of menu plans for the following four weeks. This may be an example of the workers producing paperwork as evidence that food practices in the centres are important enough to warrant paperwork or revealing the dichotomy between producing quantifiable evidence of good practice and the reality of feeding young people on a daily basis.

Considering the hierarchy of space, the workers believed that the young people should be encouraged to eat at the table and the shared meal at the table was an opportunity to create a homely feel in the centres. As discussed, the meaning of homeliness is shaped by individual values and preferences that are influenced by commonalities and patterns for the construction of 'homely homes'. A residential care centre is a complex space, where the spheres of private home and public work space overlap and contend (McIntosh et al. 2010; Dorrer et al. 2011). The workers and the young people bring their own interpretations of home to the centres. I have argued that eating at the table is an idealised interpretation of what a *normal family meal* should look like, it is not necessarily how meals happen in the workers' own homes or the young people's natal homes. The workers agreed that having a more flexible approach to eating arrangements, for instance eating in front of the television, would also create a homely feel in the centres.

Young people and the workers sitting at the dining table to share food has become an assumed cultural norm in the centres that is performed unquestioningly by the workers. I have identified that the dining table is perceived as a morally superior space. The shared meal at the table is regarded

as better than any other eating arrangement and a marked difference from historical experience when children and workers ate separately. I believe that deviating from the norm of eating at the table is a challenge for the workers today, who would have to relinquish their hierarchical powerful position that entails deciding where the group will eat. Eating with the young people on the sofa would alter the group dynamic. Just as this study has been situated at the table a similar study positioned on the sofa would provide a very different view of residential care. However, the focus would more likely be on power struggles concerning the remote control or games controller rather than food and eating practices.

8.7 Discipline

Results from the questionnaire show that 89% of the workers did not agree with the statement *young people should be able to eat where and when they like*. This research has shown that where and when a group eats is central to commensality. I have also argued that not all households eat at the table and this may be more relevant to younger people. Martin (2004) found in his study of Irish students that they generally ate in front of the television. Many of the young people in Martin's research were just one or two years older than the average age of young people living in residential care. Martin considered the transitional nature of the students, who had left the family home as being relevant, as they were developing their individual food and eating practices. I am aware that there are many benefits for both the young people and the workers in the discipline and order created by eating at the table. These include: the young people and the workers are provided with a cooked meal, everyone eats at the same time and the mess created is confined to one area and therefore easier to control. However I would argue that it is the workers who benefit most from this arrangement. Encouraging the young people to develop individual food and eating practices could interfere with adult order and authority in the centres.

The regulations require that young people living in residential care should participate in cooking, cleaning and other domestic chores to promote identification with the centre and develop life skills. According to Emond

(2000: 369) encouraging young people to feel ownership of residential centres is complicated by the young people's awareness that the 'larger social work department had control over and ultimate responsibility for it'. The young people in Emond's study considered 'screwing the system' by vandalism or food wastage as a means of gaining power or control. As discussed, there were reported incidents of the kitchen being targeted by the young people in this study. There is a dearth of empirical knowledge on the dynamic of young people attacking the kitchen – the heart of the home – in residential care centres or indeed 'normal' homes and it is an issue that requires research.

Punch et al. (2011) found young people were involved in food related chores in two main areas: resistance to doing chores and developing independent living skills. Save the Children found that young people leaving care in the UK felt that they were not sufficiently prepared for independent living especially in skills such as cooking (Hobbiss 1998). The national advocacy service for young people in care EPIC (Daly 2012) suggest, that due to the Ryan Implementation Plan (CICA 2009) which resulted in the introduction of the HSE Leaving Care and After Care Services National Policy and Procedures document (2011), some progress has been made in Ireland and the number of young people deemed to have appropriate skills to live independently has increased in recent years.

This study found that the young people were only occasionally involved in food-related chores, which correlates with few incidents of conflict being reported. The only chore I observed being carried out, by all the young people and which the workers enforced, was putting their dishes into the dishwasher. The results of this study show that the workers are aware that the young people should be encouraged to help with household chores but they do not actively encourage them to do so.

The discipline of behaviour at the table can be very subtle and delivered with a disapproving glance. Through the rules and routines a structure is provided for the enculturation of acceptable norms within the centres. While the table has been identified as a space where children are disciplined into acceptable behaviour, the young people that I observed, by my standards, were well

schooled in table manners. I did not witness any instances of the workers checking manners at the table. However, it should be noted that the young people sitting at the table, in itself, was evidence that they had been enculturated into the disciplined foodways of the centres.

Punch et al. (2009) suggest that one of the advantages of young people being encouraged to eat at the table is that they learn self-discipline. On the other hand, encouraging eating at the table aids the workers' discipline of the young people. Coveney (2006) argues that the family meal table provides parents with the opportunity to fulfil their ethical role to teach manners, choice, independence and self-regulation with regard to food. Through the disciplines of the table the workers in residential care are provided with a similar opportunity to fulfil their ethical role as carers.

8.8 Government

According to Smith et al. (2013: 46) food in residential care is 'surrounded by official rules and regulations that prevent carers from making children a sandwich without having first completed a hygiene course'. The statutory and institutional rules and regulations that govern the majority of residential care centre kitchens in Ireland are not as stringent as those identified by McIntosh et al. (2010) and Smith et al. (2013) in the UK. Except for Hillgrove, the high support centre, all the other centres were graded as domestic and therefore not liable for a HACCP food safety system. HACCP entails the strict control of temperature for the storage and cooking of food. Strict temperature control could lead to added pressure on the workers to get young people to the table to eat while the food is within a predetermined temperature.

The standards for residential child care in Scotland state 'all food handling follows good food-hygiene practices and staff are trained in food hygiene' (Scottish Executive 2005: 29). The workers in residential care in Ireland do not have to complete FSA hygiene courses, or for that matter have any formal food training. Nevertheless, the workers in Ireland are expected to provide healthy and nutritious meals and promote healthy eating just as they are in the UK. There is a significant difference here with the situation in Scotland, where kitchens in residential care are considered professional kitchens.

Coming from a professional catering background I was interested in how the workers in this study acquired their food knowledge. Punch et al. (2011) demonstrate that food and eating practices in residential care are steeped in morality and highlighted by the good food/bad food dichotomy. Coveney (2006) identifies that nutritional knowledge increases ethical interest in our individual diets that must be managed through self-regulation and self-reflection for the production of healthy or unhealthy citizens. This can be understood as governmentality in action. This study has identified that social care practitioners in general are not schooled to be experts in nutritional knowledge which leaves them open to fads and myths, such as that of the 'children's obesity epidemic'. The current problematisation of food and eating practices results in the workers, like the general public, relying on narratives of risk, fear and uncertainty about their own food and eating practices and those of the young people in their care.

Coveney suggests that within the domestic sphere there is no need for State inspection of our daily food habits because individuals want to be healthy and find expert advice on how to be. The workers in this study mainly rely on food labelling for nutritional knowledge, unlike the respondents in the Safefood (2012) survey who reported: television, newspapers and the radio were the leading sources of information on healthy eating - food packaging was the least. This, as discussed, suggests that workers' reliance on labels means that they may also be relying on processed foods.

A significant contribution to the knowledge of food and residential care in Ireland is the grading of the kitchens as domestic. A domestic kitchen is not controlled by outside authorities. Therefore it is self-regulated and responsibility appears to be on the individual workers to inform themselves about food safety and nutrition. It is with trepidation that I highlight this fact and I am not advocating that the kitchens in residential care for young people in Ireland need stricter regulatory control. I believe that the workers' food and eating practices being left to their own devices results in a homely feel in the centres which outweighs 'food safety' concerns.

Food and eating practices in residential care can therefore be better understood by applying governmentality theory. This study has shown that, despite minimal statutory regulation, it is through governmentality that the everyday food and eating practices in residential care are managed by self-regulation. The workers regulate their own eating habits while at the same time steering the young people towards developing their individual interpretation of good eating practices in order to become good healthy citizens. A significant tool in the successful completion of this task is the dining table.

8.9 Visual research

The decision to include the photo-elicitations in this research helped to highlight the symbolic significance and cultural meaning of the dining tables in the five focused ethnography sites. The photographs were originally taken as a visual record of the centres. When I began to write chapter six I decided to place the photograph of the table with the description of the centre. In discussions with my supervisors it became apparent that the symbolic significance of the photographs could and should be further explored. While the denotation of the images could be described as obvious – this is a picture of a table. The connotation of the images could stimulate a range of cultural, social or personal interpretations. This opened the door to visual research methods and I realised the images of the tables had the potential to be used as an instrument to collect additional qualitative data that could help to develop a contemporary view of residential care.

Tables, as discussed, hold significant symbolic and cultural meaning. They are considered to be the heart of the home and, for some, the epitome of family (Lupton 1997; Murcott 1997; Jackson 2009; Ralph 2013). The dining table is also considered to be a site for the socialisation of children into competent and appropriate members of society (Ochs and Shohet 2006). It is also a restrictive device, a place where children eat under the watchful eye of adults and where power and resistance can occur (Coveney 2008; Wills et al. 2008; Bell and Valentine 1997; Grieshaber 1997; Visser 1991). It can therefore be assumed

that when confronted with an image of a dining table what is seen can be interpreted in several ways.

Photo-elicitation offers the visual researcher an opportunity to elicit how their audience might define the ideological messages associated with the images. How an image is read is not 'fixed by its creator' - it is equally 'determined by its reader' (Noble and Bestly 2011: 33). Photographs can carry an enormous amount of information and how they are interpreted needs to be considered within the frame of the research project (Rose 2012). The frame within social research indicates what will be included and excluded from the investigation (Banks 2007). The frame in visual research can be physical as in the actual edge of the photograph. The 43 social care professionals who took part in the photo-elicitations had been informed that what lay beyond the frame in the photographs of the tables was a residential care centre.

It was evident from the responses to the photo-elicitation that the images of the tables did not strictly represent what I had experienced in the centres. The overwhelming identification of Hillgrove as an institution gave me the confidence to name it as such. The number of respondents seeing Woodlands as representing home helped me to realise that I needed to provide a more detailed word picture of my view of the tables. The use of photography in this research opened up unanticipated areas for analysis and brought more clarity to the contested and contradictory understandings of institution, family and home in relation to residential care.

8.10 Homely residential care centres

The regulations for children and young people in state care have been in the process of being updated since the study began in 2010. The Draft National Standards (HIQA 2010) state 'each child and young person lives in a comfortable and homely environment'. As discussed in chapter six residential care centres in Ireland are not called 'homes'. This raises the question – is the desire to create a homely residential care centre achievable? Peace and Holland (2001) suggest that the tensions between domestic and institutional living may be insurmountable, rendering the concept of 'homely residential care' a contradiction in terms. According to Clark et al. (2014: 4) residential

care centres can be clearly characterised as ‘a workplace for staff, a temporary home for residents’ that is ‘governed by eternally and internally generated institutional rules’.

Christensen et al. (2000) suggest that the contemporary family home, in Westernised societies, is based on a *house* that, through time, love and care is transformed into a *home*. A family home is strongly associated with the space to nurture children who leave when they come of age which currently in Ireland may be closer to thirty than eighteen (Eurofound 2014). The ideologically loaded idea that without family a home is only a house takes prevalence in Western imaginary that is based on ‘the white, middle class, heterosexual nuclear family’ (Mallett 2004: 74).

Bowlby et al. (1997: 343) suggest that home is a physical location and a psychological construct. The notion of home is conceptualised as a positive space that is warm and secure - ‘a haven from the pressures of paid employment and public life’. The home is deemed the most appropriate space for care because it contrasts with the uncaring public workplace. For Bowlby et al. the family home is engendered by collective and individual activities of the household, when males and females are ‘doing gender’ the household are ‘doing home’ (ibid: 346). Everyday life in residential care is further complicated by the workers ‘doing work’.

One aspect of the workers’ work is to create a homely home; to help the young people feel at home. Maier (1987) points out that residential care workers are rarely involved with the design or building of the centres. They are more often challenged with how best to adapt the present setting to fit with their interpretations of a homely environment. Clark et al. (2014: 3) ask ‘whether and how the domestic imagery of “home” serves a purpose’ for young people in residential care. They remind us that the institutionalised home is a place of unknown histories for the young people living there. Young people, when they arrive in residential care, have to construct a sense of home despite having no deep connections with how the space looks or how they should behave there.

Food is a major instrument to demonstrate and practice homely activities in the centre (Dorrer et al. 2010; Clark et al. 2014). As stated, the workers in this study believed that eating together as a group at the table provided the opportunity to create a homely feel in the centre. That belief contrasts with them also believing that not eating at the table creates a more ‘homely’ and relaxed atmosphere – highlighting the complexity of opinions on this matter. The workers associate food with homeliness, as Figure 30 on (page 254) illustrated ‘homely’ was the most frequently chosen word to sum up food in residential care. I believe that due to the relatively unregulated aspect of food and the grading of kitchens as domestic, the workers and the young people are afforded the opportunity to feel more at home in their kitchens.

My time spent in the centres was limited and therefore so was the opportunity to feel at home, but I was made to feel welcome by the workers and the young people. In all centres, the obligatory cup of tea was offered when I arrived, demonstrating that the home is where the hearth is and, as Smyth (2007) found, the kettle is always on the boil.

8.11 Limitations

Several issues arose during this study that may be relevant to further studies in residential care. The first was gaining access to the centres. Young people living in residential care are considered to be some of the most vulnerable children in our society (Kendrick et al. 2008). The residential care centres they live in are difficult-to-reach sites. As discussed in chapter five, I found gaining access to the centres complicated. While it is imperative that the young people living in care are safe and secure there is also an imperative that everyday life in the centres is known. There are very few good news stories that make it to the general public about residential care. I believe that there needs to be more independent research conducted into how residential care works, especially at the point when the CFA (2014) is indicating an overhaul of the service. A system needs to be developed within the service for the collection of valuable knowledge and research plus an ethics policy that includes the norms and standards expected of researchers, plus some clarity on parental/*loco parentis* consent. When searching for research sites, a number of centres indicated that

they were already hosting research so perhaps a way of scheduling/controlling research intrusions into centres may also be required. The promotion and implementation of high quality research could provide an outlet for a positive view of residential care.

It is recognised that ethnographies takes a protracted period of time. Fetterman (2010) argues that classic ethnography takes from 6 months to 2 years to complete. The qualitative strand of this project did take 6 months, though my time in the centres was limited. Despite this, I believe the data collected from the first strand, when added to the data from the second strand questionnaires, makes a significant contribution to the literature available on everyday life in residential care for young people in Ireland. One of the limitations of using questionnaires is that they do not normally provide the researcher with the opportunity to clarify or interpret the questions and answers. With hindsight and additional time I believe conducting focus groups with a selection of workers after the questionnaires would have been beneficial to the research.

Using a mixed methods approach, I argue, has had many benefits, but it has also raised challenges. One of the main challenges in using mixed methods was the integration of the methods when writing up the findings. As discussed in chapter four, the two main research paradigms are viewed by some as polar opposites (Miller and Deutsch 2009). Researchers positioned at the extreme ends of the paradigms believe that there is really only one valid method of research and therefore one valid way of reporting it. I have stated from the outset that I am drawn to the qualitative paradigm. I find reading and writing in that perspective both familiar and comfortable. The quantitative strand of this study challenged and forced me out of that comfort zone. I had to find a balance in the interpretation of the findings that reflected fairly on the two paradigms whilst adding to the growing body of mixed methods research and researchers.

8.12 Thoughts on the future: *Menu du demain*

This thesis has journeyed from the foundling hospitals to the present day. The perception of children in need of *care* and how they were cared *for* has

changed dramatically over that time. As referred to above, residential care for young people is once again on the point of change. Discussing the situation with the workers I met in the field, there was concern for the future of residential care. The HSE has recently increased foster care provision while the numbers of residential care spaces have decreased, despite the growth in the numbers of young people requiring care. Of the three HSE centres I spent time in, only one remains open. This suggests that the state may be withdrawing from its direct involvement in the service provision of residential care for young people in the care of the state.

We may be moving towards 'pop-up residential care'. Private companies can provide care in a more cost-effective manner. They are not bound by the established employment practices within the HSE, nor do they have to own the properties they operate in. They can employ casual workers on zero-hour contracts and rent a house to accommodate young people if needed in a particular area. The rented house can then be disposed of if the young people's situation alters. These 'pop-up residential care centres' would be subject to inspection by HIQA and the workers would be qualified and registered social care practitioners. However, there is the possibility that the centre could have come and gone before the inspectors could inspect. The rituals, rhythms and routines of these centre, not least the food and eating practices that as demonstrated are an important aspect of building relationships and creating a homely home, would have little time to become established. This is a bleak vision for the future of residential care.

Throughout this research process I have come to realise that there is some excellent work being done in residential care. That work is seldom discussed within the wider public. During my time working on this project, when people inquired what the research was about they showed interest in the food and the young people aspects, but not the residential care. Perhaps people would rather not think about why children might require residential care. However, I think it suits the current political agenda that would prefer not to advertise good news stories about a very expensive way to look after children in need of care.

“We still spend too much, far too much, on residential and special care both in this jurisdiction and for the small numbers of children and young people we send abroad for care” (Minister for Children Frances Fitzgerald 2012).

The minister does not offer an alternative less expensive solution for children and young people who need and benefit from residential care services.

8.13 And finally: *clearing the table*

This thesis makes a practical and theoretical contribution to the literature on children’s residential care. The findings are situated in the broader literatures of the sociology of food, the new sociology of childhood and the sociology of home. The study findings suggest the significance of food in residential care needs to be considered within the everyday realities of the centres as the young people’s, albeit temporary, ‘home’. This study puts forward a conceptual framework that enhances the knowledge of everyday life in residential care principally from the workers’ perspective. The research has highlighted the value of using the metaphorical table as the key focus to examine the theoretical concepts of commensality, hierarchy, discipline and government to enhance the understanding of the significance of food and eating practices in children’s residential care centres in Ireland.

The table, both literally and metaphorically, has been the focus of this study. The four themes, or legs, that have guided the literature review and research design have led to answer the ultimate question - who governs the table in residential care? The answer is, like residential care itself, complex and, like Foucault’s interpretations of power, difficult to pin down. To govern can be interpreted simply as to control. Governance, as Lemke (2007) suggests, signifies strategies, processes or procedures deployed to control, regulate or manage problems on multiple levels. Governmentality focuses attention on the diverse ways we govern the conduct of ourselves and others. According to Coveney (2006: 12) it is through governmentality that the disciplines emerged for knowing and managing populations. One such discipline is nutritional knowledge.

The role of food in confined institutions has received scant academic attention despite being the site where nutritional knowledge originated (Coveney 2006). The diet in the workhouse was formulated to the minimum required to keep body and soul together. While nutritional knowledge originally was concerned with metabolic costs by the latter half of the nineteenth century the discipline of 'nutrition' came into fruition and with it the problematisation of food choices of the 'choosing' subject. Nutritional discourses have increased as societies have become more affluent and food choice increased. The problem of food choice, through governmentality, became discursively activated, normalised and internalised. In the current climate food is a problem - not as it was in the past when there was often not enough, but today - there is concern not only about eating 'too much' of it but also what, where and with whom we eat it.

To answer the question concerning control over the table in residential care, it is apparent that governmentality sits at the top of the table. The regulation to eat together is adhered to, however, the regulations do not state that the meal should be eaten at the table. The resident group eating together in front of the television, as is the case in countless living spaces, including my own, would fulfil the regulatory requirement but in all the centres the table was used. So this aspect of doing food in residential care has become a norm that is uncritically accepted and internalised as the way things are done.

There is more going on at the table in residential care than eating because, as Tite (2014:1) suggests, 'food can act as a conduit in which social relationships are established, contested, affirmed or denied'. Smith et al. (2013) suggests that the table has the potential to be the heart of nurture in residential care. I believe that the table in residential care in Ireland is a neutral space, unlike the office, the young person's bedroom or, to a certain extent, the sitting room. At the table, a multiplicity of discursive practices and interpersonal relationships carry on in parallel while sharing food. I argue that power relations between workers and young people continue, but are less evident, during mealtimes at the table.

Finally, what is the significance of food and eating practices in Irish children's residential care settings? By focusing on the actual and metaphorical tables, this research highlights that food plays a significant role in daily life for the young people and the workers. Food and eating practices create a routine, rhythm and ritual to the day. Food is used by the workers to make young people feel welcome and cared for. A significant finding is that workers regard mealtimes as social time and not work time this is evidence that the high regard for commensality is justified and should be encouraged. Another important contribution to the knowledge of food and residential care in Ireland is the grading of the kitchens as domestic. Domestic kitchens are not regulated by food safety or health and safety. I believe this leads to a homely feel in the centres where workers and the young people might feel more 'at home'.

What will be on the menu in the future? The workers in this research know that food can be used as a symbolic instrument to demonstrate care for the young people. They are also aware that young people can use food as a symbolic instrument to reject the care on offer. What I would hope for the future of food in residential care is that the workers and the young people might, together, learn and demonstrate care for the food that they eat.

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Appendices

Appendix 1 Questionnaire

Appendix 2 Participation Information Sheet (Young People)

Appendix 3 Consent Form (Young People)

Appendix 4 Participant Information Sheet (Worker).

Appendix 5 Consent Form (Worker)

Appendix 6 Participant Information Sheet (Questionnaire).

Appendix 7 Which table?

Appendix 8 Example of how the data was coded.

Appendix 1 Questionnaire

1.0. How is food done?

This section is to gauge your opinion of the food and eating practices in the centre you work in.

Please tick the box that indicates your level of agreement in the following statements.

1.1. Mealtimes in the centre you work are at a set time.

YES NO If you answer NO go to 1.4.

1.2. Set mealtimes create a rhythm for the day.

Strongly agree Agree Undecided Disagree Strongly disagree

1.3. Set mealtimes add to the feeling of security and routine in the centre.

Strongly agree Agree Undecided Disagree Strongly disagree

1.4. Young people should be encouraged to eat at the dining table.

Strongly agree Agree Undecided Disagree Strongly disagree

1.5. Young people should be able to eat where and when they like.

Strongly agree Agree Undecided Disagree Strongly disagree

1.6. Young people eating at the dining table consume more nutritious meals.

Strongly agree Agree Undecided Disagree Strongly disagree

1.7. Monitoring the food the young people eat leads to improving their diet.

Strongly agree Agree Undecided Disagree Strongly disagree

1.8. Flexibility of mealtime and situation (e.g. pizza while watching TV) creates a homely feel in the centre.

Strongly agree Agree Undecided Disagree Strongly disagree

2.0. Menu Choice.

In this section I want to know how the young people and the workers food choices are managed.

2.1. How often are the young people consulted about what they would like to have for dinner?

Daily Weekly Monthly Other please specify

Can you tell me how the consultation works?

2.2. If the young person does not want to eat the prepared meal is an alternative meal provided?

YES NO Other please specify

2.3. Consultation with the young people on food choice can reduce waste.

Strongly agree Agree Undecided Disagree Strongly disagree

2.4. The workers' choice should be taken into account when menu planning.

Strongly agree Agree Undecided Disagree Strongly disagree

2.5. What are the three most frequently cooked meals in the centre?

- 1.
- 2.
- 3

2.6.If dining outside the centre with the young people what restaurant or type of restaurant is most frequently visited?

3.0. Food feelings and emotions.

I am interested in how food is used in residential care. Take for example: a young person makes you a cup of tea and does not have to ask if you take sugar or not. What does that seemingly every day act have to say about the caring relationship?

3.1. I can show that I care through food.

Strongly agree Agree Undecided Disagree Strongly disagree

3.2. A young person knowing what food you like or dislike can be sign that they care for you.

Strongly agree Agree Undecided Disagree Strongly disagree

3.3. Food can be used to express emotions for young people and workers.

Strongly agree Agree Undecided Disagree Strongly disagree

3.4. Young people often use food to gain attention.

Strongly agree Agree Undecided Disagree Strongly disagree

3.5. Can you give an example of how food has been used to gain your attention recently?

3.6. Food can be used to defuse tension in the centre.

Strongly agree Agree Undecided Disagree Strongly disagree

3.7. Could you use one word to describe how you feel when a meal you have prepared is rejected by a young person?

4.0. Power and resistance.

Within residential care there is a complex web of power relationships and obvious one is that between adults and children. The literature suggests that power and resistance between adults and children are routinely played through food and eating practices.

4.1. The adults in this centre largely determine what the young people will eat.

Strongly agree Agree Undecided Disagree Strongly disagree

4.2. The adults in this centre largely determine where the young people will eat.

Strongly agree Agree Undecided Disagree Strongly disagree

4.3. The adults in this centre largely determine when the young people will eat.

Strongly agree Agree Undecided Disagree Strongly disagree

4.4. Do the young people in this centre partake in food related chores?

Daily Occasionally Never

Please specify the chores in the box below.

4.5. Young people's involvement in food related chores causes' tension.

Strongly agree Agree Undecided Disagree Strongly disagree

4.6. Young people should be encouraged to help with food related chores.

Strongly agree Agree Undecided Disagree Strongly disagree

4.7. Young people's participation in food related chores should be voluntary.

Strongly agree Agree Undecided Disagree Strongly disagree

4.8. Have there been any incidents of food related physical conflict (for example disrupting mealtime or destroying/contaminating food) in this centre in the past six months?

YES NO Can you give a brief description in the box below?

(Continue over leaf if necessary)

4.9. Are the food spaces in this centre ever locked?

YES NO Please specify

4.10. Does this centre provide treats for example crisps, sweets or soft drinks for the young people?

YES NO

4.11. Is access to treats controlled?

YES NO Please specify how access to treats is controlled.

5.0. Safe food and health and safety.

This section will gauge how food safety and health and safety regulations impact on the workers and young people's experience of food in residential care.

5.1. Food safety and health and safety regulations are important in keeping young people and workers safe.

Strongly agree Agree Undecided Disagree Strongly disagree

5.2. I feel confident in my knowledge of food hygiene.

Strongly agree Agree Undecided Disagree Strongly disagree

5.3. I feel confident in my knowledge of health and safety regulations.

Strongly agree Agree Undecided Disagree Strongly disagree

5.4. The knowledge of food safety can reduce food waste.

Strongly agree Agree Undecided Disagree Strongly disagree

5.5. Health and safety regulations can restrict young people gaining cooking skills.

Strongly agree Agree Undecided Disagree Strongly disagree

5.6. Have you had experience of health and safety regulations being used to exclude young people from food spaces?

YES NO Please specify.

5.7. Can you list the top three sources (for example food labels, print media) of your nutritional knowledge?

- 1.
- 2.
- 3.

6.0. Workers experience of food.

This section is on your own experience of food at work. For the vast majority of employees eating at work is done during a break. This is not the case for residential child care workers. According to the HIQA standards during mealtimes you should be encouraging the young people to eat a healthy diet and to learn the social skills of the dining table. I hope to gain insight into how you see your role at the table.

6.1. Our food and eating practices can show how we care for ourselves and others.

Strongly agree Agree Undecided Disagree Strongly disagree

6.2. Sharing mealtimes at the table and eating the same food as the young people is an opportunity to produce a homely feel.

Strongly agree Agree Undecided Disagree Strongly disagree

6.3.Mealtimes are work times not social times.

Strongly agree Agree Undecided Disagree Strongly disagree

6.4. The food I eat at work is different to what I eat outside of work.

Strongly agree Agree Undecided Disagree Strongly disagree

6.5. The food I cook at work is similar to the food I cook outside of work.

Strongly agree Agree Undecided Disagree Strongly disagree

6.6. I eat food at work that I would not normally eat outside of work to encourage the young people to try new foods.

YES NO

6.7. I avoid cooking at work.

YES NO

6.8. Cooking is the same as other domestic duties at work.

Strongly agree Agree Undecided Disagree Strongly disagree

6.9. Could you use one word to sum up food in residential care?

7.0. Demographics.

We have almost finished. The following questions will not impact on your anonymity. I want to determine if gender, age and length of time worked in residential care has a bearing on one's food and eating practices.

7.1. What is your gender?

Male Female Other

7.2. What age group do belong to?

Under 24 25-30 31-40 41-50 51-60 Over 60

7.3. How long have you worked in this centre?

7.4. How long have you worked in residential care?

7.5. Which of the following best describes your job title?

- Worker
- Key Worker
- Assistant Manager
- Manager
- Other Please specify

Thank you very much for your time answering this questionnaire. Please return it with one copy of the signed consent form to the person you got it from who has agreed to see that the completed questionnaires are returned to me.

If you have any further comments or observations please feel free to include them. If you would be interested in further participation in this research at a later stage I would like to be able to contact you directly by email. _____

Deirdre Byrne.

Appendix 2 Participation Information Sheet (Young People)



Deirdre Byrne

Research Office

I.T. Sligo

Ash Lane

Sligo.

0719155464

Dear Participant,

You are invited to take part in this research project. I am required to give you a participation information sheet and consent form to inform you about the study. This sheet is to inform you that: your taking part is voluntary; to explain the possible risks and benefits and to help you to make an informed decision. You should feel free to ask me any questions you may have. If you agree to take part, I will ask you to sign a consent form. Please take as much time as you need to read it. You should only consent to take part in this research study when you feel that you understand what is being asked of you and you have enough time to think about your decision. Thanks again for reading this.

Purpose of research.

What are the aims of the research?

You are being asked to take part in this study about food and residential care for young people. You might wonder what is interesting about food? If you think about it, food and what it is like to be living in residential care then you can see that it takes up a big part of your daily life. By looking at what, when and where you eat this study hopes to learn more about how you are looked after and what kind of place you live in.

What do you need to do and for how long?

The research will take place in the centre over a five day period. With your permission, I will record the food and eating activities that take place. All you have to do is be yourself and behave as you usually do. You can ask me questions about what I am doing if you want.

Who will see this research?

It will just be me who hears the tape recording and if I write anything, you say I will give you a pseudonym (another name) and all the records that I keep will be kept locked and password protected. The only other people who will be able to see the written records are my supervisors Perry Share and Jacqueline O'Toole. The final report will be examined by one other person and result in qualification as a PhD for me. I will give feed back to the centre when the research is completed. The results of this

study may be published or presented at professional meetings but the identities of all research participants will remain anonymous at all times

Potential Benefits.

You will not gain anything by taking part in this research but it will lead to a greater understanding of everyday life in residential care. I would like you to understand that your contribution is key to this study. After I have completed the study, you will be invited to give your opinion on how I use your words and experiences.

Potential Risks

The potential risks of taking part in this study are few but you should be aware that if you do feel uncomfortable that you are free to stop at any stage and to withdraw immediately. All information and topics discussed are confidential and your anonymity¹ is assured at all times

Your rights, to participate, withdraw or say no.

Taking part in this study is voluntary. You have the right to say no. You may change your mind at any time and withdraw. You may choose not to answer specific questions or to stop at any time.

Contact information for questions or concerns.

If you have any questions about this study, please contact me at the address above. If you have any questions about your role and rights as a research participant, or would like to register a complaint about this study, you may contact, anonymously the following: Dr Perry Share and Jacqueline O'Toole, Humanities Department, I.T. Sligo, Ash Lane, Sligo.

Summary

Taking part in this study is on the clear understanding that you are doing so voluntarily and you can withdraw your consent at any time. A consent form accompanies this participant information sheet. I need you to sign a copy of the consent form should you agree to take part in this study. Thank you so much for considering taking part in this study.

¹ On reflection anonymity should not have been promised as I was working under the Children First guidelines and would have reported a child protection issue, if it had arisen, to a worker on duty, the manager of the centre or the CFA as required. The wording of the young persons and the workers information sheets should have read:

All information which is collected will be strictly confidential and anonymised before the data is presented in the assignment, in compliance with Children First: National Guidance for the Protection and Welfare of Children, the Data Protection Act and ethical research guidelines and principles.

Appendix 3 Consent Form (Young People)



Deirdre Byrne
Research Office
I.T. Sligo
Ash Lane
Sligo.

Please initial box

I confirm that I have read the information sheet for this study and have had the opportunity to ask questions.

I understand the information provided and have had enough time to think about the information.

I understand that my taking part is voluntary and that I am free to stop at any time.

In signing this consent form I _____ agree to volunteer to take part in this research study being carried out by Deirdre Byrne.

I understand that Deirdre will observe and record my involvement in mealtimes and food practices.

I understand that a written copy of the recording is available to me if I ask.

I grant permission to use a pseudonym (another name so that I will not be identified).

I grant full permission to use the information.

Participant

Date

Signature

Researcher

Date

Signature

Witness (if under 18)

Date

Signature

2 copies: 1 for participant and 1 for researcher to be kept with research notes.

Appendix 4 Participant Information Sheet (Worker).



Food and residential care for young people.

Deirdre Byrne
Sligo I.T.
Ash Lane
Sligo
dedebyrne@ireland.com
0719155464/0872845091

Dear participant.

You are being invited to participate in this research project and I am required to provide a participation information sheet and consent form to inform you about the study, to inform you that participation is voluntary, to explain the potential risks and benefits of participation, and to empower you to make an informed decision. You should feel free to ask me any questions you may have. If you agree to take part, I will ask you to sign a consent form. Please take as much time as you need to read it. You should only consent to take part in this research study when you feel that you understand what is being asked of you and you have enough time to think about your decision. Thanks again for reading this.

PURPOSE OF RESEARCH

What are the aims of the research?

The aim of this project is to explore the central role of food in residential care centres. I intend to use food as a lens with which to view everyday life in residential care for young people and the workers employed there. Food is an ordinary and regular part of daily life so can be taken for granted and therefore its symbolic meaning can be lost. The analysis of negotiations between young people and residential care workers that are played out through food practices will make a significant contribution not just to the sociology of food in Ireland but to the knowledge of everyday life within residential care centres.

What do you need to do and for how long?

The research will take place in the centre over a 5 day period. With your permission I will record the food and eating activities that take place. All you have to do is be yourself and behave as you usually do.

Who will see this research?

It will just be me who hears the tape recording and if I write anything you say I will give you a pseudonym and all the records that I keep will be kept locked and password protected. The only other people who will be able to see the written records are my supervisors Perry Share and Jacqueline O'Toole. The final report will be examined by one other person and result in qualification as a PhD for me. I will give feed back to the centre when the research is completed. The results of this study may be published or presented at professional meetings but the identities of all research participants will remain anonymous at all times

POTENTIAL BENEFITS

Although you will not directly benefit from participation in this study, you will be contributing to a greater understanding of everyday life in residential care. In addition, I would like to convey that you are central to this study and you will be invited to give feedback on my interpretation of your words and experiences.

POTENTIAL RISKS

The potential risks of participating in this study are limited but you should be aware that if you do feel uncomfortable that you are free to stop at any stage and to withdraw immediately. All information and topics discussed are confidential and your anonymity is assured at all times

YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW

Participation in this research project is completely voluntary. You have the right to say no. You may change your mind at any time and withdraw. You may choose not to answer specific questions or to stop participating at any time.

CONTACT INFORMATION FOR QUESTIONS AND CONCERNS

If you have any questions about this study, please contact myself at the address above. If you have any questions about your role and rights as a research participant, or would like to register a complaint about this study, you may contact, anonymously the following: Dr Perry Share and Jacqueline O'Toole, Humanities Department, I.T. Sligo, Ash Lane, Sligo.

Summary

Participation in this study is on the clear understanding that your participation is voluntary and can be withdrawn. A consent form accompanies this participant information sheet. A copy of both will be provided to you. You are required to sign a copy of the consent form should you agree to participate in this study. Thank you so much for considering taking part in this study.

Appendix 5 Consent Form (Worker)



Deirdre Byrne
Research Office
I.T. Sligo
Ash Lane
Sligo.

I confirm that I have read the participation information sheet for the
above study and have had the opportunity to ask questions.

I am satisfied that I understand the information provided and have
had enough time to consider the information.

I understand that my participation is voluntary and that I am free to
withdraw at any time.

In signing this consent form I _____ agree to volunteer
to participate in this research study being conducted by Deirdre Byrne.

I understand that Deirdre will observe and record my participation in
mealtimes and food practices.

I understand that a written transcription of the recording is available
to me on request.

I grant full authorisation for the use of the above information on the
full understanding that my anonymity and confidentiality is preserved.

I grant permission to use a pseudonym.

| | | |
|-------------|-------|-----------|
| _____ | _____ | _____ |
| Participant | Date | Signature |
| _____ | _____ | _____ |
| Researcher | Date | Signature |

Appendix 6 Participant Information Sheet (Questionnaire).



Food and residential care for young people.

Deirdre Byrne

Sligo I.T.

Ash Lane

Sligo

deirdre_byrne@ymail.com

0719155464/0872845091

Dear participant.

You are being invited to participate in this research project and I am required to provide a participation information sheet and consent form to inform you about the study, to inform you that participation is voluntary, to explain the potential risks and benefits of participation, and to empower you to make an informed decision. You should feel free to ask me any questions you may have. If you agree to take part, I will ask you to sign a consent form. Please take as much time as you need to read it. You should only consent to take part in this research study when you feel that you understand what is being asked of you and you have enough time to think about your decision. Thanks again for reading this.

PURPOSE OF RESEARCH

What are the aims of the research?

The aim of this project is to explore the central role of food in residential care centres. I intend to use food as a lens with which to view everyday life in residential care for young people and the workers employed there. Food is an ordinary and regular part of daily life so can be taken for granted and therefore its symbolic meaning can be lost. The analysis of negotiations between young people and residential care workers that are played out through food practices will make a significant contribution not just to the sociology of food in Ireland but to the knowledge of everyday life within residential care centres.

What do you need to do and for how long?

You are being asked to complete the questionnaire provided. It should not take more than twenty minutes to complete.

Who will see this research?

Only I will see the completed questionnaires. I will give you and your place of work a pseudonym and all the records that I keep will be kept locked and password protected. The only other people who will be able to see the written records are my supervisors Perry Share and Jacqueline O'Toole. The final report will be examined by one other person and result in qualification as a PhD for me. I will give feedback to the centre when the research is completed. The results of this study may be published or presented at professional meetings but the identities of all research participants will remain anonymous at all times

POTENTIAL BENEFITS

Although you will not directly benefit from participation in this study, you will be contributing to a greater understanding of everyday life in residential care. In addition, I would like to convey that you are central to this study and you will be invited to give feedback on my interpretation of your words and experiences.

POTENTIAL RISKS

The potential risks of participating in this study are limited but you should be aware that if you do feel uncomfortable that you are free to stop at any stage and to withdraw immediately. All information and topics discussed are confidential and your anonymity is assured at all times

YOUR RIGHTS TO PARTICIPATE, SAY NO, OR WITHDRAW

Participation in this research project is completely voluntary. You have the right to say no. You may change your mind at any time and withdraw. You may choose not to answer specific questions or to stop participating at any time.

CONTACT INFORMATION FOR QUESTIONS AND CONCERNS

If you have any questions about this study, please contact myself at the address above. If you have any questions about your role and rights as a research participant, or would like to register a complaint about this study, you may contact, anonymously the following: Dr Perry Share and Jacqueline O'Toole, Humanities Department, I.T. Sligo, Ash Lane, Sligo.

Summary

Participation in this study is on the clear understanding that your participation is voluntary and can be withdrawn. A consent form accompanies this participant information sheet. A copy of both will be provided to you. You are required to sign a copy of the consent form should you agree to participate in this study. Thank you so much for considering taking part in this study.

Appendix 7 Which table?

5 Tables



Please write the number on the table

1. Which table would you want to eat all your meals at?
2. Which table represents home?
3. Which table represents institution?
4. Which table represents family?

Appendix 8 Example of how the data was coded.

All the young people had left the table [EAT] at this stage and had drifted towards the fruit bowl [HNF]. The young people drifted in and out of the kitchen eating fruit [HNF] and yoghurt. Anne was making herself a sandwich [WED] as she had been out at the mealtime [EAT]. She remarked that shopping day always [RR] resulted in the young people looking in the cupboards and fridge to see what was new [YPC] to eat. I commented that they seemed to be opting [YPC] for the healthy foods even though the treat [UHNF] cupboard had been restocked [RR] and she said, “I know if you told people they wouldn't believe you” [PRC] (Anne worker GV).

At about 8pm all the young people and Anne and Una were in the kitchen. The young people were being loud and messing [DISCP]. I felt that they were performing [SURV] for me for example Darragh picked up some crisps and said “if I eat this will you write it in your note book”? [SURV] I said no that I only write things down [SURV] when I have a quiet moment and it is just to help me remember things. By this stage they had found some chopsticks and were attempting to stick them into a pineapple. Anne asked them to stop and they did [DISCP]. Darragh [SURV *watching me*] looked at me in the middle of this and said “I'm afraid to eat anything now”. Darragh had eaten from 5.30 until 8.00 a large portion of chicken curry and rice, at least 4 bananas, a plum and several glasses of cola that I had seen [SURV].

CODE

EAT - Eat at table

HNF - Healthy food

WED - Workers eat different

RR – Ritual and Routine

YPC - Young peoples choice

UHNF – Unhealthy food

PRC - Perception of res care

DISCP - Discipline

SURV - Surveillance