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Food insecurity and clinical social work

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ABSTRACT

This study was undertaken to explore the experiences of social workers with food insecurity within the field of social work. Participants were asked to reflect on their encounters, experiences, understandings, and responses to food insecurity within their practice, and the relationship of food insecurity and clinical work. A definition of food insecurity as lack of access to nutritious food was presented to participants. Participant experience with the given definition, as well as with their own definitions of food insecurity, was explored.

A snowball method was used to recruit a sample of 12 social workers with MSW degrees working in direct practice and mental health settings. The sample was notable for diversity in the types of presenting problems and range of populations served by the agencies in which participants worked.

Study findings suggest that food insecurity is perceived as a critical issue in clients' lives, but that social workers do not have the resources necessary to adequately help clients address this issue. Most participants perceived food insecurity as integrally related to the profession's social justice mission, and supported the introduction of educational and training material to assist workers in addressing the issue of food insecurity in a new and thorough way.

FOOD INSECURITY AND CLINICAL SOCIAL WORK

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CHAPTER I

Introduction

The purpose of this study is to explore the role of food insecurity and nutrition in clinical social work practice. The research question is: How do clinical social workers encounter, experience, understand, and respond to their clients' food insecurity in social work practice? Lack of access to nutritious food, disproportionately affecting low- income populations, is currently a major source of social injustice in our country and an issue that social workers inevitably encounter. While this is one important aspect of food insecurity, the other main aspect of defining food insecurity relates to hunger. Hunger is looked at in two main ways in the literature; One aspect focuses mainly on whether people have enough to eat, with less emphasis on nutritional aspects and more on the caloric aspects; the other focuses on whether there is sufficient food being produced in the country and in the world. In order to narrow the scope of this study, food insecurity is defined in terms of lack of access to nutritious food. The term *food desert* is used to describe the manifestation of food insecurity in the physical environment, at the level of community.

Generally, food insecurity and nutrition have been studied in terms of vulnerable populations, including low-income women and low-income communities, young mothers, the elderly, immigrants, poor rural families, and poor food pantry clients. The previous research does not address how clinical social workers understand and apply the concepts of food insecurity and nutrition in clinical practice.

My study will be exploratory, utilizing semi-structured interviews to gather qualitative data from a sample of social work clinicians practicing in mental health and multi-service agency settings. The interview will elicit clinicians' views on and application of food insecurity and nutrition in social work practice. To minimize geographic limitations, I will use Skype to carry out interviews with 12 to 15 participants who have been recruited through a snowball method. Interviews will last approximately 1 hour. Findings will be shared with participants who indicate an interest. The primary audience will be clinicians, the social services community, and academics who are interested in nutrition and mental health.

Examining food insecurity and nutrition in the context of social work practice is extremely important because of the prevalence of this issue among the often vulnerable populations that access mental health services in settings employing social workers as primary clinicians. These populations are likely to reside in neighborhoods in which access to foods that provide adequate nutrition is nonexistent or, at best, extremely limited. It has been well documented that lack of adequate nutrition may lead to a range of mental and physical health issues such as obesity and depression, among others (Eicher-Miller, 2009; Chilton & Rose, 2009). Understanding social workers' experience of food insecurity and nutrition as it presents in practice will shed light on the ways in which this issue may be addressed both within the therapeutic relationship as well as on a societal level. Incorporation of this issue in clinical practice may lead to improved client physical and mental health outcomes. Finally, if clinicians become more aware of, and informed about, this issue, they may be more likely to join others in advocating for policies that support increased food security and nutrition among vulnerable populations.

CHAPTER II

Literature Review

This study seeks to answer the question: How do clinical social workers encounter, experience, understand, and respond to their clients' food insecurity in social work practice? The following review will provide an overview of the state of food insecurity in the United States, including the impact of food insecurity on the populations most affected, the barriers to adequate nutritious food, and policy interventions with affected populations. The review thoroughly explores the topic of food insecurity by discussing vulnerable populations and food deserts. It will also include discussion of the attention that has been paid to this issue in the social work literature. Additionally, the impact of poor nutrition on mental health will be discussed, as relevant to clinical social workers' concerns in clinical social work practice. Social workers' roles and responsibilities regarding food insecurity in clinical work and their perspectives on food insecurity and nutrition will be explored. Finally, the social justice framework and its use as a lens through which to view the relationship between social work and food insecurity will be discussed.

Food insecurity in the US

There are several aspects of food insecurity that are important to understand. Background information on the issue, including the current status and definition of food insecurity, is a starting point. The next step is gaining an understanding of the policy dimensions

of this issue, as such understanding will necessarily lead to informed professional social work practice on the individual and community level.

Current status of food insecurity. According to experts in this field, "More than 49 million individuals living in the Unites States experienced food insecurity in 2008" (Holben, 2010, p. 1368). Belsky, Moffitt, Arseneault, Melchior & Caspi (2010) report an increase in the percentage of families experiencing food insecurity, from 11% in 2007 to nearly 15% in 2008, based on the Department of Agriculture's statistics. The Department of Agriculture reports most recently that the percentage of families experiencing food insecurity in 2008 and in 2009 has essentially remained unchanged. According to authors Chilton and Rose (2009), "…food insecurity is an urgent public health problem in the United States, affecting 11.1% of the population in 2007" (p. 1203).

Barriers to food security. Poverty is the overwhelming barrier to food security. According to Holben (2010), " . . .food insecurity rates in the United States parallel poverty rates, and food insecurity worsens in recessionary times" (p. 1369). Other barriers to food security that are tied to poverty include: high housing and utility costs, unemployment, medical and health costs, and substance abuse. Smoking has also been associated with food insecurity. When designing interventions, systems, or programs to increase food security, the above factors need to be directly addressed.

Definitions of food insecurity. Food insecurity has been defined differently by a range of organizations. The most common definition is, "limited or intermittent access to nutritionally adequate, safe, and acceptable foods accessed in socially acceptable ways" (Holben, 2010, p. 1368). The American Dietetic Association supports the above definition while the United Nations Food and Agriculture Organization defines food security as: "A situation that exists

when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life" (Chilton & Rose, 2009, p.1204).

The United States Department of Agriculture (USDA) has a similar definition. Food security is defined as "access by all people to enough food for an active and healthy life." (Chilton & Rose, 2009, p. 1204). When the USDA formally established this definition in 1990, it included two specific aspects: ready availability of nutritionally adequate and safe foods, and an ability to acquire acceptable foods in socially acceptable ways.

Policy interventions. There is a lack of a coherent plan to decrease food security as shown by the array of critical voices. One barrier to making progress toward eliminating food insecurity is the variation that exists among organizations in terms of both problem definition as well as goals of intervention. "Lack of broadly accepted definitions makes it difficult for the public to demand accountability and complicates the flow of information and education about the importance of hunger and food security to national well-being" (Chilton & Rose, 2009, p. 1205). Some researchers argue that increasing public participation by clarifying terminology will improve efforts to increase food security.

Tolma, John, and Garner (2007) emphasize that education materials in campaigns fighting for food security have room for improvement. "The quality of most of the materials ranged from 'average' to 'good.' Some of the major weaknesses include readability level, lack of cultural relevance, and inadequate coverage of food insecurity" (p. 164).

The authors conclude that very few materials on food insecurity are of high quality. This article highlights the fact that ineffective interventions can end up becoming another barrier to food security.

Some argue that there is a lack of commitment by the United States to eliminate food insecurity. The existence of the above barriers lends support to this point, but Chilton and Rose (2009) insist that the United States is lacking in its ideological commitment to decreasing food insecurity due to its refusal to commit to food as a basic human right. Chilton and Rose (2009) state: "At the Rome Declaration on World Food Security in 1996, all countries except the United States and Australia agreed to adopt the notion that food is a basic human right and pledged to make efforts to cut world hunger in half by 2015" (p. 1205).

The adoption of the notion of food as a right would lend credence to efforts that address food insecurity. The following definition offered by Chilton & Rose (2009) comes closest to supporting the notion of food as a basic right. Chilton & Rose state:

> The working definition of the right to food is: the right to have regular, permanent and unrestricted access, either directly or by means of financial purposes, to quantitatively and qualitatively adequate and sufficient food corresponding to the cultural traditions of the people to which the consumer belongs, and which ensure a physical and mental, individual and collective, fulfilling and dignified life free of fear. (p. 1204)

While the foregoing discussion focuses on a definition of food insecurity that emphasizes a lack of access to nutritious food rather than emphasizing hunger, it is also useful to look at social policy that has been constructed using a number of different definitions.

It is important to note that the United States has implemented interventions designed to eliminate food insecurity. Two such initiatives have been created by the U.S. Department of Agriculture and by the United States Department of Health and Human Services (Holben, 2010). The Community Food Security Initiative of the USDA focuses on cutting food insecurity in half

by supporting partnerships that build local food systems while the United States Department of Health and Human Services has a Healthy People Initiative focuses on eliminating health disparities and increasing quality and years of healthful life (Holben, 2010). Within the Community Food Security Initiative, one objective for the nation related to nutrition is to increase food security to 94% among United States households.

Historically, there have been interventions that, while not eliminating food insecurity entirely, have succeeded at various points in decreasing it. Lynn Parker, an advocate at the Food Research and Action Center (FRAC), explains that physicians were the motivating force behind our nation's "nutrition safety net" (Parker, 2002). Parker describes a physician's concept of food security in a discussion of Dr. Geiger's concept of a food prescription. Like generations of past physicians, Dr. Geiger believes in distributing food – like drugs – to people because "the last time we looked in the book, the specific therapy for malnutrition was food" (Parker, 2002). Physicians are credited with motivating the 1946 National School Lunch Act, the 1967 expansion of the Food Stamp Program – now called the Supplemental Nutrition Assistance Program (Chilton & Rose, 2009) – the implementation of the School Breakfast Program, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and other programs to ensure consistent nutritional adequacy based on the national nutrition standards (Parker, 2002). Currently, the United States spends more than $50 billion per year on nutrition assistance programs for the United States population (Chilton & Rose, 2009). This funding supports the Supplemental Nutrition Assistance Program, School Breakfast Program, and WIC programs. Despite this safety net, the US has not reached or even moved toward the Healthy People 2010 goal of reducing food insecurity by half (from 12% to 6%). Belsky et al. (2010) report an increase in the percentage of families experiencing food insecurity, from 11% in 2007

to nearly 15% in 2008, based on the Department of Agriculture's statistics. "In fact, there has been little change in overall rates since annual measurement of food insecurity began in 1995" (Chilton & Rose, 2009, p. 1203). Based on the current statistics, food assistance programs alone have not been effective in eliminating food insecurity. Importantly, they have not addressed the problem of food insecurity at the level of its most widely agreed upon cause: poverty.

Vulnerable populations. Several studies have documented the high level of risk for food insecurity among low-income women and low-income communities, communities of color, young mothers, the elderly, immigrants, poor rural families, and children. Disparities in food insecurity rates have not changed since 1998, and African American and Latino households continue to have two to three times the prevalence of household food insecurity compared with white households (Chilton & Rose, 2009). Female-headed households had a food insecurity prevalence rate of 30.2% or almost three times the national average, and more than 12.4 million children experienced food insecurity in 2007 (Chilton & Rose, 2009). Additionally, "Compared with food-sufficient elderly persons, food-insufficient elderly were more likely to be poor, minority, participants in food assistance programs, only a high school graduate and living alone" (Sun Lee & Frongillo, 2001, p. 1505-1506).

Children, as a group, experience food insecurity in large numbers. This is particularly alarming due to the developmental milestones for young children. "Households with children were almost twice as likely to be food-insecure as households without children" (Huddleston-Casas, Charnigo, & Simmons, 2009, p.1133). Among children, those with immigrant parents are at particular risk for experiencing food insecurity due to issues of access to the government sponsored programs aimed at addressing this issue. According to Chilton et al (2009), " . . . 20% of children under 6 years old have immigrant parents and this group is the fastest growing

population of children in the US" (p. 556). The large majority of children of immigrants are United States citizens and are eligible for federal assistance, but the programs often do not reach these children, making them vulnerable to food insecurity (Chilton et al., 2009).

Low-income single mothers experiencing food insecurity are also at risk of developing poor physical and mental health. Broussard (2010) explains:

> . . . Low-income single mothers with children remain vulnerable to multiple chronic risk factors, including financial and food insecurity, poor health care access, job insecurity, poor access to quality child care, and poor quality housing in unsafe neighborhoods . . . As a consequence, their health and mental health suffers, increasing the risks they and their children must face on a daily basis (p. 446).

Additionally, it has been documented that single mothers often reduce their own nutritional intake in order to provide adequate nutrition to their children, ultimately increasing their own morbidity over time (Broussard, 2010).

The elderly are an understudied population that suffers from health and nutritional consequences related to food security. According to Sun Lee and Frongillo (2001), "The majority of studies examining the nutritional and health consequences of food insecurity have focused on younger adult women and children" (p. 1503). The issues facing the elderly related to food insecurity are unique because this population already uses substantially more health, medical, and other services than the general population. The authors add, " . . . food insecurity can bring further physical, emotional, and economic burdens to the elderly persons themselves, their formal or informal caregivers, and the health care system" (p. 1503).

Food deserts. The term *food desert* is used to describe the manifestation of food insecurity in the physical environment, at the level of community. The lack of consensus regarding the definition and underlying causes of food deserts parallels the lack of clarity that exists regarding the concept of food insecurity, in general.

Authors in the field of public health and human development, Walker, Keane, and Burke (2010), have reviewed the literature on food deserts and provide useful examples to explain the origin of food deserts in various locations. According to Walker et al. (2010) the term *food desert* was first used in the 1990s. Since then, the phrase has been used differently in the literature, depending on the nature of the study. The definition of food desert most compatible with the goals of this study is that provided by these authors: "…areas devoid of a supermarket where access to healthy food is limited" (p.876). Walker et al. (2010) cite several studies using different definitions. For example, a study of fruit and vegetable access in four low-income communities in Minnesota carried out in 2006 by Hendrickson, Smith, and Eikenberry (2006) described food deserts as "urban areas with 10 or fewer stores and no stores with more than 20 employees" (as cited in Walker et al., 2010, p. 876). Another study, by Cummins and Macintyre (2002), described food deserts as "poor urban areas, where residents cannot buy affordable, healthy food" (as cited in Walker et al, 2010, p. 876). Most would agree that the defining aspect of a "food desert" includes having a lack of stores; variations in the definition of food desert relate to the type and quality of food available, versus the number, type, and size of food stores available to residents (Walker et al, 2010).

Others have expanded on the definition of food desert to include the underlying causes of this phenomenon. Furey, Strugnell, and McIlveen's (2001) definition of a food desert as "an area where high competition from the multiples [large chain supermarkets] has created a void" highlights the economic forces behind the creation of food deserts (as cited in Walker et al., 2010, p. 876). Often the growth of large supermarket chains on the outskirts of urban areas that offer lower prices and longer business hours causes smaller inner-city stores to go out of business. Kirkup, Kervenoal, Hallsworth, Clarke, Jackson, and Aguila (2004) and Lake and

Townshend (2006) explain that the residents of inner cities suffer twofold: one, in that they do not have access to nearby affordable healthy food, and two, in that they cannot afford to travel to the affluent areas where the supermarkets are located (as cited in Walker et al., 2010).

Rural vs. urban food deserts. Often food insecurity is thought about in terms of urban food deserts; however, food insecurity is a social problem in rural communities as well. Authors De Marco, Thorburn and Kue (2009) emphasize that the economic structure of many rural communities contributes to poverty and food insecurity. "Many rural regions depend on one or two industries to survive, which might increase their susceptibility to recessions" (p. 1010). During recessions, significant jobs are lost which leads to decreased incomes, resulting in increased vulnerability to food insecurity. "In addition, rural communities face other conditions contributing to food insecurity that urban dwellers do not, including limited access to supermarkets and limited and highly priced food items" (p.1011). While these authors do not use the term *food desert*, their work essentially supports the notion that many rural communities also contain such areas. The authors compared levels of food insecurity in rural and urban areas in Oregon and found that rural areas were more likely to face food insecurity with three main differences from urban areas. Rural residents conveyed higher levels of social isolation and geographic isolation than urban Oregonians, but reported higher levels of access to alternate sources of food, despite suffering from greater food insecurity than urban areas in Oregon (De Marco et al., 2009). This study's focus on rural food insecurity adds an important dimension to the extant literature in this area, the major focus of which has been on urban areas.

The issue of access is a key issue that links the existence of food deserts to social work practice. Social work focuses on connecting people and communities to the resources they need to live healthy lives. Neighborhoods that meet the definition of the term *food desert* are also

likely to be those that are severely lacking in other critical resources; people living in food deserts are also likely to be living in poverty and facing significant barriers to accessing quality healthcare, education, and employment in addition to quality, nutritious food.

Effects of Food Insecurity

Physical health. Seipel (1999) discusses the consequences of food insecurity for an individual's health. He states,

> When the immune system is compromised by malnutrition, the skin's ability to resist the invasion of organisms, the acid secretion produced by the stomach to resist foreign agents, or the production of chemical compounds in the blood that destroy toxins can be affected adversely (p. 420).

Food-insecure individuals and groups exhibit a variety of physical health problems. According to Eicher-Miller (2009), "Nutrition and health are negatively affected by food insecurity. Poor diet has been identified as a significant factor contributing to heart disease, certain types of cancer, diabetes, stroke, and obesity in adults" (p. 161).

The health of the elderly can be particularly affected by food insecurity because of age-related health issues. "Food-insecure elderly persons had significantly lower intakes of energy, protein, carbohydrate, saturated fat, niacin, riboflavin, vitamins B-6 and B-12, magnesium, iron and zinc, as well as lower skinfold thickness" (Sun Lee & Frongillo, 2001, p. 1503). Food-insecure elderly persons were more than twice as likely to report lower body weight and lower global quality of life (Sun Lee & Frongillo, 2001).

Children are also at particular risk from the effects of food insecurity. As Sun Lee and Frongillo (2001) explain, "The consequences include decreased dietary intake, decreased household food supply, psychosocial dysfunction, increased body weight, health problems, decreased quality of life, and sociofamiliar perturbations" (p. 1503). Additionally, Chilton et al.

(2009) found, " . . . among infants and toddlers aged 0 to 3 years, who are in the most sensitive period of brain growth and cognitive development, household food insecurity is related to reported fair or poor child health, developmental risks, and behavior problems" (p. 556). These authors demonstrate that there is a connection between physical and mental health.

Mental health. Numerous studies have demonstrated a link between food insecurity and mental health among children, adolescents and adults. According to Chilton and Rose (2009):

> . . . food insecurity has been associated with poor health status in children and adults, depression and anxiety among adolescents and adults, and adolescent suicidal ideation. Even the mildest form of food insecurity is associated with risk of poor cognitive, social, and emotional development of children younger than 3 years (p. 1203).

One study by Huddleston-Casas, Charnigo, and Simmons (2008) demonstrates that food insecurity leads to depression in rural low-income women and that the inverse is also true: depression may lead to food insecurity. Huddleston-Casas et al. (2008) also discuss an additional study by Chilton and Rose (2007) that links depression and poor mental health with food insecurity. This study of poor women in Philadelphia by Chilton and Rose (2007) found that food-insecure women experienced "hunger of the mind" which they defined as a sense of hopelessness and depression (as cited in Huddleston-Casas et al., 2008). The women in the study differentiated between "hunger of the body" and "hunger of the mind", but linked both to the concept of food insecurity. As described by Chilton and Booth (2007), study participants' sense of hopelessness and depression was experienced as hunger. In their study of African American women and food insecurity, Chilton and Booth (2007) found, "Mental health effects owing to the stress of poverty, anxiety, and violence or trauma may make up part of the wider experience of food insecurity and contribute to the association between food insecurity and poor health" (as cited in Huddleston-Casas, 2008, p. 124). Often, the women explained that their "hunger of the

mind" could lead to a "hunger of the body" and vice versa (Chilton & Booth, 2007). These studies illustrate that one of the most powerful facts about mental health and food insecurity is the nature of the relationship; that is, food insecurity can lead to poor mental health or be the result of existing poor mental health. Findings in a study by Huddleston-Casas et al. (2008), for example, indicate that depression can lead to poor eating habits.

Two additional studies (Belsky et al, 2010; Zaslow, Bronte-Tinkew, Capps, Horowitz, Moore, & Weinstein, 2009) demonstrate the effect of food insecurity on the behavior and mental health of children. Zaslow et al. (2009) examined associations between household food security - defined as access to sufficient, safe, and nutritious food during infancy - and attachment and mental proficiency in toddlerhood. The authors explain, "Food insecurity worked indirectly through depression and parenting practices to influence security of attachment and mental proficiency in toddlerhood" (p. 66). Their study demonstrates that food security affects children's development very early. The authors further explain,

> . . . greater food insecurity, measured at 9 months in a nationally representative sample of families with infants, predicted insecure child attachment and less advanced mental proficiency at 24 months, operating not directly but through food insecurity's influence on maternal depression and in turn on parenting practices (p. 76).

Similar findings were reported by Belsky at al. (2010). Using data from a longitudinal study of families with children that looked at associations among household food insecurity, income, maternal personality, household sensitivity to children's needs, and children's cognitive, behavioral, and emotional development, Belsky at al. (2010) examined the role of food insecurity in the etiology of children's cognitive and mental health problems. Findings by Cook and Frank (2008) indicate that children living with food insecurity had lower IQs and higher levels of behavioral and emotional problems compared to their peers (as cited in Belsky et al., 2010).

Fanjiang, Kleinman (2007) and Liu (2004) demonstrate a strong connection between food insecurity and children's mental health beyond the association with parents' mental health and food insecurity, shown in previous studies (as cited in Belsky et al, 2010). These authors state, "Researchers have begun to elucidate neurodevelopmental mechanisms linking early childhood malnutrition to low IQ in middle childhood and subsequently to behavioral problems in adolescence" (as cited in Belsky, p. 810, 2010). Two major findings related to food insecurity and mental health are emphasized:

> First, we found that food insecurity was associated with lasting emotional distress for children independent of their families' incomes, their mothers' personalities, and their households' sensitivity to children's needs. The emotional problems measure we used tapped childhood anxiety and depression, which are known to predict maladjustment in adulthood, including major depressive disorder, a leading cause of disability and health burden worldwide . . . Second, although exposure to food insecurity appears to make some contribution to children's emotional distress, primarily other features of children's households explained differences in cognitive, behavioral, and emotional problems between food-insecure children and their peers in this study (p. 813, 2010).

While it is clear that food insecurity contributes to mental health issues, other factors in children's lives may have an even greater impact on mental health. It is useful to take into account the host of other contributing factors to mental and physical health, in developing effective approaches to the issue of food insecurity in clinical social work practice.

Clinical Social Workers' Roles and Responsibilities in the Area of Food Insecurity

The Code of Ethics of the National Association of Social Workers (NASW) outlines ethical principles and standards to which social workers have a professional obligation to adhere. Additionally, the Code outlines the priorities social workers should uphold in their practice. The major values discussed in the Code of Ethics that link social work to food insecurity are Service and Social Justice. In relation to Service, the Code states, "Social workers' primary goal is to help people in need and to address social problems . . . Social workers draw on their knowledge,

values, and skills to help people in need and to address social problems" (National Association of Social Workers, 2008, p. 5). There is no doubt that people suffering from food insecurity are in need or that food insecurity is a social problem as the literature review will demonstrate.

Additionally, the value of social justice is integral to social workers' professional obligations. The NASW Code (2008) states,

> Social workers challenge injustice . . . Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people. Social workers' social change efforts are focused primarily on issues of poverty, unemployment, discrimination, and other forms of social injustice . . . Social workers strive to ensure access to needed information, services, and resources; equality of opportunity; and meaningful participation in decision making for all people (p.5).

Again, addressing food insecurity lines up well with social work values. Food insecurity is a social problem primarily linked to poverty and discrimination; vulnerable populations are most at risk for food insecurity and struggle the most with access to resources of all types which adds to their vulnerability. Food insecurity can be clearly identified as a social justice issue because of its powerful impact on disadvantaged groups in society. According to Chilton and Rose (2009) "Food-insecure households have documented lower nutrient intakes, poor child development, poor health, and forced trade-offs between paying for basic needs such as housing, heating, and medical care. Each trade-off increases vulnerability" (p. 1206). The theoretical underpinnings of the social justice framework will be discussed in greater detail in the final section of review.

Social work perspectives on food insecurity. While social workers may be aware of the existence of food insecurity among the population receiving services, there is a gap in the literature regarding the connection between the field of social work and food insecurity. Most commonly, the literature refers to social workers as having the responsibility to help clients find and negotiate necessary social services. Messer (2002) emphasizes that social work practice in

the community setting often involves connecting clients to federal food programs and private emergency food programs.

The traditional emphasis on social workers' role in connecting vulnerable populations to resources is illustrated in Flynn, Budd, and Modelsky's (2008) discussion of social work intervention with pregnant adolescents.

> Each month, during their prenatal period, participating teens received one home visit by a public health-registered nurse and one home visit by a medical social worker for the purpose of assisting teens to access community resources, select a prenatal care provider, and make and schedule appointments. Health education and transportation to medical appointments were also provided. (p. 140).

In this study, social workers additionally enrolled the adolescents in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC Program), a resource that provides nutrient-dense food packages to pregnant women and their children, demonstrating the level of attention these social workers paid to food insecurity. The above example demonstrates the multi-faceted approach social workers often take when working with vulnerable populations. In this case, the social workers connected the adolescents to health care, transportation, education, and ultimately a wrap-around support system. This example is also useful because it illustrates how social workers may traditionally address the issue of access to food and nutrition. While they may help adolescents enroll in a government program that acts as a safety net, they may not also engage with the clients in any other way around the issue of food insecurity. Biggerstaff, Morris, and Nichols (2002), Bywaters (2010), and Seipel (1999), make the point that connecting clients to entitlements and social services is insufficient as a means of ameliorating the impact of food insecurity.

While social workers may value food security and nutritional well-being, addressing food insecurity issues can present a challenge. Biggerstaff, Morris, and Nichols (2002) explain:

"Nutritional well-being for vulnerable individuals and families, although not directly the focus of social work practice, is an important component of healthy biopsychosocial functioning and results in challenges for practice and policy" (p. 267). These authors discuss social workers' role in linking clients to the food stamp program and explain its history as the primary form of response among social workers to the issue of food insecurity, highlighting its flaws as the single response to this issue, given the millions of people who continue to slip through the food stamp safety net.

It is helpful that attention is being drawn to the negligence of the social work profession toward addressing the issue of hunger, because hunger is a social justice issue, the root causes of which must be addressed. There is a danger however in obscuring the importance of access to nutritious food in the definition of food insecurity. Authors Biggerstaff, Morris, and Nichols (2002) explain that the social work profession does not give adequate attention to food insecurity when working with clients.

> . . . the social work profession directs little attention to the issues of hunger and food assistance programs. . . Food needs are not commonly central to the services function of social workers, resulting in social workers assuming children and adults are not vulnerable unless there are physical indications of hunger" (p. 275).

It is useful to note that while these authors highlight the fact that social workers think little about food security in terms of hunger, there is virtually no mention of food insecurity in terms of whether clients have access to nutritionally adequate food. While clients do benefit from social workers' attempts to address food insecurity defined as hunger, they would realize even greater benefits from the profession's expanded definition of food insecurity to include lack of access to nutritious food, and social workers' efforts to systemically address it.

While social workers often work with vulnerable populations - including those living in food deserts - they primarily address issues of poverty and health on an individual level rather than a policy or structural level (Bywaters, 2010). The literature describing interventions that assist clients with access to food pantries, soup kitchens demonstrates that social workers often address the issue of food insecurity on an individual level which does not address the underlying issues of poverty (Biggerstaff, Morris, and Nichols, 2002).

As the literature indicates, most of the populations who live in neighborhoods defined as food deserts are considered vulnerable populations based on demographic characteristics such as age, income, marital status, and citizenship status. Bywaters (2010) links hunger to poverty and poor health, and explains that these issues often provide the basis for contact with social workers. Social workers in all types of settings can engage with clients around food insecurity, which ultimately helps tackle health inequalities. For example, a social worker might ask clients about their diets such as what they eat and whether they have noticed emotional or mental states while eating. The social worker and the client could work together to address food insecurity by focusing on eating patterns and resulting emotions and moods.

Fortunately, there is a growing perspective in social work that food insecurity is an issue worth focusing on. For example, the perspective that social workers have an ethical obligation to address health inequalities easily lends itself to making a case for the importance of integrating the issue of food insecurity in social work practice. Bywaters (2009) argues:

> …health inequalities are a matter of social injustice, . . . the causes of health inequalities are primarily social, that poverty and poor health are common characteristics of social work service users and, that, therefore, health inequalities are a vital issue for social workers in all settings" (p.353).

Because food insecurity clearly affects physical and mental health, it falls into the category of health inequalities.

Seipel's (1999) work demonstrates more directly the growing perspective that the issue of food insecurity has a place in social work practice. He advocates for a more active role among social workers in combating malnutrition by working toward increasing the level of food security among vulnerable populations. He explains that there are four main action areas in which social workers can participate; in order to effectively increase food security for vulnerable populations, Seipel (1999) explains social workers should build awareness and interest, promote principles of human rights, oppose harmful cultural practices against women, and increase community participation (p. 423-424).

As noted previously in the discussion of the role of physicians in promoting policies that provide access to resources in the area of nutrition, clinicians in the medical field similarly have been in the forefront of bringing attention to food insecurity as an issue of social justice (Parker, 2002). The following anecdote illustrates the important contribution of proposed research in this area. Parker (2002) explains:

> A professor of mine used to tell a story about his experiences as a young man working as a psychologist at a state institution for people with severe mental illnesses. He said that he felt as if he was at the end of a long assembly line that was depositing before him damaged people to repair as best he could. He said that he wanted to get to the beginning of the assembly line to stop the damage from occurring. By playing more of a "political" role in dealing with the problem of food insecurity, clinicians can get to the beginning of the assembly line and make a difference there.

Social workers can emulate the stance taken in the medical field by addressing the issue of food insecurity in their clinical practice.

Social Justice Framework

The social justice framework is a powerful lens through which to view the relationship between social work and food insecurity. While there is general agreement on the importance of social justice within social work, the range in definitions of social justice can make it difficult for social workers to agree on how to integrate this perspective into their work. Reisch (2002) explains his interpretation of the social justice framework based on theories of empowerment articulated over the past quarter century. "A social justice approach to social policy would acknowledge the connection in the design and delivery of social services between peoples' needs for economic assistance and the supports agencies provide" (Reisch, 2002). Overall, the social justice framework works toward promoting social justice at every level; there is an emphasis on social workers working with their clients in a way that helps empower them, as well as an emphasis on thinking about social work systemically in order to address injustice at the structural level.

Over the years, certain theorists have contributed to the development of the social justice framework. According to Reisch (2002), Karl Marx, John Rawls, and Paulo Freire are key theorists whose theories have shaped social work's interpretation of social justice. Marx focused on the idea that the human condition and reality are socially constructed through socioeconomic relationships and cultural patterns. "He asserted that the roots of injustice lie, instead, in the political-economic structure that was based on subjugation, discrimination, exploitation, and privilege (Reisch, 2002, p. 345). Rawls focused on the concept of distributive justice and developed the principle of redress, "which established the philosophical basis for social policies directed toward a more just distribution of social goods" (Reisch, 2002, p. 346). Additionally, social work scholars have based their ideas on Freire by focusing on "human transformation as

part of their critiques of positivist-empiricist and rationality –centered emphases of social work research and epistemology" (Reisch, 2002, p. 348).

Reisch refers to Swenson's work to create a clear picture of the social justice foundation in clinical social work. Swenson (1998), a social work scholar, uses the writings of Rawls and Van Soest to identify strategies for basing clinical work on a social justice foundation. Swenson explains, "These include recognizing clients' strengths, an awareness of the role of the power in professional relationships, and a focus on positionality (as cited in Reisch, 2002, p. 349). Despite the differences in social work scholars' views on social justice, they all agree that it is integral to social work.

While the literature defines food insecurity in several different ways, all of the definitions exemplify various parts of the social justice framework due to their focus on a lack of access to resources. The definition of resources may vary, or the context in which lack of access to nutritious food exists may be differently described, yet all definitions are reflective of the Rawlsian concept of distributive justice. Every author of a definition of food insecurity, whether a scholar or an organization working on the issue, focuses on a more just distribution of social goods - in this case food, or access to food. The definitions of food insecurity of major authors in the field, as well as the definition used by the researcher, also acknowledge that the human condition and reality are socially constructed through socioeconomic relationships and cultural patterns as Marx explained.

Summary

Food insecurity is a social and economic problem that affects the physical and mental health of millions of Americans. Food insecurity – hunger and/or lack of access to nutritious food – is caused primarily by poverty and is manifested in the physical environment in the form

of “food deserts”. Food insecurity is a problem of inequality that affects minorities and vulnerable populations disproportionately. While various interventions, such as connections to entitlement programs and wrap around services, have been implemented, the suffering has not been alleviated. People living with food insecurity in the United States are suffering due to physical health issues as well as mental health issues. “. . . food insecurity has been linked to decreased health and increased psychological problems in adults from food-insecure households” (Eicher-Miller, p. 161, 2009).

Food insecurity is an issue of social justice that social workers have an ethical obligation to address as demonstrated by the NASW Code of Ethics. Social workers address issues of poverty by connecting clients to services and entitlements, but the literature demonstrates that food insecurity is not commonly addressed in clinical practice. Further study of the experience and understanding of social workers in the area of food insecurity is needed to advance the work of the field in this critical area.

CHAPTER III

Methodology

This chapter will include a description of the study purpose, research design, and recruitment methods. Additionally, the chapter will highlight the data collection methods and general topics covered in the interview. Finally, a summary of participant characteristics will be provided as well as a description of the qualitative analysis methods used.

Study Design and Sampling

The purpose of this study is to explore the role of food insecurity and nutrition in clinical social work practice. The research question is: How do clinical social workers encounter, experience, understand, and respond to their clients' food insecurity in social work practice? The study additionally sought to learn about possible relationship between differences in social workers' clinical experiences in this area, and differences in practice setting and population, and general level of awareness of the issue.

Utilizing a sample of masters-trained social workers practicing in direct service or mental health settings, this exploratory study sought in-depth information about participants' experiences and views of food insecurity in clinical practice. A semi-structured interview with open-ended questions was used to gather narrative data. It was hoped that the data gathered would be useful in bringing to light the nature of participants' understanding of this issue in general, as well as their views regarding its significance in the therapeutic relationship and the ways in which it may be integrated into the service encounter. Additionally, it was hoped that

participants who encounter clients affected by food insecurity would be able to discuss how nutrition has impacted their clients' lives, adding to the knowledge base of the profession.

The study's 12 participants were recruited using a snowball sampling method. The recruitment process began with contacting, via e-mail, 17 clinical social workers personally known to the researcher who met the criteria for inclusion**.** These criteria included: a master's degree in social work (MSW); currently practicing in a direct service or mental health setting; and some experience with the issue of food insecurity in their practice (Appendix D). Following recruitment of the first three participants, the final inclusion criterion was expanded upon, as follows: Experience could include work that directly addresses this issue and/or knowledge of food insecurity as part of a client's situation, even when it is not the presenting concern or major focus of work with the client (Appendix G).

The initial recruitment e-mail (Appendix D) inquired about the receiver's interest in participating in the study and requested their assistance in forwarding the e-mail to others they knew who met the study criteria and/or would also be able to forward the e-mail on to others. All individuals who expressed an interest in participating in the study were contacted by phone or email and asked three screening questions (Appendix E). If they met the study criteria, they were also asked whether they lived within 25 miles of the researcher and if they preferred a telephone/Skype or in-person interview. Those living more than 25 miles from the researcher were interviewed by telephone or Skype. Individuals who met the study criteria and who either indicated a preference for telephone/Skype interview or who lived at a distance of more than 25 miles from the researcher received an informed consent form via e-mail or mail with a self-addressed envelope. They were requested to read and sign the informed consent and fax or mail it to the researcher, keeping one signed copy for themselves. If the potential participant lived in

close proximity to the researcher and elected to participate in an in-person interview, they were contacted by phone or e-mail to arrange an in-person interview in a mutually agreed-upon location affording some privacy. These potential participants were also provided a copy of the informed consent form via e-mail to review and could either sign it in advance of the interview and bring it with them, or receive another copy before beginning the interview, at which time they signed it and returned it to the researcher, keeping a copy of the consent form for their own records.

Due to the initial small number of responses received from the snowball method, a secondary method of recruitment was utilized. A recruitment email (see Appendix D) was forwarded to the list serve for the University of Pennsylvania School for Social Work. It was hoped that the sample would be diverse in terms of gender, age, race and ethnicity as well as in workplace settings and client populations served within the time frame available. Although it took longer to recruit a large enough sample using the original snowball methods, this method proved to have been the source for all 12 participants in the final sample. Five of the participants were among the 17 who received the initial e-mail; the remaining seven were recruited through the snowball method. Although 1 participant reported that she knew other social workers who were interested in participating, no one responded beyond the 12 participants.

One participant did not work with clients' mental health issues. While this participant did work directly with clients, the services provided were not clinical in nature; this was not shared with the researcher until after the interview had begun.

Data Collection

The semi-structured interview sought to learn about how clinicians encounter, experience, understand, and respond to food insecurity issues in social work practice. Interviews

lasted one hour. All interviews were conducted in a consistent manner by using the questions included in the study instrument (Appendix B) as a guide. Nine participants were interviewed via Skype, with the remainder interviewed in person in an office setting that afforded some privacy that was mutually agreed upon by the researcher and participant. All interviews were audio recorded, with permission, and the researcher was responsible for all data collection and analysis. In order to elicit the subjective experience of participants as well as information that I may not have predicted would be forthcoming, probes were used selectively. These probes consisted mainly of phrases such as 'Anything else?', and other similar phrases, supported in the literature, (Rubin and Babbie, (2009).

General topic areas covered were clinicians' understandings and experiences with food insecurity in their social work practice, including barriers to addressing food insecurity, connections made between clinicians and clients around food insecurity, and differences as related to experiencing and defining food insecurity.

In an effort to learn about the possible relationship between experiences and perceptions of food insecurity and participant demographic and agency characteristics, the instrument also collected data on participant age, race/ethnicity, gender, type of agency, agency focus, and agency setting. Previous literature has shown a relationship between food insecurity and socioeconomic status, race/ethnicity, and age. Additionally, since the issue of food insecurity has more recently gained ascendance in both policy and practice arenas, the age of the participant was of interest. Finally, the impact of agency mission and population served on experiences and understanding of the issue of food insecurity has not been directly addressed in the literature and represented am additional area of interest for the researcher.

Sample Characteristics

The sample consisted of 12 participants, including 10 participants identifying as female and 2 identifying as male. Participant ages ranged from 29 to 58, with a mean age of 38, and a median age of 34. Participants self-identified for the category of race/ethnicity. Seven participants indentified as Caucasian and three identified as White, including one participant who identified as Italian and Irish. One participant identified as Latino, further indentifying their nationality as Puerto Rican. One participant identified as African American. Further discussion of sample characteristics, including illustrative tables, is included in Chapter Four.

Data Analysis

Transcripts were reviewed to identify relevant content, themes, and patterns related to the study question. Collected data was transcribed by the researcher. Data was collapsed into similar themed categories for analysis. The demographic data was measured for statistical/descriptive presentation. The qualitative data analysis began with a review of the transcriptions, and involved recording of repetitive themes and ideas. When the same theme was identified in a different interview, this assisted the process of theme development. Quotes were extracted from transcripts for the purpose of illustrating thematic material.

Chapter IV

Findings

The purpose of this study is to explore the role of food insecurity and nutrition in clinical social work practice. The research question is: How do clinical social workers encounter, experience, understand, and respond to their clients' food insecurity in social work practice? Lack of access to nutritious food, disproportionately affecting low- income populations, is currently a major source of social injustice in our country and an issue that social workers inevitably encounter. This chapter will review the study findings, which have been organized by theme into the following categories: barriers, connections, and difference. The theme of barriers refers to participants' report of barriers to addressing the issue of food insecurity in social work practice. Within the theme of barriers, the major subtheme is lack of resources; this includes lack of resources of the agency, the client, and the social worker. The theme of connections refers to a range of activities carried out by participants in their efforts to address the issue of food insecurity in their practice. Additionally, within the theme of connections, several subthemes will be addressed: connecting clients to resources, connecting with clients, and the connection social workers make between food insecurity and social work practice. Finally, the theme of differences refers to the differences in defining and experiencing food insecurity in social work practice. The theme of differences revealed itself as participants discussed their definitions of food insecurity and compared those definitions to the one provided by the researcher and those of their clients.

Sample Description

The sample consisted of 12 participants, including 10 participants indentifying as female and 2 identifying as male. The youngest participant is 29 years old and the oldest participant is 58 years old. The mean age is 38, while the median age is 34. Participants self-identified for the category of race/ethnicity. Table 1 illustrates participant race/ethnicity. Seven participants indentified as Caucasian and three identified as White, including one participant who identified as Italian and Irish. One participant identified as Latino, further indentifying their nationality as Puerto Rican. One participant identified as African American.

Table 1

Sample Characteristics: Race/Ethnicity

Race/ Ethnicity	Number of Participants
White/Caucasian	10
Latino (Puerto Rican)	1
African American	1
Total	12

Given noted differences in the impact of food insecurity among different population groups and between rural and urban settings, the study sought information about participants' agency setting and focus, auspice type, and population served. In addition to gender, age and race participants were asked questions about the setting of their current agency, the type of agency, the type of services their agency offers, and the population their agency serves. Table 2 illustrates participants' agency setting at the time of the interview. Most participants (N=10) worked in urban areas, with the remaining 2 participants working in urban/suburban areas. A

third category of Urban/Suburban was offered by 2 participants who explained that their agencies serve clients in both settings.

Participants were offered three choices (public, private non-profit and or private for-profit) to describe their agency auspice. Most participants (N= 11) worked in private settings; 9 worked in non-profit settings and 2 in for-profit settings. Only 1 participant worked in a public agency. (See Table 3). Four participants were unsure how to categorize their non-profit agency and included it under the "Other" category; this group was then collapsed into the private, non-profit category.

Table 2

Agency Setting

Agency Setting	Number of Agencies
Urban	10
Suburban	0
Urban/Suburban	2
Total	12

Table 3

Type of Agency

Type of Agency	Number of Agencies
Public	1
Private, Non-profit	9
Private, For-profit	2
Total	12

In an effort to learn to what extent participants carried out primarily clinical versus other types of practice, participants were asked whether their agency's services were primarily in the area of mental health, or whether it was a "multi-service" agency. Most participants (N=9) described their agency as "multi-service", with the remaining 3 participants describing their agency as "mental health". (See Table 4)

Table 4

Type of Service

Type of Service	Number of Agencies
Multi-service	9
Mental Health	3
Total	12

Participants were also asked to describe the primary population(s) and main presenting issues of the population served by the agency. Participants worked with a wide range of populations, including families (N = 6), children (N=1), and adults (N=5) (See Table 5). Client presenting issues varied widely, with substantial cross-over among the populations served.

Services provided by participants' agencies included treating children and families for trauma (N=4), working with families around hunger (N=8), homelessness (N=4), substance abuse (N=1), grief (N=1), poverty (N=8), depression (N=7), and mental health issues related to the death of an infant (N=1). Participants also reported working with children and youth around homelessness issues and LGTBQ issues (N=1). Participants who worked primarily with adults reported working with mental illness diagnoses (N=5), homelessness (N=3), and lack of access to food (N=4) (See Table 6).

Table 5

Populations Served

Population	Participant Agencies
Families	6
Children	1
Adults	5
Total	12

Table 6

Issues Addressed

Agency Population served:	Issues						
	Trauma	Homelessness	Depression	Poverty	Grief	Hunger	S/A
Families (N=6)	4	1	1	3	1	3	1
Children (N=1)	0	1	1	1	0	1	0
Adults (N=5)	0	3	5	4	0	4	0
Total	4	5	7	8	1	8	1

Themes

The major categories that emerged from analysis of responses to open-ended questions asking about participants' experience with food insecurity in their practice include: barriers to addressing food insecurity in social work practice; connections within social work practice as related to food insecurity; and differences in defining and experiencing food insecurity. Each of these categories contains subthemes. The main subthemes are lack of resources among agencies, clients, and social workers within the theme of barriers; connecting clients to resources, social workers connecting with clients, and the connection between food insecurity and social work practice within the theme of connections; and lastly, definitions of food insecurity within the theme of differences. Additionally, the subthemes contain smaller themes, such as social justice. The theme of social justice was woven into participant responses implicitly and explicitly

throughout the interviews. This chapter will thoroughly report the most relevant themes offered through participant responses.

Barriers to addressing food insecurity in social work practice. All participants perceived major barriers to addressing the issue of food insecurity in their practice. One participant's major role was to address food insecurity with clients; nevertheless he also reported barriers in his practice. Within this category, a major theme that emerged dealt with lack of resources. Lack of resources was reported in relation to agencies, clients, and social workers. The most prevalent theme throughout the interviews was the acknowledgement of a lack of resources at every level. Clinicians spoke passionately about their agencies not having enough resources to adequately address the issue of food security with clients. They often expressed surprise and then frustration when thinking about how little knowledge they have in addressing the issue of food insecurity with clients.

Lack of resources as a barrier: Agencies. All participants (N=12) spoke about the lack of resources available through their agencies to adequately address the issue of food insecurity with clients in nuanced ways. Some participants (N=4) reported lack of agency commitment to addressing issues of food insecurity at the level of their agency mission statement, while most (N=11) reported the more tangible agency barriers to addressing food insecurity. No differences were found based on participant identifying characteristics. The following quote by a social worker in a multi-service agency serving individuals aged 16-24 years in an urban environment illustrates that, in some agencies, it is not only lack of financial resources but also lack of infrastructure and physical space that defines the agency as a barrier in addressing food insecurity with clients.

> It's more expensive to provide, in some ways, to provide more nutritious options. Um, also it will depend on our set up as an agency. Like we don't have fully operational kitchens in all of our sites so being able to cook fresh meals is not possible in a lot of places. So the options are more limited. Um, so that's like a function of the agency and the kind of funding we have to be able to provide that sort of thing.

Additionally, social workers reported that they also know that other agencies that serve their population lack sufficient resources. For example, participants were familiar with lack of resources being a common issue in social work, in general, across the board. "Um, a lot of the kids that are involved with our program get the majority of their meals through programs in other shelters so they don't get much choice in what they're food options are." One participant, working in an urban, multi-service agency reported that their agency did have resources specifically designated for addressing food insecurity, although this participant's experience was an exception within the sample. Interestingly, however, this participant reported that, although the agency has been receiving funding to address food insecurity, they have only recently begun to prioritize addressing it with clients.

> Because a lot of the funding we are getting is specifically wanting us to address issues related to nutrition and be able to track that over time. So that's something very recently, like over the last month or so that we're really starting to more specifically ask them about right when they come in the door.

Lack of resources as a barrier: Clients. All participants (N=12) felt that often their agencies did not have sufficient financial resources or infrastructure to adequately address the issue of food insecurity with clients, but also felt that usually clients lacked needed resources to address the lack of access to nutritious food on their own. Several participants reported their observations related to clients' lack of nutritious food. Importantly, participants differentiated between having enough food and having nutritious food. One participant working in an urban, private for-profit, multi-service agency, mainly with parents, explained it in this way: "And they

use that as a means of control. And it can actually happen that young. Access food whenever they want which could lead to childhood obesity, but actually some kids aren't getting enough nutrients." Although, by definition, clients who are considered food insecure are lacking in access to nutritious food, participants tended to speak more specifically about clients' lack of knowledge related to nutrition as a barrier to addressing food insecurity than about their actual lack of access**.**

In the following example provided by a participant who works with children diagnosed with "failure to thrive", the social worker focuses on the clients' lack of knowledge about nutritious food rather than the lack of access due to economic reasons.

> So, the reason that the kids are referred to us is their failure to thrive. Which means they fall below the 5th percentile for their weight, so they are off the growth charts - so that's how they get to us. That's the primary thing we're seeing. The problem is, people, people's knowledge and understanding of good nutrition, high calorie versus low calorie snack and people's access to it.

In addition to not always knowing which nutritious food to buy, clients also have a lack knowledge surrounding food preparation. A participant working in an urban, non-profit, multi-service agency primarily with adults and homelessness explained:

> But sometimes people are pretty uh, they have a lot of questions. They don't know how to make pasta and so we suggest certain dishes that they would like and that they, that are pretty easy for us to explain or teach them. And then we kind of see as we go to um, see what else they would be interested in.

Participants indicated that another important aspect of clients' lack of knowledge relating to nutritious food is that often clients are not familiar with a range of healthy food that they enjoy. Often, the nutritious food of which clients are aware does not appeal to them; many have not yet learned about nutritious food that would fit with their lifestyles and cultures.

The theme of social justice emerged as social workers pondered the reality of their clients not having access to nutritious food. A social worker in an urban, outpatient, multi-service agency working with children and families around trauma issues, illustrates the view that access to nutritious food is a human right.

> I think it's definitely related to health disparities. Um, inequality, oppression, um, racism, classism, um, uh, yeah, I mean having one's health is a human right. Um, and having, only having access to um, high calorie, high fat, um, you know, low nutritious food is, is, is an inequality. It's an aspect of um, uh, racist, classist society.

Lack of resources as a barrier: Social Workers. A majority of participants (N=9) reported that often their own lack of knowledge related to nutrition and food insecurity keeps them from addressing the issue with clients. One of the three remaining participants explained that she had extensive knowledge of nutrition because of her family background. The other two participants work in agencies where there is extensive focus on issues of nutrition with clients, and they obtained much of their knowledge through the agency. The participants who did cite their lack of knowledge as a barrier (N=9) also acknowledged that this was generally not an area that was covered in their training, either in school or in the agency. No pattern emerged regarding the relationship of this finding to participant identifying characteristics.

A 32 year old, White, female participant working in an urban, private non-profit, multi-service agency with individuals aged 16-24 who struggled with homelessness and LGTBQ issues, explained:

> Um, I mean beyond just, like you know, having access to food is a basic need and a starting place for many clients. I mean in terms of nutrition, I don't I feel like learned much about that in my education.

A 30 year old, White, female participant working in an urban non-profit, multi-service agency with children and families around issue of trauma explained, "And I really can't recall

nutrition being a major component or even a minor component of practice that we really learned about in school or that I've had the opportunity to for development in practice after school."

Four participants reported that addressing nutrition in their agencies was often carried out by a nutritionist or someone with specific training related to nutrition. The descriptive characteristics of these 4 participants varied: 2 worked in mental health agencies and the other 2 worked in multi-service agencies; their agencies were located in a mix of urban and suburban settings and they served a range of populations, from children to families to only adults.

A 29 year old, White, female participant working with families and children in a school in an urban and suburban setting, reported:

> I'm not sure that food and nutrition really ever came up in my specific social work training. Um, certainly, background of thinking about the various reasons why someone may be hungry, um, was in my training. Um, training to screen a number of different issues including a lack of economic resources. You know if someone doesn't have money, you could be asking questions about whether they have access to food. Um, so I'm not sure that in my clinical training there was anything specific. However, in one job that I had, the um, agency employed a nutritionist.

A 29 year old, White, male participant working in an urban, non-profit, multi-service agency with adults and issues of homelessness, spoke about the role of medical professionals in his agency as providing a lead-in to discussion of the issue of nutrition with clients.

> Um, and so, as it, typically the best way to kind of have dialogue around people's nutritional value is kind of around their physical health. So we have a nurse on our staff and a part-time primary care physician and so we are starting to realize that a lot of people we work with have high blood pressure and so it's a good kind of starting point to have, you know.

When training regarding food and nutrition issues was available, it was usually related to eating disorders or pathological issues. As reported by a 58 year old, White, female participant in an urban, private non-profit, mental health setting working with adults in a psychiatric setting:

"Well, in my actual MSW work, I would say none. Um, a lot of the training that I got around my eating disorders came in my post-graduate fellowship."

Few participants (N=3) spoke about their lack of knowledge in relation to the steps that workers can take to begin addressing the issue of food insecurity at the systemic level. Although all participants expressed the view that addressing food insecurity and nutrition should be an important part of social work, only 3 referred directly to change at the systemic level. No pattern emerged in the relationship of this finding to participant characteristics. This quote from a 37 year old, White, female in an urban, private for- profit, multi-service agency working with parents around "failure to thrive" issues illustrates the feeling that if she knew how to solve the problem of food insecurity at the systemic level, she would have the ability to help clients live with adequate resources as the wealthy do.

> It's a systematic issue, I can't go out and solve the problem or I'd be really the same as the rich. It's a huge issue that lots of people are working on as to how to make this problem systematically change. So when you kind of line everybody up with everything, it's kind of tough.

Connections within and between social work practice and food insecurity. A major category of participant response that surfaced in the analysis was "connections". In response to questions asking about their experience addressing food insecurity in their practice, participants spoke about connecting their clients to resources, connecting with their clients, and about the connection they see between food insecurity and social work. As the interviews progressed, participants increasingly expressed the realization that the resources they bring to the table affect their ability to connect with clients. The theme of connections was present throughout and manifested in powerful ways. Clinicians were interested in connecting their clients to resources;

as they thought about how to most effectively do this, they touched upon the importance of figuring out how to connect with clients in a meaningful way.

Connecting clients to resources. Several participants (N=5) focused on the need to meet their clients' most basic needs first. While there was a range in descriptive characteristics of participants who mentioned meeting clients' basic needs first, 4 of the 5 participants worked primarily with homeless populations. One participant who did not work with homeless populations worked with children in the school setting coming from low-income families. While these 5 participants often connected clients to food resources, it did not always mean connecting them to nutritious food. A 32 year old, White, female participant working in an urban, private non-profit, multi-service agency with individuals aged 16-24, struggling with homelessness and LGTBQ issues, explained:

> Yeah, I think we operate under the model of getting their basic needs satisfied first. So whether that's literally giving them lunch when they walk in the door or before they would come into a therapy session or you know getting stabilized with housing and other basic needs, including food before we would really start providing clinical services.

Most participants (N=8) reported facilitating client access to nutritional food when possible. There was no major difference in identifying characteristics among these 8 participants and the 4 who did not mention facilitating access to nutritional food when possible. Participants highlighted other resources to which they connect clients. In response to the question, "What are the most common issues you see when working with these populations?", a 37 year old, White, female working in an urban, private for- profit, multi-service agency with parents around "failure to thrive" issues stated:

> Well, access to food. Access to nutritional food. Um, structure in the home, around feeding and meals and sleeping. Structure in general. Knowledge and understanding of childhood development, um, access to resources such as you know, people's knowledge of food stamp programs . . .

While these 8 participants reported that it is necessary and helpful to connect clients to resources, they emphasized that their ability to connect with their clients through the development of a therapeutic alliance could make the difference in how open the clients were to utilizing the services that were provided.

***Connecting with clients*.** Few participants (N=3) emphasized the need to connect with clients. These participants acknowledged that there are reasons that it is sometimes more difficult to connect due to feelings of discomfort or shame related to food insecurity. The characteristic that all 3 participants share is that they work directly children or with parents regarding their children's health needs. Participants observed that children sometimes feel more comfortable talking about hunger than an adult would, which led them to mention that some adult clients have feelings of shame related to hunger and lack of access to nutritious food. Participants may first connect with clients around more general mental health issues in order to build a trusting relationship, and may subsequently bring up food insecurity as their relationship progresses. A 37 year old, White, female in an urban, private for- profit, multi-service agency working with parents around "failure to thrive" issues explained, **"**So, I think the first step for anyone is to know to ask. And to ask people these questions. It may be uncomfortable, but people don't necessarily ask people; that's why they don't know."

In addition to the discomfort that participants reported feeling when asking clients about food insecurity, they also were aware of cultural differences that need to be taken into account. The same participant as above stated:

> We touched on that because I think that is just difficult no matter what and you can't have one way to approach that obviously. Even if it's people from the same country. Actually, here's another piece I didn't say. Literacy, language, mental limitations, we have parents that are right on the border, they're MR, so how you address an issue that's

> complicated, how to thrive and this whole issue of feeding when you gotta be able to speak very concretely. Being able to assess for all those things and how you ask things, and how you present things. It's not just culture in the sense of what country someone is from and what language they speak - it's whether they read in their own language.

Participants (N=3) felt that although they know there is a wide range of factors that need to be addressed when connecting with clients, it can be a challenge to know the best way to do so. Some participants (N=3) felt that connecting with clients, as well as their colleagues, around issues related to food insecurity could be difficult because of differences in definitions of food security. No differences were found based on participant identifying characteristics.

> I think there's a price and that's person to person, that's cultural, that's everything. People not wanting to say. Then you have the barrier of people, like I said before. Their definition of having enough food versus ours. Their definition of nutritional food and having adequate food for an entire duration of a month versus ours and what the research shows, you know as nutritional food.

The difference between clinician and client definitions of access to sufficient and/or nutritious food may pose a barrier to clinicians' ability to connect with clients. This issue will be further discussed under the theme of differences.

Participants who felt confident about their ability to connect with clients around issues of food insecurity reported that meeting clients where they are is crucial. A 35 year old, African American, female in an urban, hospital setting focused on mental health issues with families explained how she addresses food insecurity when it comes up in her work with clients. She explains that an unfamiliar nutritious option might not appeal to a client right away, but that having a variety of options is the first step in meeting clients where they are:

> And the whole meeting clients where they are and letting them get some more help. Recognizing that having something that looks absolutely foreign to them might not, they might now be for it right away, but having a mix of different healthy versus not as healthy options. So, that was a big deal for us.

Another participant told a story about creatively connecting with and meeting clients

where they are, in addressing food and nutritional needs. She talked about working at a program providing a place for homeless youth to come to in the evenings to socialize. The agency held "theme nights" where they would serve all orange food. She reported that they served Doritos and then slowly introduced oranges and carrots. She explained that using this method, the kids ate the nutritious food as frequently as they ate the less healthy options.

Connecting food insecurity and social work. Another theme within the general category of "connections" emerged in the context of participant response to questions about their experience and understanding of the link between social work and food insecurity. Additionally, participants were provoked by the question asking them to discuss how food insecurity and social work are related. For some participants, the interview was the first time they had formulated an answer to this question. For others, social justice was the immediate response to explain the connection between food insecurity and social work. Participants commonly expressed the feeling that they could not begin clinical work without meeting clients' basic needs first. A 29 year old, White, male participant in an urban, non-profit, multi-service agency working with homeless adults on housing and mental health issues explained:

> And I think also with clients, there's the, we kind of triage. We work in a harm reduction model and we have to address the most immediate needs and if somebody is you know, actively using heroin, and is at risk of losing their apartment we kind of try to address some of that stuff before we address nutrition.

Participants often defined food insecurity as hunger during this part of the conversation which led them to focus on obtaining food for clients without necessarily prioritizing nutritious food.

> I mean, we would certainly give them therapy sooner than that. But usually, it is not very effective if we haven't gotten sort of the basic needs take care of. I also think it's not really a part of the discourse or a priority, um, what healthy options are.

Another participant focused on how food insecurity causes other problems in clients' lives. "If you don't have your basic needs met, which is enough to eat, all the other stuff is just exacerbated." Participants spoke about their sense that thinking about lack of nutrition in terms of clinical work is new on the radar and that people are just beginning to figure out how to incorporate nutrition consistently in their clinical work. The following quote illustrates that for one participant, the connection between food insecurity and social work practice is located within the profession's emphasis on social justice.

> Well, it's about the human spirit, about empowering someone. It's about making someone feel whole and complete. You know. We're about empowering and social justice. It's not fair that if you're living in the suburbs eating nutritious meals. And then on the other hand if you are in the inner city and unable to afford food and access to it. It's a matter of social justice.

Participants acknowledged the systemic issues that lead to food insecurity and believe that social work has the duty to address these systemic injustices.

Differences. The theme of differences emerged from analysis of participant responses to the question about how they define food insecurity, whether this issue, as defined by the researcher, had ever entered their practice, and, if so, what their response and the response of their clients had been to discussion of this issue. More than half of participants (N=7) did not have an understanding of the term before the interview, but other participants had an understanding of the term that focused more on hunger than on nutrition. There were no differences found based on identifying participant characteristics. One participant reported that she thought the interview would be asking about her own food insecurity, rather than her clients'. Participants differed in their understanding of the term food insecurity - from one another, from the researcher, and from their report of clients' understanding of the term. The theme of

differences further appeared when the participants spoke about their experience addressing food insecurity with clients.

Differences in definitions of food insecurity. Discussing food insecurity with participants required being explicit about the definition. The researcher asked each participant what their understanding of the term was and introduced a definition of the term. Some participants included lack of access to nutritious food in their definition of food insecurity, but most defined it as lack of access to food or hunger. Additionally, there were some participants who had not heard of the term until learning of the study and seeing the term defined in the recruitment material. Even with the researcher's definition presented as the definition to use while responding to questions about their experience with the issue in practice, occasionally participants (N=3) strayed back to their definition and left access to nutritious food out of their response. But the majority of participants (N=9) did respond to the questions using lack of access to nutritious food as their definition of food insecurity. No differences were found based on identifying descriptive characteristics.

A few participants (N=3) pointed out that clients' definitions are often different from that of social workers. In addition to the differences among social workers in the definition of terms, there was little consensus between clinicians and the populations with whom they work regarding the definition of food insecurity or the meaning of "healthy eating" and its overall significance in one's own life or the live of members of one's family or community. Participants lamented the way these differences affected their ability to work with clients. A 37 year old, White, female working in an urban, private for- profit, multi-service agency with parents around "failure to thrive" issues explained:

> So, I wonder if we miss people for those two reasons. And, obviously it's a pride thing, the only thing is like you said in your definition. Some people have enough food to get through the month but that last week or two is bottom of the barrel as far as process and the corner store. Ramen noodles and everything else. Not actual access to nutritional food to last through the month.

A 35 year old, African American, female in an urban, hospital setting focused on mental health issues with families explained that she doesn't think that clients are even familiar with possible alternatives to their patterns of accessing food.

> With that being what the definition is where you're coming from. Because unfortunately the families that I work with are not even in touch with the fact that they don't have access - it's just their way of life. Insecurity is a very, I think internal process to me.

This quote further highlights the theme of differences that runs throughout the interviews: in this case, the participant interpreted the definition philosophically as well as concretely.

The themes discussed demonstrate the commonalities as well as the nuanced differences among participant reports of their encounters, experience, understanding of, and responses to food insecurity in social work. The following chapter will discuss the implications of study findings for social work practice, policy and research.

Chapter V

Discussion

The purpose of this study is to explore the role of food insecurity and nutrition in clinical social work practice. The study focus was on social workers' encounters, experiences, understandings, and responses to food insecurity in social work practice.

Participants' responses fell into three main thematic areas related to how food insecurity is encountered, experienced, understood, and responded to in social work practice: barriers, connections, and differences. The theme of barriers refers to participants' report of barriers to addressing the issue of food insecurity in social work practice. Within the theme of barriers, the major subthemes are lack of resources of the agency, the client, and the social worker. The theme of connections refers to a range of activities carried out by participants in their efforts to address the issue of food insecurity in their practice. Additionally, within the theme of connections, several subthemes were identified: connecting clients to resources, connecting with clients, and the connection social workers make between food insecurity and social work practice. This connection is broken down into clinical connections and broader, more general connections that social workers make between social work and food insecurity. Lastly, the theme of differences refers to the differences in defining and experiencing food insecurity in social work practice. The theme of differences revealed itself as participants discussed their definitions of food insecurity and compared those definitions to the one provided by the researcher and those of their clients.

All participants reported that lack of agency resources was a barrier to addressing food insecurity with their clients. They also reported that their own lack of knowledge related to food insecurity and nutrition was a barrier in adequately addressing clients' issues of food insecurity. The feeling of the participants was that, in general, clients also lacked resources to meet their food and nutrition needs; this finding was given further expression within the theme of "connections". Participants highly valued their ability to connect clients with resources and to connect with the clients. They presented with passion the connections between social work and food insecurity as being an issue of social justice. They explained how their knowledge and skills as social workers helped or hindered their ability to connect clients to resources and to connect meaningfully with clients.

Underscoring the theme of "differences" was the feeling expressed by participants that often clients have a different understanding of food insecurity from that of social workers. Several participants felt that cultural differences underlay the differences in definitions of food insecurity between clients and social workers and that these differences affected their ability to connect with clients and to address the issue of food insecurity. A social worker may define a certain client as living with food insecurity, whereas the client may consider their lack of access to nutritious food to be a normal part of their life.

The themes of barriers, connections and differences speak to overarching issues in the area of food insecurity and social work practice. Some of these issues confirm what has been addressed previously in the literature on food insecurity; others represent new areas of consideration, elucidated through exploratory study. These issues include: the role of poverty and lack of resources; cultural issues; vulnerable populations; addressing food security at the individual level; and incorporating access to nutritious food in the definition of food insecurity.

The responses of participants regarding their experience with content on food insecurity and nutrition in their agency training and formal education, confirmed the expectations of the researcher, based on her own experience in a school of social work and in various agency settings and community organizations. I was impressed with the rich narratives and complex analyses participants had about food insecurity. Despite their feelings that they were not adequately addressing the issue with clients, their passion that food insecurity and nutrition are social justice issues that social workers need to address more fully, shone through.

Poverty and lack of resources

The literature review established that poverty is noted as the overwhelming barrier to food security (Holben, 2010) and that rates of food insecurity have increased from 11% of U.S. families in 2007 to nearly 15% in 2008 (Belsky, 2010). This study's findings suggest that social workers view lack of resources as the main barrier to addressing the issue of food insecurity with clients. While a small number of participants actually used the words "poverty", "poor", or "low-income", the majority of the participants discussed clients' lack of resources - in addition to their agency's lack of resources - as well as their own lack of resources as social workers.

This study looked in greater depth at the barriers social workers may perceive in addressing food insecurity by interviewing participants with direct experience in a helping profession. The participants' responses are consistent with the literature, but broaden our understanding of the connection between poverty and food insecurity in creating a more complete picture of the role of food insecurity and nutrition in social work practice. It is striking that the lack of resources available in agencies and to social workers is as much a part of the barrier as clients' own lack of resources.

The literature reports that while there are policy interventions and programs designed to address food insecurity, these methods have not been sufficient as the sole, or major, approaches to eliminating food insecurity (Chilton & Rose, 2009). These methods did not address food insecurity at its root cause: poverty. The study participants agree that lack of financial resources is a major barrier, but also reported that lack of knowledge on the part of helping professionals and infrastructure are significant barriers as well. Infrastructure refers to lack of resources at the agency level; for example, one participant explained that her agency does not have a full kitchen, which makes it harder to prepare nutritious meals for clients. Some participants reported that their own lack of knowledge related to nutrition made it difficult to adequately address the issue with clients. The literature focused on food insecurity but did not focus on clients' lack of information related to acquiring and eating nutritious food.

Cultural issues

While the literature supports the connection between good nutrition and mental health, it does not discuss barriers to good nutrition beyond financial barriers. This study identifies additional barriers to food security such as the lack of knowledge of both social workers and clients and also addresses issues that may arise in the context of the therapeutic relationship that act as barriers.

Participants reported that food is an important part of their clients' cultures and that practitioner efforts to address food insecurity with clients must be culturally appropriate to be effective. They reported that they must be able to suggest nutritious food that is a familiar part of the client's culture and that it helps to explain the physical health benefits, in addition to the mental health benefits. They also reported that emotional content between client and social worker can make it difficult to bring up the issue of food insecurity. If clients are hungry, in

addition to not having access to nutritious food, they may be ashamed to mention it to a social worker with whom they are meeting about a non-related topic. Additionally, the participants mentioned that they are not always sure how to bring up the topic or to make sure that they are defining the concept in the same way as the client. While these barriers may be mitigated more easily than financial barriers, they are barriers that should be considered when developing a plan to adequately address food insecurity.

Vulnerable populations

The study was consistent with the literature that attributes the highest level of risk for experiencing food security to vulnerable populations. This finding underlines poverty as the root cause of food insecurity. Vulnerable populations are also at greatest risk due to their lack of resources, whether financial or educational. Participants related stories of parents going hungry and eating the cheapest food they could find, low in nutritional value, in order to have money to provide food for their children. In many of these cases, the parents were not able to afford nutritious food, nor were they aware of the negative impact that unhealthy food could have on their own and their children's health. Participants also reported a high level of food insecurity among the homeless population, consistent with the literature. Interestingly, no participants discussed the impact of food insecurity on the elderly, despite the literature reporting that it is a major population that struggles with this issue. The lack of reference to the elderly might be due to the nature of the caseloads in participants' agencies; it may also speak to a segmentalization of services to the elderly, such that this population, and the issues and challenges they face, may be "invisible" to social workers practicing in a range of settings.

Food insecurity as an individual issue

The study is consistent with the literature in that the participants reported addressing food insecurity on an individual level, if at all, rather than on a policy or structural level. It is likely that the lack of knowledge of social workers and clients regarding how to effectively address food insecurity exists widely throughout the social service arena. As confirmed in this study's findings, social workers and clients do not feel adequately equipped to address food insecurity even at the individual level, much less at the structural level.

Recognizing access to nutritious food as a component of food insecurity

It is important to note that the literature indicates that social workers, in general, think about food insecurity mainly in terms of hunger. Furthermore, the literature that discusses social workers' relationship to food insecurity does not define food insecurity in terms of lack of access to nutritionally adequate food. It is helpful that attention is being drawn to the profession's neglect of the issue of hunger as a social justice issue, the root causes of which need to be addressed; however, there is danger in the profession's practice of obscuring the lack of access to nutrition as a major component of the definition of food insecurity. It is possible that the presence of hunger in the definitions and the tendency to refer back to hunger speaks to the shocking nature of the issue of hunger as well as its presence in a wealthy and developed country. While the study focused on a lack of access to nutritious food in social work, it is significant that hunger was such a present part of the conversation. This is likely due to social workers primarily working with oppressed populations who are less likely to have access to affordable nutritious food due to poverty.

The absence of focus on access to nutrition among participants was further illustrated by participants' lack of knowledge and/or familiarity with either the term or the concept of food

deserts. While all participants were familiar client experiences of hunger, only those whose work specifically focused on issues of nutrition with clients had heard of the term "food desert". This finding is likely related to the fact that the literature addressing the concept of food deserts falls outside that of the profession. A lack of understanding of this concept, and the meaning it has in the lives of their clients, and for the communities in which clients reside, presents a major barrier to social workers' informed use of this issue in practice, including in the area of client assessment.

Strengths and Limitations

This study's main area of strength lies in the depth of the responses it produced related to food insecurity. The methodology allowed the participants to cover a range of information related to the concept of food insecurity and nutrition in social work. The findings thus add substantially to the current knowledge base within the field of social work on issues of food insecurity and nutrition and their use in practice. All interviews were conducted in a consistent manner by using the questions included in the study instrument (Appendix B) as a guide. In order to elicit the subjective experience of participants, as well as information that I may not have predicted would be forthcoming, probes were used selectively.

The small sample size limits the extent to which study findings can be generalized to a broader clinical social work population. While diverse in client population served and agency type, the sample was not as diverse in the area of gender and race/ethnicity. Further, the use of a non-probability sampling method resulted in participants self-selecting for the study based on their interest in or knowledge of the topic study. Finally, it is also possible that the researcher's biases and interest in the topic came through in tone of voice or facial expressions in the participant interviews.

Implications

This study has implications in the area of social work practice, education, policy, and research. This section will address each area. The social justice framework is used as a lens through which to consider implications for practice. This study is an important step in helping social work as a profession reconnect to its mission of promoting social justice. Utilizing the lens of a social justice framework, food security is seen as a right for which social workers should strive. The social justice framework insists that social workers work for social justice at every level; this requires addressing the issue of food insecurity and nutrition on the individual and group level, as well as on the community and policy level.

Social Work Practice and Education. While participants indicated that they believe food security to be a social justice issue, they also indicated feeling unable to adequately address the issue with clients. This finding suggests that social workers may not be thinking about what they can do about this issue at the systemic level; rather, they are thinking about how they can interact with their clients around the issue of food insecurity in a way that validates and empowers clients.

One barrier that should be addressed is the difference in definitions of food insecurity among social workers as well as between social workers and clients. This barrier should be addressed by educating social workers about the connection between mental health and nutrition and about food insecurity defined as lack of access to nutritious food. Additionally, the difference in definitions can be addressed by raising the public's awareness of a nutritious diet. This awareness could also result from changes in government policy and public institutions at the community level, such as schools. As social workers and clients gain knowledge, it is likely that their definitions will intersect, covering common ground. Participants used the definition of food

insecurity as lack of access to nutritious food and the definition of food insecurity as hunger interchangeably, indicating that these two concepts are interconnected and cannot be discussed separately. It is important to consider how concepts of power and culture are related to nutrition in the experiences of people in this society and throughout the world. What is perceived as "lack of interest" in healthy eating may in fact be a reflection of lack of access to the means and resources required to live a food secure life, rather than actual lack of interest. While participants' complete lack of familiarity with the term "food desert" was somewhat unexpected, it was less surprising that most participants failed to include "access to nutritious food" as part of the definition of food insecurity.

The failure on the part of practitioners to incorporate access to nutrition as part of the definition speaks to issues in social work education. And the differences between client and social worker definitions speak to issues in practice as well as in education. This study demonstrates the need and benefit of including more content related to food insecurity and its meaning in practice within the area of cultural competency in social work education and in social work organizations. Concepts of power, privilege, and culture should be part of the cultural competency work around issues related to food insecurity.

Additionally, the social justice framework encourages social workers to think about helping clients meet their nutritional needs in a broader way. Social workers who are able to effectively work with clients to decrease emotional or cultural barriers to eating nutritious food are able to do this by engaging in a culturally competent practice. They are able to respect a client's culture and level of education related to healthy eating while also introducing new ways of eating that would improve the client's mental and physical health. Improvements in mental health, as it relates to access to nutrition, could be realized in several ways. First, there is the

level of health that is discussed in the literature: that people feel better psychologically when they eat nutritious food. Next, there is the emotional aspect of food that can be considered. Not having enough food can take a negative emotional toll on client, but eating unhealthy food that has comforting associations can have a short-term, or fleeting positive emotional effect, even if unhealthy food ultimately has a negative effect on psychological health. As one participant stated: "With that being what the definition is where you're coming from. Because unfortunately the families that I work with are not even in touch with the fact that they don't have access - it's just their way of life. Insecurity is a very, I think internal process to me." This highlights the theme of differences that runs throughout the interviews. This participant interpreted the definition philosophically as well as concretely. Social workers need to consider the internal process of clients regarding issues of healthy eating and access to nutritious food. An important step is the introduction of the concept of food insecurity, defined as lack of access to healthy food, in the curriculum. Additionally, social work education should emphasize the need for workers to move away from a perspective that blames the victim with regard to healthy eating by considering the systemic causes of food insecurity.

Social Work Policy. The social justice framework encourages social workers to embrace new ways of thinking about and addressing food insecurity at every level. While social workers need to continue to work with clients individually around the issue of food insecurity, they also need to learn how to address the problem of food insecurity at the structural level. While lack of resources is an issue when addressing food insecurity in social work, it is worth considering the idea as reported by a participant who personally works to achieve food insecurity with her own family, and who did not mention lack of financial resources as being a significant barrier:

> A lot of people have this myth that it costs more to eat healthy, than it does to not eat healthy. In the end, the reality depends on what you do buy, you know. Beans and rice is pretty cheap, that's a pretty healthy protein, so it depends on really what you put your money towards.

While it is beyond the scope of this study to look at the influence of societal and cultural norms on our perception of the affordability and accessibility of nutritious food, it is worth thinking creatively about how we can increase access to affordable nutritious food. Perhaps social workers can embrace new ideas that increase access to nutritious food such as community supported agriculture farm shares (CSAs) and encourage clients to join community gardens. Additionally, social workers can commit to work for food security at the policy and structural levels by lobbying for policy changes with clients who are most affected by the issue, and in forming other community organizing campaigns in communities where there are food deserts and a clear need for increased food security.

Social Work Research. The study demonstrates that more research needs to be done within the field of social work on food insecurity to address the best ways to incorporate nutrition into social work practice. Additional research will answer questions about how to eliminate the barriers to addressing food insecurity that were raised from the findings of this study. While there is useful research in other fields that shed light on the experience of food insecurity in this country, social workers' voices are largely absent from that research and importantly, clients voices are also absent from the field as a whole. Most of the sample in this study works in non-profits. This may speak to the decreasing clinical opportunities for MSWs in the public sector and the need to use methods other than the snowball method to recruit from this sector. The fact that most of the participants work in non-profits may also speak to the lack of resources focusing on nutrition in public sector work. Further exploratory study with social

workers in public sector settings would be useful to learn whether they differ than their peers doing work in non-profits. In order for food insecurity to be eliminated, the public sector needs to be addressing the issue because of its far-reaching impacts on the client population most affected. Additionally, further research is needed to explore the various types of work that social workers in non-clinical settings might be doing; this type of study would add to our understanding of the role that all social workers can play at the structural level to bring about change. It is clear that other overwhelming needs of clients may tend to push the issue of nutrition to the background. Further study is needed on the ways in which social workers balance addressing crises with attention to nutrition; such study will add to our understanding of the types of services needed to help clients gain skills and knowledge to adequately address their mental health needs.

Conclusion

This study has illuminated the gap in the field of social work on the topic of food insecurity and nutrition, as well as the need for further education and training for social workers on this topic. Study participants spoke passionately about the importance of food insecurity and nutrition in the lives of clients. They connected the issues to social work through the obligation social workers have to address social justice issues as well as through helping clients achieve their mental health goals. While certain gaps in the social work knowledge base on this topic were highlighted in this study, the connection between food insecurity, nutrition, and mental health as integral to the profession's commitment to social justice, was readily expressed by all participants. Furthering social workers' knowledge of food insecurity is a first step in supporting the role of the profession in addressing this important and rapidly evolving area of social need.

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Appendix A

Informed Consent Form

Dear Participant,

My name is Katherine Paul and I am a master's student at Smith College School for Social Work pursuing research on food insecurity and social work for my master's thesis. I will be exploring how clinical social workers encounter, experience, understand, and respond to food insecurity in their social work practice. Food insecurity is defined as hunger and/or lack of access to nutritious food. The study findings will be disseminated publicly to the Smith community and may be used in published materials and other presentations.

You are participating in this study because you are an MSW providing direct and/or mental health services and have some experience with the issue of food insecurity in your practice as a social worker. As a study participant, you will be interviewed by me either in person, by telephone, or via Skype for approximately one hour. The questions will focus on food insecurity in social work practice and clinicians' varied experiences with food insecurity in the clinical relationship. Interviews may take place in-person or via telephone or Skype. In-person interviews will be held in mutually agreed-upon locations that are private and convenient for participants. I will use audiotape to record our conversations. These recordings will be kept in a secure and locked compartment and separate from your consent form and other identifying information. I will be the only one transcribing the recordings.

There is minimal risk involved in this study.

There will be benefits to your participation, including the opportunity to reflect on an important and understudied area of practice. By participating in this study, you will also be contributing to social workers' knowledge about food insecurity and nutrition as related to mental health services. Such increased knowledge may be useful in supporting enhanced access to nutritious food and improved mental health. Compensation will not be provided for participation in this study.

The data collected for this research will be confidential. Names and other identifying information will be stored separately from the data. Each participant's interview will be assigned a number code and during transcription all identifying information will be removed. In addition to me, my thesis advisor will have access to this data. However, my thesis advisor will not see the data until all identifying information has been removed. Should you withdraw from the study, all materials relating to you will be immediately destroyed.

In the thesis and in presentations or publication, no identifying information will be used. If brief narratives, vignettes, or quoted material from the interview are used in any presentation or publication, these will be carefully disguised. All notes, transcripts, and electronically recorded data will be kept in a locked, secure location for a period of three years as required by

Federal guidelines. Should the data be needed beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed.

Your participation in this study is entirely voluntary and you may withdraw at any time during the interview and may refuse to answer any question. If you wish to withdraw from the study you must notify the researcher in writing by April 1st, 2011. Upon withdrawal all materials pertaining to your interview as well as any identifying information will be immediately destroyed. If you have not withdrawn from the study by April 1st, 2011, your answers will be a permanent part of this study. You may contact me at xxx-xxx-xxxx in order to withdraw or if there are additional questions. If you have any concerns about your rights or about any aspect of the study, please call me at xxx-xxx-xxxx or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

_____	_____	_____	_____
Participant signature	Date	Researcher signature	Date

Katherine Paul
XXX Elm Street, Apt. XX
Northampton, MA 01060

Participant should keep a copy of this form for records as it has been provided.

Thank you for your participation in this study.

Appendix B

Interview Guide

First, I would like to gather some demographic information. Please list your gender, age, and race.

Second, I would like to know a little bit about your practice in general. How would you characterize the setting of your agency? For example, would you characterize it as rural, urban or suburban, or in some other way?

Is your agency public; private non-profit; private, for profit, or another type?

How would you characterize the size of your agency – for example, approximately how many workers are employed at your agency?

What would you say is your agency's main or overall focus – e.g., is it only mental health services, or is it a multi-service agency?

Are services provided to families, or only to individuals such as children/adolescents, adults, or seniors?,

What are the main populations you work with and what are the most common issues you see when working with these populations?

Next, I would like to learn about your experience with food and nutrition in your practice.

For example, how or in what contexts have these issues come up, and with which populations or presenting problems?

What experience do you have learning about food and nutrition in your social work training?

The next set of questions are related to the concept of food insecurity – your understanding of the term. I will also share a definition, but first I would like to hear from you. There is no right or wrong answer; I am interested in learning more about clinical social workers' understanding of what is a relatively new term.

Have you heard of the term food insecurity? If so, what is your understanding of the term food insecurity?

For the purpose of this study, I define food insecurity in terms of lack of access to nutritious food. There are urban and rural neighborhoods where there are few grocery stores and residents are forced to travel long distances to obtain nutritious food. Often the cost of nutritious food and distance required to purchase it are prohibitive for residents leading to areas termed food deserts which are described as food insecure areas.

Has food insecurity, defined in this way, entered your social work practice? [If yes]: How so? What has been your response and the response of the client(s) to discussion of this issue? [If no]: How or in what circumstances would you see it entering your social work practice? What would you think might be your response?

What do you see as barriers to addressing food insecurity as part of your clinical practice?

How do you see the issue of food insecurity as being related to social work practice in general?

Have you encountered the issue of food security in contexts other than clinical social work? How so?

How has food insecurity impacted your practice as a clinician?

Do you have anything else on this topic that has not been covered that you would like to add?

Thank you for your participation in my research study.

Appendix C:

Recruitment for Organizational/Agency Membership

Are you a social worker with a Master's degree?

Do you provide direct and/or mental health services to clients?

Has the issue of food insecurity* come up in your practice?

*Food insecurity is defined as hunger and/or lack of access to nutritious food.

If you answered "yes" to all of the above questions, you may be eligible to participate in a 1-hour interview on food insecurity in clinical social work practice.

Before March 15, call or email Katherine Paul at xxx-xxx-xxxx or kpaul@smith.edu.

Appendix D

Recruitment e-mail

Hello,

I am contacting practicing social workers for a study that I am conducting for my thesis in partial completion of a master's degree in social work at Smith College School for Social Work. I am studying social workers' experiences with food insecurity in the clinical relationship and am looking for 12 -15 participants. Study participation would include an in-person or telephone/Skype interview lasting for approximately 1 hour. Participants must meet the following criteria: social worker with a master's degree in social work (MSW); currently providing direct and/or mental health services in any setting; and some experience with the issue of food insecurity in their practice. Food insecurity is defined as hunger and/or lack of access to nutritious food.

In addition to learning of your interest in participating, I am requesting that you forward this email to other social workers who meet the study criteria so that I am able to recruit an adequate number of participants for the study. I am particularly interested in interviewing social workers who work in settings serving a diverse population.

Please respond to kpaul@smith.edu if you would be willing to participate in this study. Please list a telephone number and e-mail where you can be contacted.

Please respond by March 15. I may be reached by email or phone at:

Katherine Paul
xxxxxxxxxxxx@gmail.com, kpaul@smith.edu
xxx-xxx-xxxx

Thank you for your consideration,
Katherine Paul

Appendix E

Screening Questions

Hello. Thank you for your interest in participating in this study. Before going further, I would like to ask you a few questions to ensure that you meet the inclusion criteria for my study.

Do you have a master's degree in social work?

Do you work providing direct service or mental health service?

Do you have experience in your practice with the issue of food insecurity, defined as hunger and/or lack of access to nutritious food?

(If answer is "yes" to all) Thank you. You meet all of the inclusion criteria. We can now arrange a time for an interview, after you have signed and returned an informed consent form.

I am able to interview participants who live within 25 miles of Northampton, Massachusetts in person. I can also interview participants by telephone or Skype. Which mode of interview would you prefer?

(If any answer is "no") I'm sorry. You do not meet all of the criteria for inclusion in the study. Thank you very much for your time and interest in this study.

Appendix F

HSR Letter of Approval

SMITH COLLEGE
School for
Social Work

[illegible]

February 1, 2011

Katherine Paul

Dear Katherine,

I am glad that you found our suggestions helpful. Your revisions have been reviewed and they are fine. We are happy to give final approval to your study. I will be curious to know if many social workers are really thinking about this very important issue. It is awful to know that in this wealthy country, many people are hungry and one in five children is living in poverty.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable.

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion. You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Beth Lewis, Research Advisor

Appendix G

Revised Recruitment e-mail

Hello,

I am contacting practicing social workers for a study that I am conducting for my thesis in partial completion of a master's degree in social work at Smith College School for Social Work. I am studying social workers' experiences with food insecurity in the clinical relationship and am looking for 12 -15 participants. Food insecurity is defined as hunger and/or lack of access to nutritious food.

Study participation would include an in-person or telephone/Skype interview lasting for approximately 1 hour. Participants must meet the following criteria: social worker with a master's degree in social work (MSW); currently providing direct and/or mental health services in any setting; and some experience with the issue of food insecurity in their practice. *Experience could include work that directly addresses this issue and/or knowledge of food insecurity as part of a client's situation, even when it is not the presenting concern or major focus of work with the client.*

In addition to learning of your interest in participating, I am requesting that you forward this email to other social workers who meet the study criteria so that I am able to recruit an adequate number of participants for the study. I am particularly interested in interviewing social workers who work in settings serving a diverse population.

Please respond to kpaul@smith.edu if you would be willing to participate in this study. Please list a telephone number and e-mail where you can be contacted.

Please respond by March 15. I may be reached by email or phone at:

Katherine Paul
xxxxxxxxxx@gmail.com, kpaul@smith.edu
xxx-xxx-xxxx