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“It's not as easy as saying, ‘just get them to eat more veggies’”: Exploring healthy eating in residential care in Australia

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ABSTRACT

Young people living in residential out-of-home care (henceforth OoHC) are at increased risk of becoming overweight or obese. Currently, recognition of the everyday mechanisms that might be contributing to excess weight for children and young people in this setting is limited. The aim of this study was to better understand the barriers and complexities involved in the provision of a ‘healthy’ food environment in residential OoHC. Heightening awareness of these factors and how they might compromise a young person's physical health, will inform the development, refinement and evaluation of more sensitive and tailored weight-related interventions for this population. The paper presents a nuanced picture of the complexity of everyday food routines in residential care, and illustrates the ways in which food is ‘done’ in care; how food can be both symbolic of care but also used to exercise control; the way in which food can be used to create a ‘family-like’ environment; and the impact of traumatic experiences in childhood on subsequent behaviours and overall functioning in relation to food. It is argued that a health agenda designed for a mainstream population ignores the very complex relationship that children in residential OoHC may have with food. It is recommended that future intervention approaches account for personal food biographies, trauma and children's social backgrounds and how these are implicated in everyday practices and interactions around food.

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1. Introduction

For decades research has found an association between child maltreatment and a number of adverse outcomes across the lifespan (Ferraro, Schafer, & Wilkinson, 2016; Fratto, 2016; Greenfield, 2010). Broadly, maltreatment can be defined as ‘ … ill-treatment (that results in) actual or potential harm to the child's health, survival development, or dignity in the context of a relationship of responsibility, trust or power’ (World Health Organization, 2006, p. 9). Maltreatment includes a range of behavioural phenomenon but commonly relates to acts of abuse (including sexual, physical, and emotional) and/or neglect (Greenfield, 2010). Despite the current national focus in Australia on early intervention and provision of family support services to minimize the number of children who experience maltreatment, the most recent published statistics indicate that between July 2013 and June 2014, 143,023 Australian children, or 1 in 37 children aged 0–17 years, received child protection services (Australian Institute of Health and Welfare [AIHW], 2015). This includes 54,438 substantiations relating to 40,844 children (i.e., after notification and subsequent investigation, child protection concluded there was reasonable cause to believe that the child had been, was currently being or was at risk of being abused, neglected or harmed) (AIHW, 2015). In England, the number of children on the child protection register is similar, with 49,700 recorded in 2015, however, lower rates were reported for other parts of the UK: 2935 children in Wales, 2751 in Scotland and 1969 in Northern Ireland (Scottish Government, 2016). For some children, this elevated risk of harm will have resulted in them being removed from the care of their primary caregiver(s) by child protection authorities and placed in OoHC (AIHW, 2015).

Although OoHC provision differs slightly across each Australian

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state and territory, overall, there are five different placement types: (1) foster care; (2) relative or kinship care; (3) family group homes; (4) residential care (where paid staff provide 24-h care for up to four young people in a residential unit or house); and (5) independent living (Department of Families, Housing, Community Services and Indigenous Affairs, 2011). The children living in such OoHC arrangements experience a wide array of adverse physical and mental health outcomes, most likely as a consequence of maltreatment and potentially compounded by adverse experiences and placement disruption in care (Bromfield & Osborn, 2007). Particular health challenges that these young people may face include, developmental delays, disability, learning difficulties, poor dental health, lower levels of immunisations, higher levels of general health problems (including illnesses and accidents), mental health issues, behavioural disorders, and risky health behaviours (including higher rates of teenage pregnancy and self-harm) (Department of Families, Housing, Community Services and Indigenous Affairs, 2010; Wise & Egger, 2007).

There is emerging evidence that being overweight or obese is also a significant issue for children and young people living in OoHC. Indeed, a recent study in Victoria (Australia) reported the prevalence of obesity in this population to be almost three times higher than young people in the general community (Cox et al., 2014). This finding is consistent with international studies, which also report high rates of overweight/obesity within this group (Skouteris et al., 2011). While the contributors to obesity within this vulnerable population are undoubtedly complex and multifaceted, a number of biological and behavioural mechanisms linking maltreatment to obesity have been proposed (Mason et al., 2016). In particular, research has focused on understanding the impact of stress-related changes to neurobiology, physiology, affect and behaviour (Hemmingsson, Johansson, & Reynisdottir, 2014; Mason et al., 2016; Vamosi, Heitmann, & Kyvik, 2010). While understanding the pathways linking child maltreatment to excess weight is important for identifying trauma-informed targets for prevention and treatment of maltreatment-related obesity (Mason et al., 2016), there is a need to understand the *everyday* mechanisms (i.e., structural, personal and relational barriers) contributing to excess weight for children and young people in OoHC.

The Healthy Eating, Active Living [HEAL] Study, a 12-month randomised trial conducted in Australia, sought to identify and address risk factors contributing to the physical health of young people in residential OoHC, specifically being overweight or obese (Skouteris et al., 2014). The HEAL Study was comprised of three different phases: (1) Phase one established the need for intervention, including examination of the rates of overweight/obesity in a sample of young people living in residential OoHC and their carers (Cox et al., 2014); (2) Phase two involved identifying possible determinants of overweight/obesity in the target population; and (3) Phase three consisted of intervention development and evaluation. This paper draws on data collected in the second phase of the project, focusing on the ways in which young people and carers in residential OoHC experience food. Specifically, we sought to expand the current understanding of food and eating in residential settings through examination informed by the Food in Care Study [FaCS] (Dorrer, McIntosh, Punch, & Emond, 2010; Emond, McIntosh, & Punch, 2013; McIntosh, Punch, Dorrer, & Emond, 2010; Punch, McIntosh, & Emond, 2010).

The FaCS used an ethnographic approach to explore food practices and the meanings food can hold for children and young people in OoHC, as well as their carers [FaCS]. The aim of this research was to provide an in-depth analysis of the micro-level food practices that are carried out day-to-day in residential children's homes in Scotland. Some of the key findings of the FaCS include: (1) food can provide a window into how care is given but also how it is received and experienced; (2) food practices are powerful mechanisms of socialization, which emerge as a medium for expressing feelings and relationships, across many contexts; (3) food has enormous potential to help children be nurtured and recover from the absence of nurture, to feel as if they belong, that they are cared for and to feel connected; and (4) food can be used to exercise control (Punch, Dorrer, Emond, & McIntosh, 2009).

In the current study, our specific focus was on understanding the barriers and complexities involved in the provision of a 'healthy' food environment in residential OoHC in Australia. Arguably, food and weight are imbued with moral and ideological meaning (Evans, Davies, Rich, & DePian, 2013), and in a residential context, the condition of children's bodies is increasingly seen as an indicator of 'good' or 'bad' care. Food has become a nexus for measuring care, yet very little is known about the day-to-day experience of how food is 'done' in this context and the meanings given to the practices that surround it. This paper argues that by deepening understandings of these factors and how they might compromise a young person's physical health, the development, refinement and evaluation of more sensitive and tailored weight-related interventions for this population will result. The paper critically engages with the current discourse of 'healthy' living and draws on the FaCS (Dorrer et al., 2010; Emond et al., 2013; McIntosh et al., 2010; Punch et al., 2010) with a view to expand understandings of food and food practices that contribute to a 'healthy' food environment in residential OoHC.

2. Methods

Eleven focus groups with residential staff and 18 face-to-face interviews with young people were conducted with representatives from one participating community service organisation, and one therapeutic residential care facility run by the Department of Health and Human Services. Sixty-nine staff were invited to take part in a focus group, and 56 agreed (81.2% response rate; mean age = 38.0 years (SD = 11.9), 78% were female, 62% held certificate or diploma qualification, and the average time spent working in residential care was 28 months (SD = 30.0)). Eighteen of the 32 young people who were approached took part (56.2% response rate; mean age = 13.0 years (SD = 2.0), 55% were male, 27.8% Aboriginal or Torres Strait Islander, and the average time spent living in residential care was 24 months (SD = 26.1)). This study was approved by the Deakin University Human Ethics Research Ethics Committee and the (former) Department of Human Services Research Coordinating Committee. Participation was voluntary and young people and carers were eligible if they could provide informed consent.

For both groups, a semi-structured interview schedule including both open- and closed-ended questions was used to explore the barriers to creating a healthy eating environment in residential care. This included a series of interview/focus group questions developed for the UK FaCS study (Punch et al., 2009) and adapted for the HEAL study context. Staff were asked specific questions relating to food preparation and storage, mealtime routines, the role of food in residential care, and current strategies to support healthy eating. In turn, the interviews with young people explored their likes and dislikes in relation to food and the surrounding practices, how they experienced mealtimes, and the varied regulatory practices around food. All focus groups and interviews were audiotaped.

Techniques drawn from a framework analysis approach were used in the current study (Ritchie, Spencer, & O'Connor, 2003) to gain a contextualised understanding of micro-level food practices in residential OoHC and the meanings given to this by staff and young people. This approach allowed relevant themes to be

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