Hunger Is A Health Issue

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Dr. Laura Gottlieb once diagnosed abdominal pain in a patient when the real problem was hunger. "I confused social issues with medical problems in other patients, too," she wrote in a well-known 2010 opinion piece published in the *San Francisco Chronicle*.[1]

She mislabeled the hopelessness of long-term unemployment as depression, and the poverty that caused patients to miss pills or appointments as noncompliance.

"My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients' lives, but because I had neither skills nor the resources for treating them, I ignored the social context of disease altogether."

Gottlieb's experience resonates with me in my own work as a consulting nutritionist at the Connecticut Mental Health Center. I also was unprepared for the many barriers my patients faced in achieving a healthy diet and lifestyle. My education and training left me with knowledge gaps across areas such as food access, stable employment and safe housing that can impede nutritional and overall health.

The relationship between eating well and good health is well established. Much of the national conversation around food is about increasing vegetable and fruit consumption and limiting intake of calorie-dense, fatty food. However, lower socioeconomic populations consume less nutrient-rich foods due to their higher cost; they eat more energy-dense, inexpensive foods that are high in salt, saturated fat and refined sugar to stretch food budgets. And health care professionals often lack training to screen for hunger and to refer patients to resources in their communities.

WHAT IS FOOD INSECURITY?

According to the World Health Organization, a state of food insecurity occurs when there is uncertainty about future food availability and access, insufficiency in the amount and kind of food required for a healthy diet, or the need to use socially unacceptable means to acquire food because of resource or physical constraint.

Food security rests on three pillars: food availability, food access and food use. Food availability is associated with sufficient quantities of food available on a consistent basis. Food access requires resources to obtain food appropriate for a nutritious diet. "Food deserts" or geographic areas with poor access to affordable healthy foods create community-level social disparities in food access that contribute to health disparities. Food use is based on knowledge of basic nutrition and care. [2]

VULNERABLE POPULATIONS IN THE U.S.

The United States is an affluent nation with an abundant food supply and yet 12.7 percent of American households struggle with food inse-

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curity. Children, and especially children of single parents, are vulnerable. Summer often presents challenges to feeding children who rely on free school lunch and breakfast during the academic year.

Experiences with hunger have a negative impact on the health of children 10 to 15 years later. Children who are hungry are four times more likely to need professional counseling. Hungry teens are five times more likely to commit suicide.

Hunger is pervasive among college students. A recent Temple University study showed that of 43,000 students at 66 colleges surveyed, 36 percent had trouble getting enough to eat daily.[3]

Food insecurity is linked with depression and anxiety, and poor dietary quality is linked to mental health problems, creating a negative feedback loop. Older adults also are at increased risk for food insecurity, some having to choose between healthy food or medication.

HEALTH CONSEQUENCES

Diet is one of the central determinants of many health conditions including chronic diseases such as cardiovascular disease, type 2 diabetes and cancer. Individuals from food-insecure households are at increased risk for these and other diseases, difficulty in managing these illnesses when they occur, and poorer clinical outcomes associated with such illnesses.

Episodic food insecurity occurs when food funds are exhausted at certain points in time, usually at the end of the month. In 2014, Dr. Hilary Seligman and her colleagues found that inpatient admissions for hypoglycemia in California were more common in low-income populations than in high-income populations. Additionally, risk for hypoglycemia admission increased 27 percent in the last week of the month compared to the first week in the low-income population.[4] This happens because monthly food budgets are depleted at the end of the month, resulting in skipped meals and erratic feeding patterns.

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Food insecurity is strongly associated with cost-related medication underuse. A study reported in the *American Journal of Medicine* by Seth Berkowitz and colleagues showed that food insecure patients with chronic illness were more likely to be unable to afford a prescription, to delay a prescription, to skip doses due to cost and to take less medication than prescribed due to cost. The prescriptions they studied were for cardiovascular disease and hypertension, diabetes, asthma, chronic obstructive pulmonary disease, arthritis and cancer.[5]

COPING STRATEGIES TO AVOID HUNGER

Hunger is a physical sensation caused by a lack of food. Food insecurity is a household-level condition that is broader than hunger; it is complicated by the coping strategies used to compensate for food inadequacy.

Food insecurity is often episodic, such as with end-of-month food budget exhaustion, or seasonal, when children lose access to school lunch programs. When cycles of food adequacy and inadequacy occur, adaptive behaviors are used to cope with these food fluctuations. When food is available, there is a shift toward low-cost food that is low in fruits and vegetables and high in sugar and saturated fat. There is also overconsumption, hoarding, reliance on highly filling food and extreme avoidance of wasting food in anticipation of a food shortage. When food is scarce, eating patterns are erratic and meals are skipped. Parents often feed their children while going hungry themselves.

CLINICAL SCREENING FOR FOOD INSECURITY

Enrollment in federal food assistance programs, such as the Supplemental Nutrition Assistance Program, commonly called SNAP, and the Special Supplemental Nutrition Program for Women, Infants and Children, known as WIC, is associated with improved outcomes across multiple dimensions, including food security, nutrition, health and health care costs. However, most health professionals lack training to assess food insecurity and most health care systems lack tools for referring food insecure patients to community-based resources such as food banks, congregate meal sites and afterschool meal programs for children.

The American Academy of Pediatrics, the American Diabetes Association and the Centers for Medicare and Medicaid Services recommend

universal food insecurity screening and referral to food resources.[6] Food insecurity can't always be identified by an individual's appearance due to the co-occurrence of obesity and food insecurity. People struggling with food insecurity are 2.45 times more likely to be obese than the general population.

Food insecurity is assessed in clinical settings using a specific screening tool that includes two statements.

The screener asks an individual whether each of the following statements were often true, sometimes true or never true for his or her household.

1. Within the past 12 months we worried whether our food would run out before we got money to buy more.

2. Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

"Often" or "sometimes true" responses to either question indicate a positive screen result. Screening success hinges on connecting food insecure households to community resources specific to household needs and delivered out-

HELPFUL RESOURCES TO COMBAT FOOD INSECURITY

- The Nutrition and Obesity Network has gathered an interdisciplinary team of researchers, clinicians and food systems leaders committed to raising awareness of food insecurity within health care settings and improving nutrition policies and priorities in the hunger safety net through shared research and evaluation. For information on this "clinical linkages" work, please visit: https://nopren.org/working_groups/food-security/clinical-linkages/.
- For referral to federal nutrition programs, call the USDA's National Hunger Hotline at 866-348-6479 or 877-842-6273 for Spanish.
- If ineligible for federal nutrition programs and/or emergency food is needed, call 211 or the Eldercare Locator at 800-677-1116.

FOOD RESOURCES

Supplemental Nutrtion Assistance Program (SNAP)*
https://www.fins.usda.gov/snap
Money on debit card to purchase food. The average benefit is $127 per month per person.

Women, Infants and Children (WIC) Program*
https://www.fns.usad.gov/wic
Money to purchase pre-specified foods for pregnant/post-partum women, infants and children under the age of 5. Nutrition education and breastfeeding support also is provided.

School, Afterschool and Summer Meals Programs for Children
https://www.fns.usda.gov
Free or reduced-price healthy meals or snacks for students. Eligibility criteria for programs during the school year and summer may vary.

Food Pantries
www.feedingamerica.org
Free food and grocery items for people of all ages. Food must be picked up in person by patient or a proxy.

Congregate Meal Sites
Meals provided to older adults at specific sites, such as senior centers, churches or housing communities.

Home-Delivered Meals
Meals delivered to older adults who cannot otherwise prepare or obtain nutritionally adequate meals.

Medically-Tailored Meals
Home-delivered meals tailored to meet the needs of specific health condtions.

Soup Kitchens/Free Dining Rooms
Free prepared meals for people of all ages.

*Eligibility calculators available online.

What It's Like Living with Hunger

Serena Spruill, a recovery support specialist at the Connecticut Mental Health Center, gave a talk about her own experience with hunger and food insecurity at a training session for co-workers. Some of her comments are excerpted here, with her permission.

I have had hunger issues in every phase of my life: throughout childhood and into my teen years, as a young teen mom, all during my married life and especially as a single parent with five children to support. When I really sat down to think about it, hunger (food insecurity), never went away.

I was born in New Haven, Connecticut, in 1954, at St. Raphael's Hospital. My parents had 12 children. I am number 11, the baby girl. My mother died when I was 18 months old. My father vowed to keep us together, and he did. But keeping us all fed was really hard. We, at times, went three days without food. Mostly we would eat one meal per day. We were ecstatic if we got to eat twice in one day.

We ate a lot of the same cheap foods. We ate a lot of sandwiches: bologna and cheese, tuna fish, spam, peanut butter and jelly, or just plain mayonnaise, if that was all we could afford at the time. We would go to the Wonder Bread Bakery on Goffe Street to get our bread. We would buy cans of sardines and eat those. My father made us eat a lot of beans, pinto beans to be exact. Three bags of pinto beans in a large pot with lots and lots of water can feed a crowd. We could have a few bowls of that if we were still hungry after eating the first "helping." We did eat rice with our beans, but not every time. One other family staple was oatmeal. My father would use that big pot to make oatmeal for us. He would treat us by adding raisins or bananas to it. No one could make oatmeal better than my father.

So, like I said, we only ate one to two times per day. Back at that time, it was before school lunch. It was mandatory that all students go home for an hour and return for the second half of the school day. I tried to stay on school grounds during the lunch hour and got reprimanded for it. The only reason I didn't go home was because there was no reason for me to go home. There wasn't any food there for me to eat. But, regardless of that fact, I still had to walk all the way home, sit down for 20 minutes, get up, and walk all the way back to school. I did this every day throughout my grammar school years, before hot lunch came to be, and before food stamps came to be.

Things got better in school when I got to middle school. That's where hot lunch was available for all students. I didn't have to go home and come back.

Now we progress to high school. It turns out I was a teen mom, and I, of course, experienced financial challenges in response to that. Granted, this was in 1969, pre- Pampers era, but I still had to buy milk, and it was before WIC. So, I went through all of that. I did it the cheapest way that I knew how, by breast-feeding for three to four months and then using Carnation milk and Karo syrup formula for the duration.

Then I got married and realized how much it cost to feed our growing family. I got the cheap cuts of meats and the cheap everything, and tried to make it taste as good as possible. I would get the protein and the carbohydrates. I couldn't afford the vegetables. I would put the vegetables last. I was a very plain cook. This all changed when I took part in a community garden. I was able to buy everything else that I needed for consumption, and even (began) freezing the excess bounty of the garden's harvest.

By this time, I was a single parent with five children to support. I took advantage of the food banks. It was very hard for me. I had no car. I was on public transportation, and at the time I was in school. I had to rush around to be at these sites at certain days and at certain times. Then I had to lug these heavy bags all the way home after that. I don't mean to sound unappreciative, but, when I would arrive home and empty the bag's contents, it would be bad because, I would get maybe a can of this and a can of that and it wasn't enough of anything that I could make a meal out of that night. I would have needed to have had gotten three more bags just like that to be able to make a meal for my family. I don't know how it is nowadays, but that is how it was back in the '90s. I am sure it is better now.

The food bank was used to supplement what I contributed and what my food stamps didn't cover. The community garden saved my life! That was the missing piece. It improved my health through an increase in exercise and an increase in good nutrition.

What do I want providers to know and take away from what I am sharing?

I deal with clients up front and personal on a daily basis. They speak frankly about being hungry, and especially their frustrations about the red tape they have to go through, for whatever reasons, in regards to food. Repetition matters. You will most probably become weary of repeating the same information to the same client, but that is what that client needs from you. People with mental illness need repetition!

You can never know by looking at a client what a client is going through. You just have to listen and ask. And remember, a cup of coffee goes a long way!"

side of the practice setting.[7] This process requires coordination among clinicians, administrators, policymakers and community providers. (See sidebar, Page 8).

THE REALITIES OF HUNGER

At the community mental health center where I am a consulting nutritionist, most patients I see live on low or very low incomes.[8] Eighty percent of this patient population is food insecure.

One client, a 43-year-old man, struggles to afford food between pay periods. He does not qualify for SNAP benefits due to his income, which places him just above the threshold of eligibility. He was managing his food budget well until his car broke down, and he had to pay to repair it. This unexpected expense set him back financially. I encourage clients to keep a two-day food diary between nutrition appointments; here is what he recorded:

Day 1
Breakfast — Skipped
Lunch — Skipped
Dinner — 2 hot dogs and cole slaw; fruit punch

Day 2
Breakfast — Skipped
Lunch — Bag of chips
Dinner — Chicken nuggets and iced tea

He weighs 485 lbs. and is 5' 11" tall.

I referred him to a six-part cooking series we offer to assist clients with basic cooking skills, grocery shopping field trips, label reading and creating a personal pantry. This program was created to address the many challenges faced by patients like this man. They are often poor, mentally ill with comorbidities, food insecure and lack basic cooking skills. The pantry lesson is designed to encourage participants to build their own stock of nutritious, shelf-stable food that will bridge gaps when their food budget is exhausted. We cook a meal from our sample pantry called Indian Dal. It is from a book we distribute to all participants titled *Good and Cheap: Eat Well on $4 a Day* by Leanne Brown. The book includes cost per serving for each recipe. The Indian Dal costs 65 cents a serving.

Other patients at the mental health center struggle with other basic needs. Many have missing or low functioning teeth. That makes it difficult to eat healthful foods such as nuts and salads but easy to eat French fries and ramen noodles. Some patients don't own plates or pans.

I asked the client who enrolled in the cooking series why he hasn't cooked the dal recipe he enjoyed for his teenage son. I realized the man doesn't have a kitchen table or a coffee table. It's hard to eat a meal sitting on the floor when your weight is almost 500 lbs.

In another case, a 62-year-old woman presented with pedal edema. When I noticed her swollen legs, I was concerned and referred her to a vascular doctor. She was hospitalized for a week and her edema improved significantly. She told me it was sleeping in a bed that helped more than the diuretic. She didn't own a bed. The primary care provider in our clinic found her a bed, and she continues to improve.

Food security, dental needs, cooking skills, housing status and household dynamics all must be considered when writing my dietary recommendations. Other health care providers can play an important role in asking simple questions such as: "What have you eaten today?," and intervening when food insecurity is identified.

A chaplain at another psychiatric institution tells the story of his work with those in an inpatient setting who have serious mental illness. One woman showed up every week for his voluntary support group. She was often unpleasant and hostile, but she consistently showed up.

One day she said, "Father, I'm having a good day."

The chaplain replied, "Is that right?"

"Yes, a life-changing day," she replied, and continued "the psych meds make my hands shake so I worry when I carry my food tray to a table that the food will spill. Today, another patient said, `have a seat, I'll carry it for you.' That's why I'm having a good day." This small gesture made for a life-changing moment. The chaplain's message was that we should all do the "next right thing in our own power." It won't fix everything but if we all did the next right thing, we'd be living in a better world.

CONCLUSION

Managing hunger is stressful and takes up a lot of brain space. It leaves less energy for registering and renewing benefits, applying for and maintaining employment, taking care of health needs, parenting children and managing recovery from substance abuse and addiction.

For every $1 spent on food, and feeding an indi-

vidual who is food insecure, approximately $50 is saved in Medicaid expenses. It is less expensive to feed an individual healthy food for one year than to cover the costs of hospitalizations and related medical expenses for one day. From a policy perspective, it would make sense to pay for nutrition support on one end to curtail higher health expenditures on the other end.

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NOTES

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QUESTIONS FOR DISCUSSION

Francine Blinten is a clinical nutritionist concerned with the connection between food insecurity and mental health in her roles at the Connecticut Mental Health Center and the Yale University School of Medicine, Department of Psychiatry. She contends that many health care professionals aren't trained to identify hunger and food insecurity, which leads to patients being misdiagnosed or disregarded.

1. How widespread do you think Blinten's examples of misdiagnoses are because of lack of training and insufficient awareness of social determinants? What are the consequences if patients are deemed non-compliant when they don't have the means or access to carry out directives or suggestions for healthy foods and proper intakes?

2. What screening practices does your ministry have in place to help patients with issues related to food insecurity? Where is the best place/what is the best time to pursue those screenings and fill in that aspect of whole-patient care? How does it fit into the discharge plan? Who is the right person to make sure food and nutrition issues are pursued for the patient's best health outcomes?

3. Blinten distinguishes hunger from food insecurity: the former is a personal sensation caused by lack of food; the latter is a larger issue that is household based and often ongoing and episodic. Talk about the two situations in terms of justice and how Catholic health care can contribute to both the immediate alleviation of hunger and the long-term goal of having healthy foods accessible to everyone. Does your ministry partner with other area health and social service organizations to alleviate hunger and food insecurity in your community?

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