Health Effects of the Current Housing Crisis on Residents of Jamaica Plain

A Report by the Health and Housing Task Force, Jamaica Plain Health Planning Committee

September, 2003
The Jamaica Plain Health Planning Committee works with residents of Jamaica Plain to identify ways to improve the health and well-being of the community. We will identify health issues through community input and analysis of data; convene individuals, providers, and organizations to address those needs; and promote communication and coordination of health programs for the Jamaica Plain community.

The Committee serves as:
A subcommittee of the Jamaica Plain Neighborhood Council
A committee of Jamaica Plain Coalition: Tree of Life/Árbol de Vida
The Jamaica Plain organization for the Boston Alliance For Community Health

We welcome participation. Contact the Committee through Margaret Noce, 617-522-4832 or nocemnoce@aol.com, or write us at Jamaica Plain Health Planning Committee c/o Jamaica Plain Coalition: Tree of Life/Árbol de Vida, 295 Centre St., Jamaica Plain, MA 02130

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Executive Summary

From 1997 through 2002, Jamaica Plain experienced a very rapid rise in rent levels and home prices. As the Jamaica Plain Health Planning Committee (JPHPC) looked at health issues affecting JP residents in late 2002, one issue kept coming up over and over again—**the biggest health issue was the lack of decent, affordable housing.** JPHPC convened a Health and Housing Task Force, with three goals.

- To define a framework of health problems related to housing, and as much as possible make it specific to Jamaica Plain
- To share our health and housing framework with community residents, and with medical and service providers.
- To share our findings with those engaged in setting public policy, in the hope that we could in this way contribute to solutions.

The Task Force report which follows details four key areas where housing has impacted the health of community residents. **Displacement and shelter poverty** can have serious repercussions on health. Displacement is not limited to physical displacement or eviction but also results in economic and social effects. Health effects of displacement may include loss of continuity of health care, loss of support systems, reduced quality of housing, increased levels of stress, and a threat to employment stability. Shelter poverty, referring here to those individuals who spend more than 30% of their income on housing, also significantly impacts health. Residents living in shelter poverty may be unable to purchase medications, afford good nutrition, afford transportation as well as maintain continuity of health care.

**The health effects of the home environment** are very significant in the connection between housing and health. Household hazards contribute to illnesses such as asthma, lead poisoning, and injuries, especially in children. The current high rents and lack of affordable units make it very difficult for many tenants to assert their rights regarding a safe home environment.

It can be expected that the stresses of substandard housing, overcrowding, financial burdens of shelter poverty, homelessness and fears of homelessness would have a negative effect on the **mental health** of both children and adults. Testimony from community residents and a survey of local mental health providers strongly suggests that these negative health impacts are occurring. Anxiety and depression are commonly identified, with symptoms such as insomnia, difficulties in concentration, anger, feelings of shame, inadequacy, hopelessness and helplessness, increased panic attacks, excessive worry and emotional instability.

A serious consequence of **homelessness** is its negative impact on health. Not only does homelessness exacerbate existing chronic conditions, it also causes certain illnesses from exposure to extreme conditions. The homeless increasingly become vulnerable to other illnesses, and homelessness has been associated with mental health problems. As a
neighborhood that for many years has had a large immigrant population, JP has had a significant, though hard to quantify, population of homeless residents, with doubling up of families the most prominent aspect.

How many JP residents have been displaced in the last ten years due to the crisis of affordability? Of those who left and those who were able to stay, how serious and extensive have been the health effects? These seem to be fundamental questions for a society that cares about its citizens, that spends billions on health care and on housing subsidies. Yet we don’t know the answers. Information is not systematically collected.

When market forces operate on a neighborhood like JP as they have over the past 10 years, there are few protections for the health and well being of residents. Nobody is counting the human and health costs to the people and families of Jamaica Plain. In this report we have described the effects and made an attempt to count the costs. In many ways, the fact that our system does not count the costs, does not include these costs as part of the equation, is the most damning indictment of our housing system.

The report is divided into four sections, which deal with the range of health effects related to JP’s housing crisis—
1. Health Effects related to Displacement and Shelter Poverty.
2. Health Effects of the Home Environment,
3. Mental Health Effects of Housing Issues, and
4. Health Effects of Homelessness,

Rapidly rising housing costs affected many JP residents during this period. Those who were not able to stay in their homes may be homeless (section 4) or displaced to other sections of Boston, or to a location outside the city (section 1). Those who stayed may be living in a poor physical environment (section 2), living with the stress of knowing they may soon be forced out (section 3), or paying a huge percentage of their income for housing (section 1). The report looks at all these groups.

The Task Force report includes 12 recommendations, ranging from educating providers about health effects of housing problems, to collecting better data about the health effects, to supporting and protecting tenants, creating more affordable housing, and providing more protection to tenants against unhealthy housing conditions.
1. Introduction

Imagine what it would be like if thousands of people lost their homes each year due to floods… imagine the response that would come from the government, from individuals, the aid and resources from all levels of society… now recognize that the natural disaster is instead man-made, is wholly preventable, and is the housing crisis today! – Boston Tenant Coalition

Housing is not only a necessity of life; it has a pervasive impact on all aspects of our existence. – Michael Stone, Shelter Poverty

Some composite profiles that represent Jamaica Plain’s housing crisis:

Margaret is a 72-year old lifelong resident of Jamaica Plain. She rented from her upstairs neighbor for 34 years before the neighbor’s death two years ago. Now Margaret’s rent has doubled from $500 to $1000 per month. Each month she must make painful decisions – to go without food, medicines, heat? In addition, Margaret’s peace of mind has been shattered. She dreads what the future may hold for her if her rent is raised again.

Jorge and Juana lived in JP for 10 years until a $600 rent increase forced them out in 1999. They found nothing they could afford in JP and now live in Brockton. Juana’s life has become much more stressful now that she can’t rely on her mother to come over and watch her three children when she has to do errands. Though Juana still sees her old friends, life is harder and she is resentful to be separated from her community.

Maria and her daughter finally received a Section 8 certificate after 6 years of waiting, but were unable to find an apartment where the landlord would accept it. She lost the Section 8 and has been forced to share an apartment with her sister’s family.

As the Jamaica Plain Health Planning Committee looked at health issues affecting JP residents in late 2002, one issue kept coming up over and over again - the biggest health issue was the lack of decent, affordable housing. The Committee had focused on more traditional health problems such as asthma in previous years, but had also at times taken on issues that were not traditional medical issues, such as Domestic Violence. In the past taking on a health issue has meant for the Committee finding a way to intervene to address the problem- how would we do that with the housing crisis?

In the end, we convened a Health and Housing Task Force, with three goals.

- To define a framework of health problems related to housing, and as much as possible make it specific to Jamaica Plain
To share our health and housing framework with community residents, and with medical and service providers.

To share our findings with those engaged in setting public policy, in the hope that we could in this way contribute to solutions.

As we have worked to put together this report, we have tried to keep our focus local, look at JP trends and realities, listen to people’s stories as well as looking at available data and studies.

What is the housing crisis we refer to which led us to look at health effects?

From 1997 through 2002, Jamaica Plain experienced a very rapid rise in rent levels and home prices. Advertised rent levels for newly available apartments rose 32% (Boston Department of Neighborhood Development, 1997-2002) during this period. Many existing long-term residents experienced large rent increases as landlords “caught up” with the market rents.

- Housing sale prices increased 90% for single family homes, 113% for two-families, 177% for three-families, and 102% for condominiums. (Boston Department of Neighborhood Development, 1997-2002) Thus home ownership in Jamaica Plain became unaffordable for those who would have otherwise moved from renters to ownership.
- Many residents who were affected by rent increases or the high price of housing became “shelter poor,” paying greater than 30% (and in some cases a much higher percentage) of their income for housing costs.
- For those existing owners and renters who were not severely affected by these increases, housing options were very limited within Jamaica Plain. Many of those who otherwise would have moved due to poor conditions, domestic violence, increase in family size or other reasons were forced to stay in their existing housing.
- Many residents were displaced, forced to move for a variety of reasons and unable to relocate within Jamaica Plain.
- Some residents became homeless, ending up living in a shelter, on the street, or doubled up in an overcrowded housing unit with friends or family.

We have divided our report into four sections, which deal with the range of health effects related to JP’s housing crisis-

1. Health Effects related to Displacement and Shelter Poverty.
2. Health Effects of the Home Environment,
3. Mental Health Effects of Housing Issues, and
4. Health Effects of Homelessness,

Rapidly rising housing costs affected many JP residents. Those who were not able to stay in their homes may be homeless (section 1) or displaced to other sections of Boston, or, more likely, to a location outside the city (section 4). Those who stayed may be living in a poor physical environment (section 2), living with the stress of knowing they may soon
be forced out (section 3), or paying a huge percentage of their income for housing
(section 4). Our report looks at all these groups.

The Health and Housing Task Force’s preliminary findings were released to the
community at a public meeting held at English High School in Jamaica Plain on May 27,
2003. The preliminary findings were presented by a panel of Task Force members that
consisted of Tom Kieffer, Executive Director, Southern Jamaica Plain Health Center;
Boston City Councilor John Tobin (District 6); Juan Leyton, Executive Director, City
Life/Vida Urbana; and Barbara Ferrer, Deputy Director, Boston Public Health
Commission.

The meeting was attended by approximately 35 members of the community and
testimony was taken from 20 attendees, including community residents, social service
providers and health care providers. English-Spanish translation was provided. The
testimony reinforced much of the Task Force’s previous findings and added new issues,
both as providing the personal stories and feelings that make the issues of health and
housing so compelling. Excerpts from the testimony taken at the meeting are included in
the relevant sections of this report, attributed to the May 27 Community Meeting.

2. Health Effects of Displacement and Shelter Poverty

Rising rents and housing costs have forced some JP residents into homelessness, meaning
living on the street or in a shelter, or doubled up with others in overcrowded living
situations. Homelessness and the health effects for those residents who become homeless
are described in section 3 of this report.

For those who did not become homeless, rising housing costs led to a dilemma—find less
expensive housing by leaving Jamaica Plain (displacement), or pay a larger percentage
of household income for housing costs, causing difficult economic choices in obtaining
other necessities such as food, medicines, health care, transportation, etc. (shelter
poverty). In this section, we will address the health effects of displacement and shelter
poverty on JP residents.

For those who have been displaced, these health effects may include loss of continuity of
care; loss of support systems, including language, transportation, social service, and child
care; reduced quality of housing or overcrowding with resultant health problems;
increased level of stress; threat to employment stability or employment options, again
with resultant health problems and threatened access to health insurance; and school
disruption or failure. Before describing these effects in detail, we will look at the
question of how many JP residents have been affected by displacement.

Key Concepts: Displacement and shelter poverty can have serious repercussions on
health. Displacement is not limited to physical displacement or eviction but also results
in economic and social effects. Health effects of displacement may include loss of
continuity of health care, loss of support systems, reduced quality of housing, increased
levels of stress, and a threat to employment stability. Shelter poverty, referring to those
individuals who spend more than 30% of their income on housing, also significantly impacts health. Residents living in shelter poverty may be unable to purchase medications, afford good nutrition, afford transportation as well as maintain continuity of health care.

How much displacement?
How many JP residents have been displaced to nearby neighborhoods (Roslindale, Hyde Park, etc.) or more distant communities with more affordable housing opportunities (Brockton, Chelsea, Lawrence, etc.)? For longtime JP residents, the prevalence of displacement, especially to distant communities, is obvious. It is common knowledge for many who are still living in JP that significant proportions of their friendship and family networks have left JP for economic reasons. And nearby communities such as Roslindale are often not options, because they are also impacted by sharply increased housing costs. But there are no statistics kept on economic displacement, so we are left with more indirect measures if we wish to quantify this “common knowledge” of economic displacement.

Evictions – since 1994, the annual number of eviction cases in Boston Housing Court (covering all of Boston) has jumped substantially. In the first four years of the ‘90’s, eviction cases averaged 4,983 annually. Since then eviction cases have averaged 6,605. We do not have JP specific data. We know that many if not most cases of economic displacement do not end up in eviction proceedings, but are resolved through the tenant moving out without court intervention. But the rise in eviction cases is certainly a proxy for increased displacement.

A look at demographics of health center patients is suggestive though again far from definitive. Using Southern JP Health Center data, we can see a significant rise in the proportion of active patients who live in more affordable but more distant locations such as Brockton, Chelsea, Everett, Malden, Revere, Lawrence, Quincy, and as far away as Attleboro and Rhode Island. Active patients who live in these towns rose from 123 to 505, an increase of over 300%, between 1994 and 2002. During this period, the number of health center patients rose only 100%. Especially notable are the farther away locations such as Brockton, Attleboro, and Rhode Island, rising from a total of 4 patients in 1994 to 173 in 2002.

Of course many health center patients displaced from Jamaica Plain have found health care providers nearer to their new homes, so these numbers are more important in reflecting a trend than in quantifying displacement. The numbers are more significant because they are entirely consistent with the “common knowledge” and anecdotal evidence of community trends.

Who is affected by economic displacement?
Who is at risk of displacement? A look at the most basic elements of JP’s population profile as reflected in the 2000 Census makes it clear that it is the Latino and African-American population whose housing is most at risk (this and subsequent data from Census 2000, US Census Bureau). Of white households, 73% have more than one adult,
with two thirds of these households having no children. Forty-two percent of white households were owner occupied. Only 43% of Latino households had more than one adult, and two thirds of single-adult households contained children. Fifteen percent of Latinos were owner-occupants. Of the African-American households, 33% have more than one adult, and two thirds of single adult households have children. Sixteen percent of African-American households were owner-occupied. While 15% of JP residents are children under 14, within JP the percentages vary from 7% of white residents, 22% of African-American residents, and 27% of Latino residents being under 14.

Clearly Latino and African-American households are more vulnerable to economic displacement, having more single adult households, more children, and much less home ownership. The health effects of displacement will disproportionately affect them.

**What are the health effects?**

The key areas in which health may be affected are:

**Loss of continuity of care.** Individuals and families who had established relationships with health care providers often lose these relationships when displaced from their community. There is clearly a spectrum of result—some are able to simply transfer their medical records and continue with a new provider, while for others there are significant health effects. The loss of the caring individual or organization can lead to fragmented and ineffective health care, or even a lack of access to care. Those who decide to continue with their JP provider, such as the SJPHC patients noted above, find that there are difficulties with transportation, or sometimes a trip to a local emergency room for what would have been a doctor’s office visit if their doctor was local.

**Loss of support systems, including language, transportation, social service, and childcare.** For what groups of people are these support systems most important? For immigrant populations, they are crucial. For those without the income to pay for childcare or to have a reliable car, these support systems are extremely important. For families with multiple or complex problems who have relied on the community’s social service network and their friendship network, continued successful functioning can be difficult in a distant community. As a nation, we move around frequently, establish new friendship networks and adapt to our new surroundings. But many of the families economically displaced from JP are not families who would choose to do so; they may lack the economic, social, language, and educational resources to adapt. Clearly those who choose to move to a distant community or state are much more prepared to do so than those who have been economically displaced. When support systems are lost, we believe that children and adults are less likely to keep regular preventive health care appointments, appropriate home care for illness is less likely to happen, and mental health issues and domestic violence situations are less likely to be addressed.

**Reduced quality of housing or overcrowding.** Those who are displaced from JP may end up in better, worse, or similar quality of housing. Because housing displacement often coincides with a period of financial crisis as a family tries to pay the higher rent and fails, options may be very limited. New housing may not only be far away but may be in poor condition or of inadequate size. Families may be forced to accept housing where
lead paint has not been removed, or where the internal environment is unhealthy for a child with asthma.

**Increased level of stress.** The experience of housing displacement is frequently an extremely stressful one for an individual or family. Especially for a low-income family, even a voluntary move to a new community involves multiple complex tasks related to the housing itself, schools, jobs, and relationships. An involuntary move may also be accompanied by court appearances related to eviction, anger and frustration, confrontations with a landlord, a sense of defeat and sometimes blaming within families, and difficulty approaching the new community with a positive and hopeful attitude.

Stress has been shown to exacerbate many medical conditions as well as cause or exacerbate mental health issues such as anxiety and depression.

*We came to Boston for a better life. There’s no rent control because it was voted out. My husband has diabetes, which can affect the kidneys. The problem is our salary is very low. It’s not enough. I tried to find a better job – we both need to work to afford an apartment. His health has really gone downwards. We came here for a better life and that’s the problem we’re having. We don’t want anyone to give us anything. We just want a decent place to live. - testimony at May 27, 2003 community meeting*

*As a doctor working in JP, I can say that there’s a big connection between stress and health. There are big demands of energy and time having to deal with housing problems, and priorities have to get reordered. People can’t address chronic illnesses, especially silent problems like heart problems and diabetes – care gets put off. Lots of people have had to move too far away from their providers. Stresses lead to family problems, drug and alcohol use, and worsens chronic conditions. - testimony at May 27 community meeting*

**Threat to employment stability or employment options.** Current employment may be threatened by transportation difficulties, or a long commute may make family responsibilities more difficult to sustain. Looking for a job in a new community may mean lacking the connections to job possibilities, and familiarity with local work opportunities, that many people rely on to get employment. While displacement to a distant community can be difficult for an individual or family, combining displacement with loss of employment or long-term unemployment can be disastrous. Unemployment is tied to mental health issues such as depression, as well as higher levels of a variety of medical issues. The additional side effect of job loss can be the loss of health insurance for individuals and families, which can impact access to health care.

**Shelter Poverty**

Many individuals and families manage to stay in JP despite increased housing costs. Households that pay more than 30% of their income for housing are referred to as “shelter poor”. Shelter poverty is a complex phenomenon to fully understand and characterize and we will not do so here. Michael Stone in his book Shelter Poverty (1993) conceptualizes and defines shelter poverty, and analyzes why using a simple
percentage of income, unadjusted for income level, family size, and other factors, is inadequate, and tends to underestimate the extent of shelter poverty. He estimates that in 1991 40% of all renters and 20% of homeowners were shelter-poor. For our analysis we will use the 30% of income measure as a basic definition of shelter poverty, to try to understand how the health of community residents may be affected when their housing costs go up.

Several attendees at the May 27 community meeting testified that individuals and families face difficult health-related decisions when so much of their household’s income has to go toward housing. Residents either must delay or forego care, or ration their prescriptions to make ends meet. These dilemmas flow from the realities of shelter poverty.

Before addressing the health effects of shelter poverty, it would be useful to quantify it in JP. We don’t know how many JP residents are shelter poor, using this definition. We can use some census data to help think about how much this phenomenon is increasing.

Boston Department of Neighborhood Development (BDND) figures are available for average advertised rents for a two-bedroom apartment during the years 1997-2002. During this period the figure went up from $1100 to $1450, an increase of 32%. We believe the rent increases for JP residents may have been more than this, but we will use advertised rent data since that is what is available.

Assuming a household is paying 30% of income for rent, the income required to afford this average rent went from $44,000 in 1997 to $58,000 in 2002. Assuming 3% annual inflation, we would have expected income to rise from $44,000 to $51,000 over this period. For those renters with household incomes between $51,000 and $58,000, they became shelter poor during this period due to rising housing costs. This would be, using census data, about 460 households or almost 7% of JP’s population. But there are also 3,452 households, or 50% of JP households, who make less than $51,000. Just over half these households live in subsidized or public housing and thus have their rent set at 30% of their income. We can estimate that JP’s “shelter poor” population went from 23% to 30% of the total population during these six years, or from 8,785 to 11,458.

Why is such a calculation important? It helps to reflect the order of magnitude of this problem. It gives us some confidence in saying that during this period, a few or several thousands of JP residents joined the 25% who were already experiencing shelter poverty. As we think of the health effects that are related, we can keep these residents in mind. These are the ones who have managed to avoid being displaced from JP, but are paying the price of shelter poverty. Few of them are officially poor, if defined as having incomes below the federal poverty guidelines. For the most part, those at these extremely low-income levels are either living in subsidized housing or doubled up in an overcrowded situation, and are not included in our Shelter Poor.
Why is Shelter Poverty a health issue?
These individuals and families struggle to:

- Purchase their medications - even if they have insurance, the co-pays can be very burdensome
  
  I’m a social service provider in JP. A year ago, my landlord sold my apartment. I looked into buying, but I can’t afford to. I’m now paying my $1600 rent by myself. I used to tell people that your health is first. But I’m an asthmatic and diabetic. I’m finding myself in a position where I think about using my inhaler three times a day, maybe I can get by with just two and stretch my medications. Maybe it’s time for me to not give so much to my community and get a higher paying job. I work two and three jobs, but how much more can you do? It’s juggling every month. This was a shock to find my family in this predicament. - testimony from May 27 Community meeting

- Afford the variety of foods they need to provide good nutrition
  
  Lack of affordable housing has been linked to inadequate nutrition, especially among children. Relatively expensive housing may force low-income tenants to use more of their resources to obtain shelter, leaving less for other necessities such as food. (Krieger and Higgins, 2002)

- Adequately heat their home during the winter

- Afford transportation to get to the doctor’s office for appointments which provide preventive services and help control chronic conditions

- Pay co-pays for medical visits if they have insurance - many individuals may choose to forego an needed appointment rather than be unable to pay the copay

- Find and consistently use a health care provider who will give them free health care

- Maintain a focus on preventive health issues that will give them and their families optimal health

- Buy air purifiers, vitamins, new toothbrushes, exercise equipment, gym or team membership fees, car seats and bike helmets, infant cabinet locks, recommended amounts of fresh fruits and vegetables, dental checkups, and so many other things that may contribute to health but are not available to households whose income is being used to pay exorbitant rent or house payments.

Displacement or Shelter Poverty: Unhealthy Dilemma

JP families and individuals facing rent increases which they can’t afford face choosing displacement to another community or staying in JP in the condition of shelter poverty. Either will likely have detrimental health effects. Even this unhealthy dilemma is preferable to homelessness, which also becomes an all-too-real possibility in this situation.

3. Health Effects of the Home Environment

The inequitable socioeconomic distribution of substandard housing reflects underlying disparities in income, assets, and power. Tenants are often powerless to improve their housing conditions in the context of low vacancy rates, high rental
costs, weak tenant protection laws, and politically influential landlord associations commonly found in American cities. (Freeman, 2002)

**Key concepts:** The health effects of the home environment are a formidable factor in the connection between housing and health. Household hazards contribute to illnesses such as asthma, lead poisoning, and injuries, especially in children. The current high rents and lack of affordable units make it very difficult for many tenants to assert their rights to a safe home environment.

**Overview**

An analysis of the health effects of Jamaica Plain’s housing crisis must include the effects of the internal environment of the home, for those who are able to stay in the Jamaica Plain community.

Substandard housing conditions that affect the health of residents are nothing new to Jamaica Plain. The housing stock, especially in lower-income sections of JP, is old (often over 100 years old). As JP went through a period of disinvestment and economic decline in the 1960’s and 1970’s, much of the housing fell into a state of disrepair. A significant percentage of housing contained lead paint. Many landlords chose not to invest in buildings in disrepair, and in the late ’70’s a wave of arson cost the neighborhood many buildings. For residents, large rent increases were a less common problem than bad housing conditions.

Two waves of soaring rents and property values, in the late ’80’s and late ’90’s, have led to a very different situation. Huge increases in rent and housing cost have led to displacement, doubling up, and homelessness. The increase in housing value has also led to investment in and upgrading of a substantial portion of the housing stock.

For many low-income residents who remain, poor housing conditions and the resultant health problems remain a serious issue, in spite of this new investment. A new element has been added to the equation— the fear of complaining about conditions is much greater because of the desperate lack of affordable units in the neighborhood.

At the May 27, 2003 community meeting, many residents reported poor, unsafe or unsanitary conditions in their apartments, including rodent and cockroach infestations, mold, and problems with heat. Residents and tenant activists testified that in many cases landlords have been unresponsive to complaints about apartment conditions. Some tenants testified that they had been evicted after having called the City of Boston Inspectional Services to complain about health code violations. Although tenants theoretically have legal protection against such evictions, many tenants are unaware of their rights, lack access to assistance in asserting their rights, and find that battles with landlords are stressful and difficult. This is particularly true for families whose wage earners are already working two or three jobs each just to survive. Some residents also testified that landlords have raised rents after fixing the conditions, sometimes beyond what a tenant could afford to pay.
I have six kids, one with asthma, one with psychosis, one with ADHD. My apartment has 36 violations. What is the process for the city and the Council to work together to force landlords to fix the apartments and not raise the rents? Right now, I pay $1800 and I have to move because my landlord raised the rent to $2200 and I can’t afford it. I was homeless for two years with six kids. We are human beings. We aren’t animals. - testimony from May 27 community meeting

Significant research demonstrates the harmful association of asthma, neurological damage, malnutrition, stunted growth, accidents, and injury with household triggers like poor insulation, combustion appliances, cockroach and rodent infestation, dust mites, hyper- and hypothermia, unaffordable rent, and dangerous levels of lead in soil and household paint. (Bashir, 2002) Poor and immigrant families are often afraid to complain, because living in substandard housing is better than being homeless. Too many families resign themselves to suffering in shame and watching their family’s health deteriorate, with little hope for help. (Bashir, 2002)

Norma Rosario is Director of City Life/Vida Urbana’s Healthy Homes project. She has worked with hundreds of tenants each year who are patients at JP’s three community health centers. “Families are many times forced to remain in the bad conditions of an apartment, whether it be because they are not on the lease of the particular apartment, or unaware of their rights as tenants,” says Rosario. “Many families feel trapped in the bad conditions in which they live. Their options for living arrangements are limited due to their lack of economic resources, and they are unable to pay for market rate apartments.”

These families have seen their friends and neighbors forced to exodus to Chelsea and Brockton, or even worse become homeless. Asserting their rights as tenants can be very difficult in this situation.

I’ve been homeless for thirteen months. My landlord refused to fix a problem with my electricity. I complained and got evicted. I got evicted from a second apartment because I called the inspectors because of the mold and the mice. There’s no solution. I’ve lost all my belongings because I’m homeless, and DSS got involved, and now my son can’t live with me. - testimony from May 27 community meeting

There are many other conditions hazardous to health that may be present in the context of tenants who are reluctant to assert their rights because of lack of alternative affordable housing. Some are social issues such as a threat of domestic violence or other abusive situations. In this section we will focus on health conditions of a medical nature that are impacted by internal environmental conditions. The key health issues we will look at are asthma, lead poisoning, and childhood injuries.

Asthma

Asthma is estimated to affect more than four million children in the United States. There has been an increase in the prevalence, morbidity, and mortality of children with asthma during the past two decades. From 1980 to 1993, prevalence of asthma increased by 75%, with the largest increase occurring in children under five years old. Each year in the U.S., asthma leads to more than three million clinic visits, 550,000 emergency visits, 150,000
hospitalizations, and greater than 150 deaths in children under 15 years old (Lanphear, Aligne, Auinger, Weitzman, & Byrd, 2001). The Institute of Medicine’s study of indoor air exposures and asthma cited studies estimating the annual economic burden of asthma to be $6 billion in the mid-’90’s. Asthma is the most common chronic illness among children and is the leading cause for school absenteeism. It often impairs the child’s ability to participate in a full range of activities.

In Boston, asthma is the number one reason for preventable hospitalization for children under nine years of age and the number one health reason for school absenteeism (Andelman, Graham, & Loh, 2003). The prevalence of asthma in Boston's neighborhoods reflects national trends with higher rates in poorer neighborhoods. The rates of asthma hospitalization in Boston’s Roxbury section between 1994 and 1997 were the highest in the city, about six to eight times that in wealthier Back Bay (Powell, 2002). The Massachusetts Division of Health Care Finance and Policy analyzed 1999 asthma hospitalizations and found that Jamaica Plain was number nine on the top ten list with 105 per 1,000 cases. According to the Boston Public Health Commission’s (BPHC) Health of Boston report (2002) Jamaica Plain had the third highest rate of asthma hospitalization rates among Boston’s neighborhoods, after Roxbury and North Dorchester.

Asthma is triggered by exposure to allergens and irritants. Substandard housing increases the possibility of exposure to irritating factors including pest infestation; moisture and mold; dust; smoke; and poor air quality with inadequate ventilation due to dry heat, lack of heat, and use of gas oven or stove for heat. Too often asthma triggers are beyond families' control. Annually in Massachusetts, it is estimated that there are 9,995 asthma hospitalizations of children ages four to nine due to cockroach infestation (Sandel & Sharfstein, 1998). The presence of cockroaches is not simply a measure of cleanliness. Many apartments are infested because of the building's structure, not individual families' habits. Removal becomes complicated, considering that the chemicals used in extermination are additional asthma triggers. Integrated pest management techniques such as keeping homes clean, potential pest entryways blocked, and food sealed tightly are emphasized by asthma educators as ways of managing pest infestation; this can be difficult unless the entire building is in compliance. Families who are doubled up often cannot complain about cigarette smoke in housing common areas, another common asthma trigger. Another significant issue with substandard housing is the location; inner city housing is often crowded, surrounded by dumpsters and public transportation, which leak airway irritants into the air.

The coordinator for the Community Asthma Program at Brigham and Women’s Hospital performs home visits in Jamaica Plain to help educate patients and their families regarding asthma management, and identifying and removing existing household asthma triggers. She has found homes in significant disrepair loaded with asthma triggers. The common response from the residents in these homes is that they are too concerned about safety and having a place to live, and that they have complained numerous times to landlords to no avail. She has shared the following stories about what she has seen-
...I performed a home visit with a 40 year old single woman with two daughters, age 10 and 12, living in public housing. I visited in the winter, just after a recent heavy snowstorm. The window, which made up about half the size of the wall in one of the bedrooms, was out - it had been broken and never repaired, making that room very cold. The living room and the rest of the apartment were terribly overheated. There was a leak in another apartment directly upstairs, and the wall between the bathroom and the bedroom was dripping heavily, the equivalent of a waterfall. There was severe mold on the window surfaces in the bathroom. Roaches were crawling everywhere, and rodent droppings were all over the place. The woman admitted to being on the verge of 'losing it'; her two children slept with her in her bedroom, because she was terrified for their safety due to the broken window in the other room. The woman wasn’t working and couldn’t afford to move. I connected her to City Life, and she is currently working with a case manager. However the processes are so slow, she is still living in this place with no improvements taken place.

I had an unforgettable home visit with a 30 year old single woman with an 8 year old daughter, renting the 3rd floor of a private house. Both had asthma. The apartment appeared to be under construction. Areas of the floor had missing floorboards, the walls were unfinished, and there were missing tiles in the bathroom as well as a severe mold problem. There was clutter everywhere in the home, and an non-functioning old stove in need of repair, and in the yard there were old refrigerators, dishwashing machines, old car parts, and the like. I recently performed a 6 month follow-up visit and sadly, no improvements have been made despite letters from my program and her health care provider concerning her poor living conditions.

**Lead Poisoning**

Childhood lead poisoning is a major public health problem in the U.S. Lead can be found in housing, soil, lead dust, or other sources such as water pipes. The risk for lead poisoning is greatest in poor, urban, and minority communities and between 18 and 36 months of age. Paint, dust and soil are the most common sources of lead for U.S. children. The major source of childhood lead poisoning in Boston is in homes built before 1950, when lead paint was commonly used. Lead hazards tend to be greatest in homes whose residents are of low socioeconomic status, in part because the paint in such homes is likely to be in poorer condition (Binder, Matte, Kresnow, Houston, & Sacks, 1996). These homes tend to be old and in various states of disrepair. The landlords are often not in compliance with lead laws, or may tend to discriminate against families with children under 6 years old in order to avoid the stringent lead laws.

Lead poisoning damages a young child’s developing brain, causing learning and behavioral disabilities. Where prevalence is high, the impact goes beyond just the child and their family, to affect the entire community – poor performance in schools, higher dropout rates and less employable young people. Studies of chronic lead exposure have shown that it can result in half of the expected number of children with IQ scores greater than 125 and twice the number with IQs less than 80 (Needleman, 1993).
The Lead Action Collaborative (LAC), a partnership to reduce the incidence of childhood lead poisoning in Boston’s highest risk neighborhoods, funded a geographic information system (GIS) mapping project to identify the three tiers of risk for lead poisoning, with tier one as the highest risk level. Tier one is given the highest priority because of the higher risk and greater number of children who are lead poisoned. Jamaica Plain was classified as tier two.

The Boston Public Health Commission, Childhood Lead Poisoning Prevention Program provides environmental and medical intervention, surveillance, and health education to families of children with elevated blood lead levels as well as homeowners. In Boston for the year 2002, a total of 24,115 children were screened for lead poisoning. There were 79 cases of children with elevated blood lead levels between 15-19 micrograms per deciliter (µg/dl), 32 cases between 20-24 µg/dl, and 34 cases 25 µg/dl or higher. For Jamaica Plain in CY2002, 1,267 children were screened for lead poisoning. There were only 2 cases of children with elevated blood lead levels between 15-19 µg/dl, 2 cases between 20-24 µg/dl, and only 1 case greater than 25 µg/dl.

Between 63-67% of all the housing units in Boston neighborhoods were built before 1950. The overall prevalence rate of Elevated Blood Lead Levels (10 µg/dl or higher) for the City of Boston declined from 4.6% in 2001 to 3.99% in 2002. The prevalence rate for Elevated Blood Lead Levels in Jamaica Plain for 2002 was 3.16%. Over the past 10 years Elevated Blood Lead Levels in Boston neighborhoods have trended downward, and the Boston Childhood Lead Poisoning Prevention Program of the Boston Public Health Commission is working in partnership with state, local, federal, private agencies, health centers, and neighborhood activist groups to eliminate childhood lead poisoning before the Reach 2010 goals.

Remediation of situations where high lead levels exist in children is particularly difficult. It often involves great expense for the owner or landlord, necessitates that the family move to alternative housing while lead removal is in process, and challenges the adaptive skills even of families that have resources and support. In the current setting, asserting a family’s right to have lead paint removed can be very difficult if a family is doubled up, or living at a lower than market rent.

While stringent lead paint removal laws and aggressive enforcement have helped reduce lead levels in Boston’s children over the years, the ability of families to assert their rights freely is crucial to the process of avoiding lead poisoning in children.

**Childhood injuries**

Accidents associated with housing conditions include falls, burns, drowning and fires. Problems associated with housing which can lead to these accidents include lack of fire alarms, fire extinguishers and fire escapes; exposed or old wires; radiators without protective covers; windows without screens or guards; and unstable stairs, railings or porches (Baker, O’Neill & Ginsberg, 1992). These poor housing conditions are often found in homes not up to code. Families put up with these conditions because they can’t afford better housing.
Accidents are the leading cause of death in the U.S. among children ages one through fourteen. Although motor vehicle accidents are the most common, accidents associated with housing conditions almost equals that number. Each year in the U.S., 13.5 million nonfatal injuries occur in and around the home; and 2,900 people die in house fires (Krieger & Higgins, 2002). Annually in Massachusetts, an estimated 1,485 burns to children from exposed radiators and 187 child deaths due to fires potentially attributable to electrical and heating problems in poor households (Sandel and Sharfstein, 1998).

The Boston Public Health Commission’s Injury Surveillance Program (2002) found that Boston had a higher injury fatality and hospitalization rate for children, than the rest of Massachusetts. The BPHC’s Health of Boston (2002) reports that childhood falls account for an estimated two million emergency department visits a year, with the majority of falls occurring at home.

The Injury Free Coalition for Kids looked at Children’s Hospital’s records for Boston and Jamaica Plain residents. In Boston, 127 deaths were related to injuries between 1995 and 1999. Children were most often admitted to the hospital with an injury due to falls. Between 1999 and 2001, 65 children from Jamaica Plain had injuries that required hospitalization. During this same time period, 1,332 children from Jamaica Plain were treated for injuries at Children's Hospital Emergency Department, and the types of injuries included 345 wounds, 174 sprains, 171 fractures, 166 contusions, 96 brain injuries, 44 foreign bodies, 40 abrasions, 22 burns, and 120 other injuries.

As with asthma and lead poisoning, childhood injuries are a particularly dangerous threat to health in a setting where tenants are reluctant to assert their rights. Case managers, tenant organizers, and housing inspectors agree that current conditions in JP and other communities often lead to just such reluctance.

Other Health Issues
Poor housing conditions are associated with many other health issues. Krieger and Higgins (2002) found that “Deviation of indoor temperature beyond a relatively narrow range has been associated with increased risk of cardiovascular disease. Living in cold housing has been associated with lower general health status and increased use of health services. These health concerns have contributed to the development of standards for thermal comfort.” The also note that “Crowding is associated with transmission of tuberculosis and respiratory infections. Lack of housing and the overcrowding found in temporary housing for the homeless also contribute to morbidity from respiratory infections and activation of tuberculosis.”

Infestations can be associated with other health problems in addition to asthma. JP Head Start parent Mrs. C. reports:

*In my apartment, there’s a lot of mice. I put traps but only some mice get trapped. It’s a lot, the more you catch, the more you see. A mouse bite is very dangerous. I have three kids and a year and a half baby, and I know mice are harmful to your health, and mice are around food too.*
Looking at the variety of health problems related to the home environment, the question arises as to whether these problems are getting better or worse. We do know that a huge amount of investment in housing improvements has accompanied each of the two waves of gentrification and increased housing costs that have affected JP in the past twenty years. It is difficult to know the effect of this investment. Clearly there are large segments of the JP population who are living in housing that has been upgraded and is in excellent condition. In the case of lead poisoning, there is clearly a downward trend over time. Testimony from housing counselors, medical providers, and tenants themselves makes it clear that the problem continues, and in the case of asthma, may well be worsening. The specific aspect of the problem that seems worse is the fear tenants have of calling a housing inspector or complaining about their poor housing conditions. Fear of losing the housing they have is forcing tenants to live in unhealthy homes.

4. Mental Health Effects of the Jamaica Plain Housing Crisis

This section discusses the mental health effects of the housing crisis on Jamaica Plain residents. As noted in the previous sections, both rents and home prices have risen dramatically from 1997 through 2002, resulting in frequent displacement from Jamaica Plain and in shelter poverty, homelessness, overcrowding, and substandard housing conditions among Jamaica Plain residents. This section draws its observations on the mental health effects of these housing issues based upon both quantitative and qualitative data collected from the three Jamaica Plain community health centers: Southern Jamaica Plain Health Center, Brookside Health Center and the Martha Eliot Health Center, as well as from interviews with community members.

Key Concepts: It can be expected that the stresses of substandard housing, overcrowding, financial burdens of shelter poverty, homelessness and fears of homelessness would have a negative effect on the mental health of both children and adults. However, the mental health impact of these housing issues have not been rigorously studied, making it difficult to assert that housing issues cause negative health impacts. Testimony from community residents and a survey of local mental health providers strongly suggests that these negative health impacts are occurring. Anxiety and depression are commonly identified, with symptoms such as insomnia, difficulties in concentration, anger, feelings of shame, inadequacy, hopelessness and helplessness, increased panic attacks, excessive worry and emotional instability.

Psychological Distress: Poverty has been shown to be highly correlated with mental health issues, although a causal relationship has not been determined. Concerns about substandard housing and fear of homeless have been shown to be psychosocial stressors that can lead to mental health problems (Krieger & Higgins, 2002). Shelter poverty, which we estimate affects nearly a third, or approximately 12,000 Jamaica Plain residents, and fear of homelessness have never been studied in this regard, but poverty itself should constitute a reasonable proxy for these phenomena. Further, in a study measuring psychological distress among immigrants, housing issues were shown to have a powerfully negative effect on emotional well being (Ponizovsky & Perl, 1997). Stone
(1993) describes some emotional effects of poor housing conditions. “The dangers posed by unsafe wiring, plumbing, heating, porches, and stairs, or the presence of lead paint and vermin, threaten not only physical safety but emotional security.” (Stone, 1993) 

I work with pregnant women at a health center here in JP. There are always problems with housing. I’m seeing much more depression this past year, especially situational depression and some pretty serious problems. Many women have a difficult time staying in the area to get healthcare for their children. Many more are doubled up and there have been more hospitalizations due to depression. Many patients are getting pushed further and further out of the community, and it’s difficult for them to stay with healthcare providers that know them and care for them. - health care provider testimony at May 27 hearing

Speaking of the overcrowding, bad housing conditions, and unstable housing that her clients face, City Life/Vida Urbana’s Director of the Healthy Homes Project, Norma Rosario says, “Depression and anxiety are among the most common symptoms I see in adults in these situations.”

The housing problem is affecting my health. Right now I am at the point that I am afraid I will do any crazy thing. I am in a very difficult situation with my kids, and I feel they bother the other people in the house. I can’t hold this any more. I came here to progress but I find a wall here. I am in my kid’s grandmother’s house, and I am in one bedroom with my kids. I have a boy 4 years old and a girl three months old and this situation is too difficult for me, the only thing I do is cry. I think when you have two babies, and you don’t have your own apartment where you can live in peace where you do not feel you bother anybody - that’s an emergency- I don’t think an emergency has to be necessarily because you have been abused or because your house burned. I think the government has to consider which is a real emergency. - Ms. B., Head Start parent

Crowding: Overcrowded housing is defined as housing that is occupied by more than one person per room. For example, if five people occupy a four-room house or apartment, that housing unit is overcrowded by the definition used by the federal government.

Crowding was associated with psychological distress among women aged 25 to 45 in London. Homelessness and living in substandard, temporary housing has been related to behavioral problems among children. (Krieger & Higgins, 2002)

Studies have shown that overcrowding in childhood home can be connected to a variety of serious diseases later in life. Overcrowding and poor quality housing have a direct relationship to poor mental health, developmental delay, heart disease, and even short stature. (Bashir, 2002).

For doubled-up families, in addition to the lack of space, there can be the constant tension around household routines and activities, and the strongly felt need for independence from parents and relatives:
The housing situation is affecting me because I need a home for myself and my children, because I am living with my parents, and we don’t have any space where the kids can play, and we don’t have privacy. - Mrs. L., Head Start parent

High-density and crowding have been shown to be associated with academic and cognitive difficulties, low motivation and behavior problems in children, especially in boys. Nationally, renters are more prone to overcrowding than owners (Myers, Baer & Choi, 1996). The highest rates of overcrowding nationally are found among recent immigrants, especially Latinos and Asians. Other correlates of overcrowding are expected to be income, age and family size (Myers, et al., 1996). Statistics relative to affordability and vacancy rates need to carefully considered: in large samples, socioeconomic status has a greater influence on crowding than do median rents, while vacancy rates have no effect (Myers, et al., 1996). When viewed at the neighborhood level, however, results may differ, as large samples aggregate upper and lower income neighborhoods. It should also be noted that advertised rents are generally higher than existing tenants’ rents, offering a further possible explanation for the apparent vacancy rate anomaly.

**Housing Quality:** Poor housing quality is associated with behavioral problems, low motivation and psychological symptoms in children (Evans, et al., 2001) and with psychological symptoms in adults (see lit review in Evans, et al., 2000, as well as Evans, et al., 2000 findings). (Katz, Kling & Liebman (2001) report similar findings.) Lead poisoning in children can result in neurological damage, reduced IQ, hyperactivity, aggression, learning disabilities and behavioral problems (Bashir, 2002; Krieger & Higgins, 2002). Finally, excessive indoor temperature is associated with irritability and social intolerance; cold and damp conditions with anxiety and depression (Krieger & Higgins, 2002).

**Survey Method**
Mental health providers at Southern Jamaica Plain Health Center, Brookside Health Center and Martha Eliot Health Center were surveyed to determine the impact of various housing issues on the mental health of their clients who reside in Jamaica Plain. Thirteen providers responded: five psychologists, four social workers, one psychopharmacologist, two psychology interns and one social work intern. Length of time working in that particular health center ranged from eight months to fifteen years, with the mean tenure being just over five years.

Jamaica Plain residents accounted for more than half of the providers’ caseloads. 62% of the Jamaica Plain residents with active mental health cases have been seen by their provider within the last month. Providers were asked to provide information regarding the housing status and mental health impact of those 146 clients who were both Jamaica Plain residents and had been seen in the previous month. Providers were not asked to disclose information regarding individual clients, or to identify their clients in any way.
It should be noted that the data collected by this survey relied on the providers’ recollection of what clients reported during their sessions; information regarding housing issues is not systematically collected by providers in any of the health centers. That is, housing issues are reflected in client sessions only to the extent that a client volunteers the information, or to the extent that the provider pro-actively seeks the information. It can be assumed that a client will only report a housing issue to a mental health provider if it is having a significant impact on his or her life. By the same token, it is also probable that some providers may be more or less sensitive to housing issues and may therefore be more or less prone to seeking this type of information from clients.

Results
All 146 clients in the sample currently have a diagnosis of and are receiving treatment for some mental disorder as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (APA, 2000), which is the standard diagnostic manual for all mental health providers nationwide.

Half of all clients in the sample identified some housing issue to their mental health provider. 45% reported difficulty in meeting the housing costs of their current residence, 32% that they currently lived in poor, unsafe or unsanitary conditions, 18% that they had had to stay with family or friends at some point in the previous year because they had been unable to find permanent housing, 18% currently live in overcrowded housing, 15% have had to move at least once in the last year because their housing had become unaffordable, and 7% had been homeless for some part of the previous year.

In terms of the mental health impact of these housing issues, 41% of clients with a housing issue felt that the housing issue impacted their mental disorder somewhat, 33% that it impacted their mental disorder significantly and 14% that it was having a severe impact on their mental disorder. However, providers themselves, who have the opportunity to observe their clients over time, and who, it could be argued, can observe their clients more objectively than clients themselves can, tended to view housing issues as having a greater impact on their clients’ mental health than did the clients. In the providers’ opinion, 15% of clients’ housing issues impacted their mental disorders only somewhat, 66% significantly, and 17% severely.

Rating the impact of housing issues on clients’ mental disorders on a scale with “no impact” equaling zero, “some impact” equaling one, “significant impact” equaling two and “severe impact” equaling three, the clients in the sample overall rated the impact at 1.48, or about halfway between “some” and “significant” impact, while providers rated the overall impact at 1.95, or as having a significant impact on the mental health of their clients.

When asked what symptoms clients report that are worsened by the housing issues that they have identified, all thirteen providers surveyed noted that anxiety is worsened by the housing issues that clients experience and even noted that depression is worsened. Other symptoms noted are: insomnia, difficulties in concentration, anger, feelings of shame,
inadequacy, hopelessness and helplessness, increased panic attacks, excessive worry and emotional instability.

All nine of the providers who have worked in their health center for more than two years noted that housing issues have been on an increase among their clients in the last several years, including rising costs, long waits for public housing, worsening conditions in public housing, increased difficulty in finding housing, increased displacement, overcrowding and homelessness and worsening mental health.

Perhaps the most illuminating information comes from the comments of the providers, a few of which follow:

[About half of my clients] have moved out of JP but continue to come here for mental health needs/services, which makes them miss appointments because of the distance, and get less support from family members.

As a therapist, I believe that in order for people to be able to use therapy, their basic needs need to be addressed. I consider that having a roof over your head a basic need and it is almost impossible to achieve good mental health if you do not have this basic need covered.

Housing is a basic for people to have emotional health. Housing has become increasingly expensive and unavailable for low-income people in Jamaica Plain who opt for moving away from their support network or live in overcrowded situations.

More and more, low income families have had to move out of Jamaica Plain due to the increase in the cost of housing. The only ones who can afford to stay are those who get into public housing or the young, single people who live with roommates.

I believe that the housing situation in Massachusetts has reached and passed a state crisis. The fact that many people have to struggle with their lack of a decent home to live in creates an alarming situation that could be avoided by the state becoming more responsible in attacking this problem.

Personal Stories Related to Mental Health and Housing

Two years ago, I came home and the guy who bought my building had raised everybody’s rents right way, $300 to start. I couldn’t afford that rent, and I was homeless for eighteen months. I went from place to place, and sometimes you’d have to stay out in the street – a couple times a week I’d be out in the street. I would probably doze off for a bit, but not the type of sleep you would get in a bed. Anything can happen, so anything you hear, you respond to right away – you’re on guard all the time.

When you’re homeless, you feel worthless. Like you’re nothing. Like you’re nobody. I got very depressed. I just didn’t want to live anymore. I was out of the
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street and I got really physically sick, too. I was in the emergency rooms all the time. You feel like a charity case. You feel a lot of shame. You have a useless life. You're useless compared to others. You stop caring about yourself, period. That's what basically happens, you just don't give a damn anymore. I would start drinking, just try to forget. I got into counseling and I started taking medications, which helped.

Things started to really change when I had a home finally. I don't have to ask anybody, can I take a shower? Or can I go to bed now? Bed? Not a bed, can I sleep on your sofa? Everything's different now. I have a key that I can stick in my door any time I want and I can leave and go any time I want. And it belongs to me. And I started caring in myself. So everything's changed. I got a home. My 9-year-old daughter visits me now – I spend a lot of time with her.

There are a lot of people that have to go to counselors and doctors and take medications – they end up getting sick mentally because of the situation they're in. If you don't have a home, it affects your mental health. You do get sick, and sometimes physically, too and that costs money. It costs society a lot of money. More money than I think the housing.

Joseph (not his real name), 48 years old, JP resident for 33 years

The last few years, my landlord just keeps raising the rent. Every year the increase is twice what it was the year before. It's too much. It's just too much money. I ended up in housing court because the landlord wanted to evict me. It was scary – I was a nervous wreck. Not just being threatened with eviction, but being in court. The landlord's lawyer tried to make me out like I was a bad person because I was behind in my rent, and I started kind of questioning myself, like I wasn't sure that I even deserved to try to stay in my apartment. But really, I didn't have any choice. I don't have anyplace to go. I don't have any family in the area, and none of my friends have room to take me in.

Well, I'm not homeless yet. But it's always hanging over my head. I got laid off a year ago and haven't been able to find a job. I'm trying to get by on unemployment, and I'm just getting more and more into debt. It's really scary. I had to start back on antidepressants a while ago, but I can't afford to see my therapist, because I don't have insurance.

I'm a grown woman, you know? Do you know how lousy it feels to feel like I can't take care of myself? I can't take care of the necessities of life on my own. Sometimes, it just feels so hopeless – like I'll never have any stability. I'll never have any security. I hate to think that I'll have to move out of the area. I have friends here now, I have a community, a life. I just want to cry whenever I think about how if I lose my apartment, I'll probably have to leave the area, then where will I go? If I'm depressed and anxious now, what'll it be like if I have to leave all my friends and have to start over somewhere else? Carol (not her real name), 40 years old, JP resident for 10 years
5. Health Effects of Homelessness

The number of people becoming homeless has been steadily rising over the past decade. In 1999, 35,000 households were homeless in Massachusetts. This figure represents approximately 60,000 men, women, and children; this is larger than the entire population living in Brookline, Holyoke, or Jamaica Plain. Parents and children make up 58% of Massachusetts’ homeless population. These numbers do not include families or individuals who were doubling up with relatives and friends while they searched for new housing. This only reflects the number of people who actually sought emergency shelter in 1999. A study by the University Of Massachusetts’ McCormack Institute estimate that an additional 370,000 renter households are shelter poor: they have a place to live but due to limited income they cannot meet their non-housing needs.

The number of homeless families has increased by 112% since 1990. These families included approximately 21,000 children; half of these children were pre-school aged. A startling fact is that 90% of these families were female-headed households. The average age of the head of the household was 32 years old.

Twenty-five thousand unaccompanied individuals were homeless in Massachusetts in 1999. The number of homeless individuals has increased by 14% since 1997, and doubled since 1990. Almost 75% of individuals using the emergency shelter system are between the ages of 25 and 54 years old. 11% were 18-24 and 8% were elders. 52% of the homeless adults have paid employment, but do not make enough money to secure housing. Approximately 1/3 of homeless individuals are veterans, 25% have mental health issues and 30% are struggling with substance abuse.

It is very difficult to quantify how many homeless families are doubled up with other families. The number of doubled up families is not available because it represents the unrecorded number of people who are turned down from shelters because they are over the income eligibility requirements. In addition, overcrowding through doubling up of families is hidden, due to the threat to the host family of loss of their own housing by breaking housing code space requirements.

Key Concepts: A serious consequence of homelessness is its negative impact on health. Not only does homelessness exacerbate existing chronic conditions, it also causes certain illnesses from exposure to extreme conditions. The homeless increasingly become vulnerable to other illnesses, and homelessness has been associated with mental health problems. As a neighborhood that for many years has had a large immigrant population, JP has had a significant population of homeless residents, with doubling up of families a prominent aspect. Yet Jamaica Plain’s population affected by homelessness is hard to quantify.

Dilemmas families face

At the May 27 community meeting, many residents testified on the multitude of difficulties facing families who lack permanent housing that they can afford.
Homelessness itself poses serious health risks, in addition to exposure to violence, loss of property, stress, anxiety and shame that homeless persons often experience. Residents and social service providers testified that shelters are full and the waiting list for subsidized housing may be years long. Families at risk for homelessness find themselves in a difficult position: families living doubled up are not considered homeless by government agencies, and therefore do not have priority for subsidized housing. However, due to the lack of housing, going into a shelter – if room is even available, and where conditions are sometimes crowded and inadequate – does not guarantee that a family will get housing. To make matters worse, a family can be evicted from subsidized housing if they are found to have allowed another family to double up with them. Residents testified that these impossible situations, which are so overwhelming and immediate, often cause them to drop out of health care; can cause chronic conditions, such as asthma and diabetes, to worsen; and cause much depression, anxiety and panic disorders.

If your income is over by 50 cents, you’re not eligible to go into a shelter. Or you can’t because of your legal status. People are in bad situations with few options. There’s no way out, and sometimes people have to stay in bad situations where their health is jeopardized. Depression, emotional distress, asthma, allergies. A lot of children have asthma, having to move from place to place, out in the cold looking for another place. Kids are affected by having no stable place to stay. It’s really sad. – testimony at May 27 community hearing

One patient of mine, a Latino women, struggled for years to keep her family together, and she managed until she lost her housing. She moved in with a series of friends and had to juggle her schedule. She dropped out of care and showed back up two years later. Her hypertension and diabetes were out of control. She now has permanent kidney damage. Most doctors working in JP treat families facing these kinds of problems. -local physician’s testimony at May 27 hearing

Key Health Effects of Being Homeless
There are four key health effects that can be a result of an individual being homeless.

1. **Homelessness exacerbates chronic illnesses.** When an individual is homeless it makes caring for chronic illnesses such as diabetes, hypertension, and AIDS very difficult. Homeless diabetics face an enormous challenge. They must watch their health very carefully, and the normal difficulties in caring for diabetes are multiplied. Insulin injections that should be given once or twice a day are very difficult to manage. It is hard for the homeless diabetic to carry supplies or find an accessible place to store or refrigerate them. Most shelters are very wary of drug abuse and an individual that they are not familiar with who tries to bring needles into a shelter will meet much opposition. It is also difficult for many homeless people to make sure they eat on a regular basis, and that what they eat meets their needs as a diabetic. For homeless persons living with HIV, the task of obtaining medications and taking them properly is almost insurmountable, and factors such as adequate rest and nutrition become difficult. For other chronic or
progressive diseases from cancer to thyroid disease to multiple sclerosis, homelessness multiplies the difficulty of proper care and treatment.

2. **Homelessness causes illness.** The physical strain of homelessness can cause medical problems. One of the major ones that the homeless encounter is foot problems, especially infections. Most homeless individuals spend much of their day on their feet, either walking everywhere or just standing around. It is very common for foot problems to develop in these people. Also being homeless makes people susceptible to otherwise uncommon diseases. The doctors at Health Care for the Homeless have encountered some diseases among their patients that are very rarely seen in the United State any more. The living conditions that the homeless encounter such as over crowded shelters and living on the streets are a breeding ground for rare and infectious illnesses.

3. **Homelessness makes individuals vulnerable to other illnesses.** The constant exposure to extremes causes illnesses such as frostbite, hypothermia, and heatstroke. Homeless people have very little control over their living environment usually experiencing extreme cold in the winter and extreme heat in the summer. A startling number of persons living on the street show visible signs of exposure to the cold. Homelessness also increases vulnerability to communicable diseases, like tuberculosis, influenza, stomach infestations, and insect diseases. Homeless people suffer from TB more than any other demographic group. They also appear to be more susceptible to diseases such as scabies, an illness that is caused by small insects that live under the skin. Scabies is highly contagious and is especially prevalent in the shelters. It can be very devastating for a homeless person since clothes of the infected individual must be thrown away. The nature of being homeless and living in the shelters and other overcrowded places makes it very easy to get these illnesses.

4. **Homelessness is associated with mental health problems.** The prevalence of mental illness among the homeless is a major issue often debated among policymakers and health professionals. The McCormack Institute report in 1999 approximated that at least 25% of the homeless have mental illness. Yet leaving aside the cause and effect of mental illness and homelessness, we know that homelessness is extremely stressful, whether it involves living on the street, in a shelter, or doubled up in an overcrowded situation.

*As a homeless mother, I’ve been arrested for trying to protect my stuff on the street. I now face 2½ years. Being treated as less-than – that’s the worst. I’m alienated from my friends and family because they think I’m looking for a handout. I’m not looking for a handout, I’m looking for genuine help.* - testimony at May 27 community meeting

*The Housing Department said that I need to live in a shelter with my son. I am not taking welfare, and my income is too low to pay a full rent... because of all this situation, I need to go to the psychologist and I have prescriptions. But I have to do without medication because I have my child.* – Ms. L., Head Start parent
Some Reasons for Homelessness in Boston

- Poverty (#1 for reason for homelessness in the U.S. and Boston)
- Insufficient Affordable Housing (#2 reason U.S. & Boston)
- Rents are rising at twice the general inflation rate and requests for emergency shelter are increasing.
- Loss of 96% single room occupancy dwellings in Boston since the ‘80’s
- Changes in welfare programs including time limitations for eligibility
- Poor discharge planning from institutions
- Mental illness.
- Lack of job skills and/or training
- Limited education and/or literacy
- Loss or lack of any personal support networks
- Lack of affordable health care

The Face of Boston’s Homeless

- The average age of the homeless child is 8. The average age of an adult is 24. The fastest growing individual population is the 12-18 year old range
- Of Boston’s homeless, 33% are African American, 33% Caucasian, 20% Latino, and the remainder are from other ethnic backgrounds
- Over 50% of the homeless work full-time or more but are unable to obtain affordable housing in Boston.
- Over 50% of homeless women and children are fleeing abuse and domestic violence.
- Over 50% of the homeless never graduated from high school and 39% went no further than high school or a GED. 10% have some college experience.
- Of the homeless in emergency shelters, 25% are self reported to have AIDS or are HIV positive. The actual number is much higher.

6. Conclusion and Recommendations

How many JP residents have been displaced in the last ten years due to the crisis of affordability? Of those who left and those who were able to stay, how serious and extensive have been the health effects? These seem to be fundamental questions for a society that cares about its citizens, that spends billions on health care and on housing subsidies. Yet we don’t know the answers. Information is not systematically collected.

Our housing system treats housing as a commodity, not as a basic human right. Housing is bought and sold for profit, and the housing market is central to a huge speculative industry. When market forces operate on a neighborhood like JP as they have over the past 10 years, there are few protections for the health and well being of residents. Nobody is counting the human and health costs to the people and families of Jamaica Plain. In this report we have described the effects and made an attempt to count the costs. In many ways, the fact that our system does not count the costs, does not include them as part of the equation, is the most damning indictment of our housing system.
As within the housing system, resources in the health care system are distributed unequally and irrationally. The great majority of funding goes to cure disease, not to prevent it. A huge proportion of funding goes to prolong the end of life, not to promote lifelong health. Similarly, the limited resources we put into housing are dwarfed by the needs and by the inequity of the system. A small group of speculators can buy and sell in an unregulated market, and move on with huge profits after displacing large number of low-income families. Families are devastated, live in fear and poverty, and are separated from their supportive community. Re-creating the lost affordable housing, unit by unit, at a huge expense and effort, offsets only a small percentage of this loss.

**Recommendations**

*I think there is no remedy for this. I read in the newspaper, Mayor Menino wanted to put rent control and he did not get good results, because everybody voted against that. Then I see this situation is too difficult because if they have the law they can use, and they don't do anything, imagine us? – Mrs. G., Head Start parent*

*We need to put our voices together to see if as a community, we can make a better plan, and handle this situation. - Mrs. L., Head Start parent*

Our recommendations are meant to be general. The Task Force did not have detailed discussion of housing policy or of how the health care system needs to respond to these issues. Given the information gathered for our report, we recommend the following:

1. Health care providers should be aware of the variety of ways housing issues can contribute to health problems. Where appropriate, screening questions should be asked of all patients to ensure that housing-related health problems are identified. Health providers should have adequate information to be comfortable addressing the health aspects of these issues. Resources such as the JP Asthma Environmental Initiative’s (JPAEI) Asthma Resource Guide, and other reference materials, should be available to providers. Providers should have easy access to referrals to JPAEI, Brigham and Women’s Hospital’s Community Asthma Program and the Boston Public Health Commission’s Healthy Homes program for home visits; City Life/Vida Urbana’s Healthy Homes, Healthy Families program for advocacy or housing search; and to Jamaica Plain Legal Services for legal support.

2. Information regarding displacement, poor housing conditions, rent increases, and homelessness should be more aggressively gathered and used in a way that gives an accurate picture of what community residents are experiencing. The City of Boston should initiate an annual neighborhood report on the state of housing, modeled on the “Health of Boston’s Neighborhoods” report. This report should bring together existing data on status of housing, and add new measures that better reflect the housing realities of neighborhoods as they affect tenants.
3. Provide funding for the Boston Public Health Commission to investigate and monitor the health effects of housing and of the current housing crisis in Boston, and make any needed recommendations to the Mayor.

4. Find an equitable way to limit rent increases and protect residents’ rights to decent housing conditions, to protect the health of Jamaica Plain and all Boston residents.

5. Establish regulations requiring that housing be built or rehabbed in a way which protects against asthma triggers and other health issues.

6. Develop more affordable housing, especially rental and Section 8 units.

7. Extend the protection period from 6 months to one year against landlord retaliation for tenants who exercise their legal rights.

8. Provide more funding for tenant advocacy and organizing programs. Provide information to tenants regarding their rights regarding rents, evictions, and housing conditions.

9. Provide information and sustainable resources for landlords who want to keep their housing affordable and safe, specifically addressing lead paint, asthma triggers, and injury hazards.

10. Provide better funding for community-based treatment programs for persons with chronic mental illness who are at risk of becoming homeless.

11. Provide more funding for medical services for shelters and Healthcare for the Homeless facilities.

12. Provide funding for homelessness prevention programs, using funds currently supporting expensive motel shelter programs to provide short-term help to tenants to prevent homelessness.

Notes


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Resources

- **Boston Public Health Commission’s Healthy Homes**
  1010 Massachusetts Avenue, Boston, MA 02118
  Phone: (617) 534-5966   Fax: (617) 534-2372

  This program addresses asthma through outreach activities for children and families, asthma education, and improved access to quality medical care.

- **Boston Urban Asthma Coalition (BUAC)**
  622 Washington Street Fl. #2, Dorchester, MA 02453
  Phone: (617) 279-2277   Fax: (617) 282-3950

  BUAC works on city-wide efforts to improve housing conditions, school indoor air quality, air quality, and access to quality medical care in the community.

- **Brigham and Women’s Hospital Community Asthma Program**
  15 Francis Street, Boston, MA 02115
  Phone: (617) 732-5500 X32833   Fax: (617) 732-7420

  A hospital outreach program providing asthma education, home visits, follow-up, and referrals to asthma resources to adults 18-54yrs in the Greater Boston Area.

- **City Life/Vida Urbana (CL/VU)**
  PO Box 117, Jamaica Plain, MA 02130
  Phone: (617) 524-3541   Fax: (617) 524-3555

  Provides housing advocacy, classes for new home buyers, and asthma education. CL/VU collaborates with the Boston Public Health Commission’s Health Homes Program and the Jamaica Plain Asthma Environmental Initiative.

- **JP Asthma Environmental Initiative (JPAEI)**
  75 Bickford Street 2nd Fl., Jamaica Plain, MA 02130
  Phone: (617) 971-0863   Fax: (617) 971-0286

  A community-based project working to eliminate asthma environmental triggers in the home and in the schools. Provides asthma education, home visits, offers support resources, including referrals to housing and legal agencies, and a support group for parents of children and teens with asthma.
• **Jamaica Plain Health Planning Committee (JPHPC)**
  (617) 983-6039      Fax: (617) 524-1716

  The Health Planning Committee is the Community Health Network Association (CHNA) for Jamaica Plain. The JPHPC links community agencies and residents to assess the health status of the community and develop programs to respond to community concerns.

• **JP Legal Services Center**
  122 Boylston Street/Jamaica Plain, MA 02130
  Phone: (617) 522-3003 Ext 2564      Fax: (617) 522-0715

  Provides free legal assistance program for tenants with asthma and helps tenants advocate to eliminate indoor environmental asthma triggers (roaches, mice, rats, mold, mildew, dust, excessive use of pesticides and leaks and chronic dampness).

• **Massachusetts Coalition for Occupational Safety and Health (MassCOSH)**
  12 Southern Avenue, Dorchester, Ma 02124
  Phone: (617) 825-7233 xt 15 Fax: (617) 929-0434    Hotline (617) 825-SAFE

  Advocates for safe, secure jobs and healthy communities. Offers training and technical assistance. Through the Healthy Schools Initiative and a collaboration with JPAEI MassCOSH looks at the environmental quality of schools and advocates for policies and resources to promote healthier schools in Jamaica Plain and Boston.