Foodservice for the Homeless: An Innovative Approach

Jane Broughton, M S R D
Consulting Nutritionist, Food Coordinator, Community Shelter, Chicago, IL

This article first appeared in Brief Communication, December 1987, Volume 87, Number 12, Journal of the American Dietetic Association
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The homeless situation attracted new attention in the early 1980s. Hardships have been imposed by the worst economic recession since the 1930s and by significant cuts in national welfare programs (1). America’s homeless population is estimated to be as high as 3 million persons. Chicago has an estimated 12,000 to 25,000 homeless persons and 1,100 shelter beds. In cities across the country, people search garbage cans for food, a visible sign of the hunger that accompanies homelessness (2).

The Physician Task Force on Hunger in America (3) stated that hunger in the United States was more widespread in 1985 than at any time in the previous 10 to 15 years. Chicago reported a nine-fold increase in the demand for emergency food between 1981 and 1983. The number of soup kitchens in Chicago jumped more than 80% from 1983 to 1985. The Greater Chicago Food Depository (a Second Harvest Food Bank) distributed 400% more food in 1985 than in 1983. (3) Chicago’s population decreased from 3,369,357 in 1970 to 3,005,072 in 1980, a reduction of 364,285 (4). The mounting evidence of increase in hunger coupled with a decrease in population indicates a sharp increase in the percentage of those who are hungry. According to the Physician Task Force on Hunger in America, (3) “poverty in the country is at the highest rate in 20 years. and the purchasing power for the poorest 40% of the population is lower than it was in 1980.” The Chicago Coalition for the Homeless did a pilot survey among the homeless in 1983 and found that 44% reported eating once a day or less. The survey found that soup kitchens and shelters are the most important sources of food for Chicago’s homeless (5). Another article about the same survey showed that 38% saw a doctor only for the treatment of emergencies. (2)

The homeless have an increased incidence of morbidity and a disproportionate need for emergency medical care. (6,7) Their chronic illnesses include hypertension, arteriosclerotic cardiovascular disease, chronic obstructive pulmonary disease, diabetes, and alcoholism. (7) Infection, very common in the homeless, could be a complication of, or at least aggravated by poor nutritional status. A high caloric intake is needed to ward off infections, although nutrient imbalance is even more critical than low caloric intake. Alcoholism may induce nutritional deficiencies. Many of the homeless are on drugs (psychotropic drugs, street drugs, or medications for particular illnesses) that interact with food to cause deficiencies. (7)

Solutions to the growing problem include emergency feeding stations and pantries and Second Harvest food banks and clearinghouse/distributors. (8) Mobile soup kitchens or sandwich trucks are popular in some areas with a large homeless population. Community volunteers can donate prepared casseroles for certain types of foodservice. (9) Dietitians need to assist in alleviating the hunger of the homeless.
Shelter Survey

Telephone calls were made to the 51 shelter providers listed in the Chicago Coalition for the Homeless handbook. The purpose of the survey was to determine whether the shelters served food and to obtain details of the foodservice or type of operation, problems encountered, use of donated food, and food funding. All but one of the shelters served some food. Most food was cooked on the premises, but some was cooked and brought into the shelter. Four centers employed a registered dietitian to assist in meal planning. Centers did not mention volunteer services by registered dietitians other than the author. Problems observed by the respondents were obtaining fresh items like produce, fresh meats, dairy products, eggs, and condiments and spices to make foods appealing: inadequate storage and cooking facilities; picking up donated foods from USDA commodities and the Greater Chicago Food Depository; and obtaining funds from the Federal Emergency Management Agency (FEMA) and private donors. Shelters obtained funds for food by sponsoring food drives and fund-raising events with churches and through private donors and organizations.

Initiation and evaluation of a foodservice

The author initiated and evaluated a foodservice in an overnight community shelter. She developed a plan that met nutritional criteria of one-third to one-half the Recommended Dietary Allowances for adult men. For emergency use, she organized a package of non-perishable food that did not need to be cooked. (Contents of the package are canned fruit juices, tuna and potted meat in pull-top cans 13 ½ oz. crackers, canned fruits. canned tomato juice, and hot chocolate [a mix plus nonfat dry milk, to which hot water can be added].) However, the shelter guests much preferred hot food.

Guidelines gave directions for preparing, bringing to the shelter, and serving a nutritious one-dish meal for 25 persons. The guidelines were posted next to a volunteer sign-up sheet in the shelter. One person or a group volunteered to bring food each night from November through April, the coldest season in Chicago.

Ninety-one volunteers served 3,500 hot meals during the 6-month season. To complete the nutritional quality of the foodservice, orange juice was served for breakfast and hot chocolate was served for dinner and for breakfast. The shelter purchased those items, along with the non-perishable foodstuffs for the emergency packages.

A follow-up questionnaire was sent to 35 of the food volunteers. Fifteen of the volunteers returned the questionnaires and donated their recipes. Questions concerned the volunteers’ understanding of the nutrition guidelines: the acceptability of the food to the shelter guests, problems in preparing, bringing, or serving the food; and what the volunteers had learned by preparing and serving the food to the guests.
The recipes they donated showed that the volunteers understood the hot food guidelines. Volunteers most often brought beef stew with vegetables, spaghetti, and chili to the shelter. An extensive variety of stews, soups, and casseroles was served. Bread and soft fruits or desserts often and salads occasionally accompanied the entrees. Guests generally liked the food very well, often gave it rave reviews, and went back for second or third helpings when food was available. A variety of textures appealed if the food was not difficult to chew. Many of the guests had poor dentition. The guests appreciated spicy, flavorful foods, commented when the food was not spicy or salty enough, and added salt in large quantities.

Problems most often cited in preparing, transporting, and serving food were lack of large pots in which to cook for a large group, carrying and transporting the pots while they were hot, estimating the amounts of food needed, and serving the food late at night. However awkward, 91 volunteers found the project to be workable. Approximately 75% of the volunteers cooked one time only, though several cooked more than once. Many volunteers found this foodservice to be a way for them to have some impact on the homeless situation. Volunteers learned that the guests like simple “home cooking, and plain, old-fashioned, and filling foods. Guests welcomed breads with butter and preferred soft fruits to sweet desserts. The guests liked items that they could carry away with them, such as raisins, soft fruits, and boiled eggs.

Even though many of the guests were probably hypertensive, salt restriction would be difficult to impose on these rather independent-thinking persons. Priority was given to adequate calorie and nutrient consumption.

The food coordinator (the author) set up the nutritional criteria, coordinated the food volunteers, purchased the non-perishable foods, and prepared the hot chocolate mix with nonfat dry milk. The food purchasing and preparing of the hot chocolate mix will become part of the shelter coordinator’s job description.

Guidance is essential in several areas. The food volunteer needs help to know what to prepare and when to bring the food. Shelter coordinators need instructions on stocking and purchasing the non-perishable, non-cooking food. Shelter board members need a food budget and established nutrition criteria for use in planning.

Having cooked food brought in was the only feasible approach to foodservice for this shelter. Since the shelter was located in a community with many single, professional people, late night foodservice was workable. Other shelters may give consideration to this cost-effective method for meal planning. Volunteers involved in shelter programs later become advocates for the homeless.
References


