



Food for thought: An ethnographic study of negotiating ill health and food insecurity in a UK foodbank



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ABSTRACT

Emergency foodbanks have become an increasingly prominent and controversial feature of austerity in Europe and the USA. In the UK, foodbanks have been called a 'public health emergency'. Despite this, there has been no UK research examining the health of foodbank users. Through an ethnographic study, this paper is the first to explore the health and health perceptions of foodbank users via a case study of Stockton-on-Tees in the North East of England, UK during a period of welfare reform and austerity. Participant observation, field notes and interviews with foodbank users and volunteers were conducted over a seventeen month period (November 2013 to March 2015) inside a Trussell Trust foodbank. Foodbank users were almost exclusively of working age, both men and women, with and without dependent children. All were on very low incomes – from welfare benefits or insecure, poorly paid employment. Many had pre-existing health problems which were exacerbated by their poverty and food insecurity. The latter meant although foodbank users were well aware of the importance and constitution of a healthy diet, they were usually unable to achieve this for financial reasons – constantly having to negotiate their food insecurity. More typically they had to access poor quality, readily available, filling, processed foods. Foodbank users are facing the everyday reality of health inequalities at a time of ongoing austerity in the UK.

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1. Introduction

Emergency food banking has become an increasingly prominent – and politically controversial – feature of austerity measures in the UK as well as internationally in Europe and the USA. In the USA and Canada there are lengthy histories of charitable emergency food provision and a range of research literature around its origins, development and effectiveness (Poppendieck, 1998; Riches, 2002; Tarasuk, 2001). Some countries reacted to the financial crisis of 2008 by implementing austerity measures – reducing budget deficits in economic downturns by decreasing public expenditure and/or increasing taxes. In the UK, as with some other European countries, this has led to large scale cuts to central and local government budgets, freezes to healthcare funding and service privatisation as well as cuts in welfare services (such as social care) and benefits (including tighter eligibility criteria and caps to the

duration and value of claims). Unemployment rates have also increased since the crisis, wages and welfare benefits have fallen substantially in relation to prices, and poverty rates – including food poverty – have increased rapidly.

Food poverty – the inability to acquire or eat an adequate quality or sufficient quantity of food in socially acceptable ways, or the uncertainty of being able to do so (Dowler and O'Connor, 2012) – has reached epidemic proportions with an estimated 4.7 million people in the UK now living in food poverty (defined as spending ten per cent or more of their household income on food) (Centre for Economic and Business Research, 2013). The most deprived households in the UK spent almost a quarter of their income (23.8 per cent) on food in 2012 compared with an annual spend of around four per cent by the most affluent households. Cooper and Dumbleton (2013) estimated that at least 500,000 people in the UK are now food-insecure (defined as the lack of economic and physical access to sufficient, acceptable food for a healthy life Department for Environment, Food & Rural Affairs [Defra], 2014; Dowler et al., 2001). Further, there was a 19% increase in people hospitalised in England and Wales for malnutrition in 2013 (UK

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Faculty of Public Health, 2014). UK food prices have risen by twelve percent in real terms since 2007 (Defra, 2013: 8). Taylor-Robinson et al. (2013: 1) maintain that ‘access to an adequate food supply is the most basic of human needs and rights’, and they conclude by arguing that ‘We should not allow food poverty in the UK to be the next public health emergency’ (ibid). Together with high fuel prices, rising inflation of food (Defra, 2013), fuel and living costs (Davis et al., 2014) has translated into families cutting back on fresh fruit and vegetables and buying cheap, sweet, fatty, salty, or processed foods that require little cooking (Ashton et al., 2014) leading to people living in poverty often having worse diets and contributing to the rising rates of obesity, diabetes, and other dietary-related diseases. Figures from Defra (2006: v) also indicate a widening consumption gap between rich and poor. In 2001/2, there was little difference, with the richest 10th consuming a total of 2420 calories daily, about 4 per cent more than the poorest. In 2013, the richest group consumed 2294 calories, about 15 per cent more than the poorest. People in the lowest income decile spent 22 per cent more on food in 2013 than in 2007 but received 6.7 per cent less.

In this context, emergency foodbanks have emerged in the UK, across Europe and the USA as a reaction by the charitable sector to rising food insecurity amongst individuals and families. The Trussell Trust is a large, national, Christian foodbank franchise in the UK which operates a voucher system for those seeking emergency food provisions. Vouchers are provided by referring care agencies such as General Practitioners (GPs) or social workers. Foodbank users bring their ‘red voucher’ to a foodbank centre where it can be redeemed for three days emergency food provision, up to three consecutive times within a period of crisis. The food parcel contains ‘a minimum of three days nutritionally balanced, non-perishable food’ (Trussell Trust, 2014a) such as cereal, tinned soup, tinned vegetables, pasta sauce, long life milk, tea or coffee, pasta, rice, juice, and other basic staple items. In 2013, almost a million people in the UK received emergency food from a Trussell Trust foodbank, a three-fold increase on 2012. In the North East of England, food parcel receipt in 2013 was five times the 2012 level (Trussell Trust, 2014b). Whilst the Trussell Trust are the only national network currently in operation, it is difficult to quantify the number of food banks in existence as there are many organisations and independent groups running local food banks in the UK.

The lifestyle choices of foodbank users have been called into question by the government and the mass media (UK Government House of Commons Hansard, 2013), reinforcing the neoliberal narrative of ‘deserving’ and ‘undeserving’ poor which is often associated with benefits recipients (Garthwaite, 2011; Shildrick et al., 2012). Hansen et al. (2013) draw attention to the historical nature of these cycles of blame and stigma surrounding the ‘undeserving poor’ in which the 16th century spectre of the “unworthy poor” is resurrected and reinforced by such neoliberal ideologies. In a UK context, Wells and Caraher (2014) highlight media stories of food bank users making use of a system where no real need exists; instead, the ‘undeserving poor’ are seeking out bargains so they can spend their money on luxury items such as alcohol, cigarettes and large televisions. Despite assertions relating to the lifestyle choice of people accessing foodbanks, the empirical evidence shows that it is need driving use as food poverty is increasing in the UK (Taylor-Robinson et al., 2013). In their study of foodbanks, Dowler and Lambie-Mumford (2014) identified two key sets of triggers for food aid uptake – people with precarious housing circumstances, and people experiencing financial difficulty as a result of changes to their social security benefits, which involved either their experiencing a complete absence of income (because of sanctions or errors), or a sudden increase in outgoings as a result of changes to housing and/or council tax benefit. They note that: “rising costs of living, not least in increased food and fuel prices, and static or falling

incomes from wages and/or social security have meant that for more and more households stark food insecurity is becoming the norm, however skilfully people budget, shop and prepare food” (Dowler and Lambie-Mumford, 2014: 17). Such food insecurity is not a public health crisis facing the UK alone. There is evidence to suggest that the general growth trends in the UK, particularly in relation to the Trussell Trust foodbank network and amount of food redistributed, are being experienced elsewhere in Europe. Similar to the UK, foodbanks have become much more common across continental Europe since the crisis that began in 2008, and especially since austerity began to take effect from late 2010. The foodbank model operated by the Trussell Trust is distinct from soup kitchens and food redistribution that can be found in countries such as Canada, USA and elsewhere in Europe. In Spain, for instance, food banks can operate on the warehouse model, supplying a network of surrounding soup kitchens and other food relief agencies. In Germany increasing numbers of people have been seen accessing food aid (Tinnemann et al., 2012). This is supported by evidence from Pfeiffer et al. (2011) who point to existing circumstantial evidence of the increase of food banks in Germany, and go on to explore the range of mechanisms German households employ to manage experiences of food insecurity (including reducing the quantity or quality of food purchased and eaten, food bank use and turning to friends and family).

Despite the escalating research interest in emergency food provision in the UK and elsewhere (e.g. Dowler and Lambie-Mumford, 2014; Lambie-Mumford et al., 2014; Lambie-Mumford, 2013; Tarasuk et al., 2014), as well as the ill health effects of austerity (Stuckler and Basu, 2013), the relationships between foodbank use, health and austerity remain relatively unexplored. This paper is the first to examine the relationship between ill health and food insecurity among foodbank users in the UK in detail by drawing on data from an ethnographic study of health inequalities and austerity in Stockton-on-Tees, North East England. It focuses specifically on the mental health of people who accessed the foodbank, how people using the foodbank experience ill health and food insecurity, and the costs and constitution of negotiating a healthy diet on a severely limited budget.

2. Methods

2.1. Study context

The research reported here is situated within a wider five year, mixed method project examining localised health inequalities in an era of austerity in the town of Stockton-on-Tees, North East England. As part of the ‘urban ethnography’ section of the project, this paper focuses specifically on the collection and analysis of observational and interview data on the operation of a Trussell Trust foodbank. The foodbank operates out of an Evangelical church in the Town Centre and was chosen for the high levels of deprivation in the surrounding area. To date, since the foodbank opened in June 2013 to December 2014, there have been 2324 food parcels distributed.

Originally, Stockton-on-Tees was a market borough serving a largely rural and agricultural population. In the nineteenth century, the shipping and railway industries developed alongside manufacturing and engineering and, to a lesser extent, the chemical industry and iron and steel production. Throughout the 20th century, the borough experienced cyclical economic upheaval and since the 1970s, large-scale deindustrialisation has radically reshaped the character of the area (Beynon et al., 1994). The shift to a post-industrial service economy in this area has only been partially successful as whilst most current employment is in the service sector, this is accompanied by above average levels of long-

term unemployment (for example, in July 2014 the Job Seekers Allowance [JSA] claimant rate was 4.6% in Stockton-on-Tees compared to a national average of 2.9%). In Stockton-on-Tees, health inequalities are the highest in England outside of London with life expectancy gaps of 16 and 11 years amongst men and women respectively between the least and most deprived wards (Association of Public Health Observatories [APHO], 2014). These figures are indicative of a wider contrast within Stockton-on-Tees in terms of deprivation levels, as the Borough has areas of high disadvantage (six wards in Stockton-on-Tees are within the 10% most deprived wards nationally) juxtaposed with areas of high affluence (three wards are within the 10% least deprived nationally).

2.2. Data collection and analysis

2.2.1. Participant observation

The methodological design was ethnographic both in terms of data and in terms of mode of analysis (Hammersley and Atkinson, 1983). Hansen et al. emphasise the importance of ethnographic research in health and policy in a special edition of this journal in 2013, stating ‘*ethnographers of health answer a call to document what researchers using other methods cannot*’ (2013: 118). A researcher (KG) volunteered at the foodbank on a weekly (sometimes twice weekly) basis and participated fully in all aspects of foodbank operations. Volunteering and participant observation began in November 2013 and is ongoing. The volunteering role included preparation of food parcels, distributing food parcels, liaising with referring agencies, and administration of the red vouchers that all foodbank users are required to obtain in order to receive emergency food provision. Care was taken to ensure that observations encompassed all major activities (e.g., set-up, administration of the red voucher system, engaging with users, liaising with referring agencies, food distribution). Her identity as a researcher was made known to all foodbank users, volunteers and referring agencies.

Observations and interviews were directed by the ongoing positioning of the analysis, as is the practice in most forms of qualitative research. Field observations focused on the material environment, appearance and behaviour of users and volunteers, and interaction (Lofland and Lofland, 1995). Field notes were taken before, during, and immediately after volunteering in the foodbank and included observations, conversations, and reflexive experiences. Observational notes and interview transcripts were analysed with the assistance of qualitative data analysis software (NVivo 10). The long and intensive period of observation and the researcher's personal familiarity and experience with the people and subject of the research, in terms both of the trust she was able to develop with participants and the subsequent observations and interpretations drawn from this, enabled the establishment of sound and trustworthy relationships and allowed for a comprehensive understanding of how the foodbank operates.

2.2.2. Interviews

50 semi-structured interviews were undertaken – 42 interviews with foodbank users and eight interviews with volunteers. Six of the 42 foodbank users were then interviewed again in their own homes up to two weeks after the receipt of their food parcel to find out their experiences of the food given. Eight volunteers took part in individual, semi-structured interviews, which lasted between 20 min and 45 min and were held in a quiet part of the foodbank. Of the 42 foodbank users interviewed (20 women and 22 men) the age range of the sample varied from 18 to 60 years. Participation was voluntary, confidential, and secured by informed consent.

Interviews with foodbank users typically lasted between 30 and

90 min and took place either within the foodbank or in participants' homes. Interviews that took place in the foodbank were not digitally recorded; detailed notes were taken immediately afterwards. Interviews that were arranged to take place in people's homes were recorded and transcribed verbatim. Data were fully anonymised before thematic analysis was undertaken. The findings of the qualitative interviews were then compared with the observations that had previously been noted. Ethical considerations were respected throughout the research with the research being approved in advance by Durham University Department of Geography Ethics Committee.

3. Findings

3.1. Mental health problems

Trussell Trust (2014b) statistics indicate that the main reasons why people are referred to foodbanks are: benefit delays (30.93%); low incomes (20.29%); and benefit changes (16.97%). Perry et al. (2014) emphasise how although illness was not the immediate cause of foodbank referral, there was a high prevalence of ill health, particularly in terms of mental health problems such as depression and anxiety, amongst foodbank users. This is reflected in our observations and interview data. ‘*Scanning the red vouchers as they come in to the foodbank, these are also the most cited reasons why people are using the foodbank here in Stockton Town Centre—or the primary reasons. Talking to people, it's obvious that health problems, mainly mental health problems, affect many of the people coming for food*’ (Field Notes 2014). Tom, 53, had been to the foodbank three times, the allocated amount of vouchers he can redeem in a six-month period of ‘crisis’. The extract taken from field notes below highlights how his health problems interweave with complex factors such as relationship breakdown, job loss, and welfare reform:

Field Notes.

28th February 2014

Tom, 53, is a ‘regular’ who has now definitely received the allowed 3 vouchers. Angie said to me I needed to tell him it was his last time as he'd been 3 times now. Tom has been on Jobseekers Allowance since July 2013 following a split from his partner down South. He said that he finds it hard coming to the foodbank as he's worked all his life as a long distance lorry driver so finds it hard asking for handouts. ‘*The government won't let you live*’ he says. He tells me he must apply for ‘*50 jobs a fortnight*’. He currently gets £140 per fortnight JSA – ‘*I used to spend that on baits in one week at work*’ he says ‘*going out for lunch and then for tea after work when I was on the road*’. He tells me about his ongoing problems with depression and anxiety and how he ‘*just want[s] to get back to work so I can start having a proper life again*’. I talk about the project I'm working on and he proudly tells me the company he worked for delivered the stone to build the University campus where I work. He is interested in what the project is looking at but perplexed, too, as he thinks all of the findings will be the same – ‘*You couldn't write a book on it round here as it would all be the same - depression and mental health*’.

The narrative underpinning Tom's story was an oft-repeated one. Rob, 45, came to the foodbank due to a two week Jobseekers Allowance (JSA) sanction, but after spending time with him it was clear that he is dealing with complex mental health problems. I'm shocked to hear that Rob was stabbed by his ‘friend’ six months ago. They had been drinking alcohol in his house and had an argument

that led to his friend slashing his face with a Stanley knife. The perpetrator has recently been jailed for five years, ten months. Since the attack, Rob has suffered with depression, stress, anxiety, and post-traumatic stress disorder (PTSD). Rob is afraid to leave the house and struggles to sleep at night: *'I get flashbacks of it ... the doctor says I have PTSD, stress and depression now. I find it hard to leave the house ... I'm always looking behind me, checking who's about'*. This is the second time Rob has come to the foodbank, despite the fact he finds it 'embarrassing': *'I was embarrassed the first time I came, especially if there's people outside, I don't like people seeing me come here'*. Rob was sanctioned after failing to turn up for his appointment to 'sign on' [to receive out of work benefit Jobseekers Allowance] at the Jobcentre – *'I was having a really bad day and just couldn't leave the house, there was no way I could have got down there'*. The frustration at having to use foodbanks was evident when talking to Rob – prior to the attack, he had *'worked all me life'*, labouring since he had left school aged 16.

David and Jenni came to the foodbank for the first time after David left work due to mental health problems. Both were currently not working but had lengthy histories of employment – David as a chef and Jenni in retail. The ongoing threat of austerity impacted upon David's health on a day-to-day basis:

It's just been stress cos I'm the worrier me, Jenni doesn't worry about nothing, it's me that worries. We'd come back home and I was half expecting the landlord to be there with all our stuff out on the front, like 'get out' type of thing y'know like you see on the telly when they repossess the house.

For people with mental health problems, coming to the foodbank could sometimes be described as being beneficial to them in terms of having someone to talk to. The sense of community that volunteers aim to foster in the foodbank – tables set up café style, pretty orange, pink and white checked tablecloths, plates of biscuits and little crystal bowls of sugar for tea and coffee – attempted to create a non-judgemental and relaxed atmosphere. Seeing that there were 'other people like me' helped alleviate feelings of stigma and shame for people accessing the foodbank, and encouraged a sense of community, perhaps strengthened by the setting of the foodbank which was located inside a local church (Jacobs Starkey et al., 1998). Often, people using the foodbank would comment on the friendliness of the volunteers, and how they appreciated having a hot drink and a space to chat with someone who they saw as being there to help them, providing the listening ear that is the aim of the Trussell Trust foodbank network (Perry et al., 2014; Lambie-Mumford, 2013). This was reflected on by volunteer Maureen:

I think with all the stress of what they're going through it tends to be mental health problems more than physical and they openly say that to you, y'know. I think like Carol [another volunteer] was saying, a lot of them will say 'Thank you for listening'. They feel they've got nobody to talk to about it and that so they're quite happy to do that y'know and feel that at least somebody is taking a bit of interest, a bit of notice of what they're going through.

3.2. Negotiating food insecurity

The problem of health inequalities in relation to food consumption has tended to be located within 'food policy' as an issue for the market to address in terms of keeping prices low and people in work, along with the responsibility of consumers to budget, shop, cook and eat effectively (Dowler et al., 2001; Dowler and O'Connor, 2012). People manage variously on minimal diets, food gifts and charitable support, but the consequences in terms of social

wellbeing and nutritional health, while potentially severe, is often hidden (Dowler and Lambie Mumford, 2015).

Various strategies were employed by people accessing the foodbank to ensure the maximum food consumption with minimum means. I met Naomi at the foodbank and asked her if I could come and see her the following week to find out her experiences of using the food parcel. Naomi, 36, had been receiving Employment and Support Allowance (ESA) and Disability Living Allowance (DLA) for five years due to her physical and mental health problems. She has arthritis, Irritable Bowel Syndrome (IBS), depression, and anxiety. Naomi is also recovering from a heroin addiction that she has been dealing with since she was 18. She was unaware of the provision available at foodbanks in Stockton-on-Tees until her GP signposted her to Trussell Trust:

It was actually the doctor's that told me about it, I'd gone in to get my prescriptions and we were talking and I can't remember how it came about, I think it was cos I've put weight on and I said to him 'I'm putting weight on in the first week and then I'm losing it on the second week cos there's no more food'.

Naomi described how her food shopping involved 'shopping around for the cheapest thing', searching out reduced items in maybe three or four different stores, all across the town centre. When asked if she plans her food shopping, Naomi replied:

Well we normally what we do in the first week, we fill up our cupboards like with tinned stuff, noodles, things like that, fill up the freezer with like chicken, there's always meat, vegetables, chips, stuff like that. I've just been paid so I've filled up the cupboards now but when you get to the end of the week you see it all go, all the fresh stuff's gone and it's really hard to keep some money in your account for the following week. If something happens and you need some cash for summat y'know you've got to take it out for something else.

This cyclical nature of food consumption was echoed in Anna's experience of using the foodbank. I met Anna, 51, and her eleven-year old daughter in the foodbank and arranged to visit her two weeks later in her home. Anna had worked as an administrator for the police and was also running a successful self-employed business until anxiety and depression led to her withdrawing from both. She also has digestive problems that make consuming wheat and dairy difficult. Like Naomi, Anna spoke of how her food consumption patterns altered on a weekly basis, as the following interview extract shows:

Our eating is far more inconsistent with the way that we have to buy food now, so we'll maybe have a healthy week but then we'll maybe have quite a poor nutrition week ... I suppose a healthy week for us will be where we've got some fruit and veg within the diet, maybe a tuna sandwich with some cucumber and tomato on the side, and then we'll have what I would class as a proper meal which is at least some meat in the meal and some peas, mashed potatoes. But then on the other week I bake a lot so we eat scones, there's no meat involved, we'll have pasta just with a plain sauce cos there's no fruit or veg to put into it. I try to incorporate rice as well, rice and pasta aren't unhealthy but without any fruit or veg in it, that's when I start to get stomach problems ... My daughter's been quite constipated recently which she's never been like that and that's no good for her ... we could always afford yoghurts, always afford something with fruit in but we really struggle to do that now.

Consuming food in this way led to a detrimental health impact on both Anna and her daughter, which in turn had a further negative impact on her mental health. Like Anna, due to health

problems, for Naomi eating certain foods can be problematic:

I have IBS (Irritable Bowel Syndrome) and a lazy bowel and I'm allergic to white wheat ... I know at the foodbank you do get a lot of like white, wheat based food but at the moment I'll eat anything. Like I told yer I was bad over the weekend because of everything that I ate that I shouldn't have cos I can't afford to buy fresh vegetables and fruit all the time, and that's what I'm supposed to eat. I can't eat anything fried, spicy and a lot of cheap food is the type of food that I can't eat ... but when you're hungry you'll eat anything and I suffer the consequences afterwards.

Despite this, Naomi and Anna both described the foodbank provision as 'a lifeline' and said they 'wouldn't have known what I'd have done without it' even though they suffered negative health consequences after consuming the food they received. The supply driven nature of foodbank provision is shown to be problematic here, as it fails to take into account the health needs of people like Anna and Naomi who are intolerant to wheat and dairy. This can be made even more problematic when food supplies are running low, as foodbank volunteer Angie says:

When you're [the foodbank] running out of food and you're buying stuff, you're buying maybe cheaper meat products than you would if you had an unlimited supply of money, cheaper alternatives to fill out the parcel.

Angie followed this by saying:

I would say a lot of what we give out ... maybe not everything but the majority of the times in the bag, middle class families would get that on their shop. And yeah the cereal most of it has sugar and salt but most people eat cereal regardless of what financial bracket they're in. Rice, pasta, tins of tomatoes ... I would say it's quite a healthy pack. Ok, you're giving them biscuits but it's not bad to eat some biscuits, I think most people would eat something sugary.

This point leads on to the idea of how healthy food was perceived by people who accessed the foodbank.

3.3. Financing a healthy diet

Foodbank users generally followed the consensus that eating well was too expensive. Fruit and vegetables were often overlooked in favour of processed, 'filling', cheap alternatives. Volunteers and referring agencies felt that basic cookery courses and advice on meal planning was a positive idea that they were keen to implement, as they tended to believe that people who accessed the foodbank were largely unaware of how to cook properly, more typically relying on unhealthy convenience foods as a result. Such an approach places the emphasis on the individual to learn about budgeting and nutrition, suggesting they are uninformed of these concepts. On the contrary, continuing with Naomi's narrative, she was acutely aware of the type of food she is 'supposed to eat', but this was often overlooked in favour of cheap, processed food in the second week whilst she was awaiting her benefits payment:

I try and do the best I can with what I've got like I say it costs so much to get the food that I need, and it's easy for a GP to say to me 'Well you're eating the wrong stuff', I haven't got the money.

Although Naomi was conscious of what should be consumed in order to manage her health conditions, the reality is that rising food prices, coupled with only slight benefits rises, means that Naomi

could not afford the food she needed to stay healthy, despite her best efforts. Similarly, David told me how he and his wife now shop in the cheap frozen food stores in the Town Centre, despite the fact that 'it's cheap but the quality isn't very good. We've had fish fingers from there and they were disgusting'. Naomi and David were mindful of how their health needs should be aligned with their nutritional needs; the fulfilment of those requirements was the issue. Speaking about her health problems, Anna said:

I have a couple of medical conditions ... I don't do very well with wheat and dairy, and I tend to get lots of acid reflux now ... I also suffer with anaemia so I really do need lots of broccoli, lots of things with iron in it and meat is one of those things that's higher in iron and we're really struggling on that score at the moment. We're eating lots of pasta, lots of cheap sauces, things like that. I have resorted to doing more baking and things but it is a bit of a struggle cos then I do tend to get more health problems the more pastry, bread, things like that that I eat ... but we can't afford to do anything other at the moment.

Instead, Anna and her daughter had to eat 'tinned foods that are often out of date' and were overlooking fresh produce because 'the more fresh fruit and veg you buy the more chance of wastage'. When asked if this impacted on her health, Anna said:

Completely ... because of the anaemia my energy levels are that low, I do nod off regularly and towards the afternoon I don't have energy to do the housework ... I'm not unintelligent, I know what I need to keep my levels going, I know what I need for my diet but it's hard to keep that going when you're left with eating just bread with maybe a chocolate spread on it cos that's all you've got left for that day. The carbohydrates are the short-lived things for energy and I know enough about that, what I should be eating but you can't always manage to do it.

In summary, we have shown how people accessing the foodbank were often suffering from chronic health problems, with mental health problems being particularly prevalent. Although the food assistance from the foodbank was viewed as a 'lifeline', the food provided could have negative consequences upon people's health, especially for those with food intolerances. In this sense, the food given was therefore largely separate from the needs of foodbank users with health problems. People accessing the foodbank were aware of how to eat healthily but were unable to do so due to affordability.

4. Discussion and conclusions

For the vast majority of foodbank users in the study, ill health was not the immediate cause of foodbank referral, which could help to explain why health impact has not been considered in previous research surrounding foodbank use. However, it was clearly a significant factor that had social consequences, impacting upon employment, service access and benefit receipt, relationships, and coping with debt. It was common for foodbank users to have experienced ill health, bereavement, relationship breakdown, substantial caring responsibilities or job loss, findings also reported by Perry et al. (2014: 7). This led to a situation where deepening struggles with mental health inhibited other coping mechanisms or exacerbated wider crises, leading to a further worsening for some of already poor health.

Our findings are in keeping with the wider literature about the role of food insecurity as a social determinant of health (Raphael, 2009). Previous research has shown that food insecure

individuals tend to have a less varied, nutritionally inadequate diet with lower intakes of fruits and vegetables (Gorton et al., 2010; Kirkpatrick and Tarasuk, 2008; Power, 2005). Drewnowski and Eichelsdoerfer (2009: 1) note that *'as income drops and food budgets shrink food choices shift toward cheaper refined grains, added sugars and vegetable fats'*, leaving those with low incomes nutritionally vulnerable as they must compromise quality and variety in order to satiate their hunger. Resultantly, healthy food purchases *'fall precipitously as income declines'* along with the nutritional quality of other purchased foods (Kirkpatrick and Tarasuk, 2008: 209). Foodbank users are likely to be living with long-term financial problems, arising from low waged work, accumulation of debt, and living in areas of multiple deprivation, leading to difficulties in sourcing affordable healthy food (Dowler et al., 2001; Rex and Blair, 2003; Lloyd et al., 2011). Nutritionally poor diets equate with a lack of security and consistency around food intake. The residual effect on health is damaging, with individuals in households characterised by food insufficiency having significantly higher odds of reporting poor or fair health, multiple chronic conditions, of suffering from major depression and distress, and of having poor social support (Vozoris and Tarasuk, 2003).

Foodbank provision can be unsuitable even in the short term for people with certain health conditions. This relates to the supply-driven nature of foodbanking in terms of what kind of, and how much food, people can and cannot obtain; this has been previously noted in an international context by Poppendieck (1998) and Tarasuk and Eakin (2003, 2005). For example, when supplies are severely constrained, food giving can become more of a symbolic gesture than a response to need, as Tarasuk and Eakin (2003) found in their ethnographic research on foodbanks in Canada. In their study of food bank use in the Netherlands, van der Horst et al. (2014) recognise how *'even the most appreciative receiver is disappointed with the amount of high fat and sugary products in the parcels'* as food bank users are trying to eat healthily on very limited budgets. This suggests that foodbank use can be seen as part of an *'inability to acquire or consume an adequate or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so'* (Radimer et al., 1992). In order to achieve this, people require sufficient income in terms of wages or benefits. Research has regularly shown that those on benefits or the statutory minimum wage have insufficient money to buy the food they need for health, however carefully they budget and shop (Davis et al., 2014). This in turn has long-term health consequences in terms of obesity, diabetes, and other dietary-related diseases (Ashton et al., 2014).

Finally, neoliberal ideological discourse suggesting lifestyle choice is to blame for increasing foodbank use neglects the constraints facing foodbank users. People facing food poverty are not only food deprived but are also likely to be financially, time and resource poor. This is not new; during the Great Depression of the 1930s George M'Gonigle conducted a series of studies into deprivation and health in Stockton-on-Tees (M'Gonigle and Kirkby, 1936) and found that the vast majority of deprived families, whether employed or unemployed, did not have an income that was sufficient to sustain a diet that was adequate to ward off disease and death. Morbidity and mortality amongst the most deprived was a result of inadequate wages and welfare benefits and was not the fault of the 'poor choices' or budgeting skills of individual families (Bambra, 2011: 2). Similarly, today, the idea that people are unaware of how to eat healthily does not align with the findings presented here – participants strived to maintain a healthy diet and were fully aware of the nutrients they were missing out on, and the resulting impact this had upon their quality of life. This suggests that the adoption of a 'lifestyle drift' (Popay et al., 2010) approach as an explanation for foodbank use, for instance, suggesting that people using the foodbank do not make the right choices or cannot

budget, does not adequately address the issue of food choice in people who have used the foodbank. Food choice is a concept no longer relevant to foodbank users. Necessity, not choice, means that people are forced to eat food that is cheap, readily available, filling and will not result in any wastage.

These findings bring into question the appropriateness of foodbanks as a response to austerity, particularly for people with health problems, and highlight the broad array of factors that are contributing to increasing foodbank use in the UK. It has been argued that insofar as foodbanks give the illusion of effectively responding to hunger, they unwittingly facilitate the further erosion of income supports to those at the bottom, leading to increased poverty and income inequality and a continued and growing need for charitable food assistance (Poppendieck, 1998; Riches, 2002). A normalisation of emergency foodbanks as an everyday response to austerity can mean there is scant motivation for policymakers to seek alternatives, with the social right to be 'free of want' (Beveridge, 1942) eroded by the continued neoliberal epidemic of "austerity justified" welfare reform (Shrecker and Bambra, in press). Further research into the stigma of foodbank use and its impact upon health, alongside how foodbanks can be situated within a wider narrative of surveillance, would add to the debates surrounding growing foodbank use both in the UK and internationally.

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