

# A safe home....



## HOMELESSNESS AND HEALTH

The definition of homelessness varies across and within countries. While those who are unsheltered and sleeping rough are obviously homeless, so also by many definitions are those living in overcrowded, substandard or transitional accommodation (Fazel, Geddes and Kushel, 2014). Statistics' New Zealand's definition of homelessness, updated in 2015, encompasses a wider grouping than those literally roofless. It reads, "Homelessness is defined as a living situation where people with no other options to acquire safe and secure housing are: without shelter, in temporary accommodation, sharing accommodation with a household, or living in uninhabitable housing". This does not necessarily cover those who may be living long-term in caravan parks or boarding houses, yet the stressors inherent in these living situations may well impact on health. Some authors prefer the term "severe housing deprivation" as it more accurately covers the multiple complexities of the phenomenon of "living in severely inadequate housing due to a lack of access to minimally adequate housing" (Amore, 2013, p.29) or the term "concealed homelessness (Harris, 2015).

The proposal that housing influences health is not a new one. As early as the mid-nineteenth century Florence Nightingale is said to have argued that "the connection between health and the dwellings of the population is one of the most important that exists" (Nightingale in Lowry, 1989). In order to maintain that homelessness influences health, it is necessary to define the concept of health and the particular dimensions of human life to which it applies. As with homelessness the definition of health does not have one single core meaning (Seedhouse, 1986), however in New Zealand a widely accepted model of health is that of Te Whare Tapa Wha, (Durie, 1985). This holistic model of health incorporates te Taha Wairua - the spiritual, te Taha Hinengaro – the mental, te Taha Tinana – the physical and te Taha Whanau – the family/social. These dimensions are closely interconnected and inseparable. If one aspect is compromised, the health of the individual and / or family is compromised. International research has shown that "residential stability is one of the most important predictors of community health" (Rauh, Landrigan, Claudio, 2008) – more so than poverty or ethnicity.

In 1998, while undertaking a Master of Arts degree, I had the privilege of interviewing thirteen individuals, from nine households, who were at the time experiencing housing deprivation. The aim of this research was to gain insight into the impact that charging market rentals for state

housing would have upon the tenants' ability to maintain and promote their health. The stories shared by participants who generously agreed to take part in this research clearly demonstrated a link between housing deprivation and compromised health. I would have hoped that in the intervening 18 years since this research was completed New Zealand would have witnessed a marked improvement in the housing / health situation of vulnerable families. Sadly, this is not so – in fact the situation has worsened.

Families in this study spoke of the health hazards, such as asthma and meningococcal disease, associated with living in overcrowded accommodation. Two participants, from different households, had been diagnosed with tuberculosis. The links between damp, overcrowded housing and respiratory diseases have been recognised for decades. In 1998 Dr Colin Tukuitonga, a General Practitioner and then Senior Lecturer at the Auckland School of Medicine, stated that removing market rentals from state housing was the action that would go furthest to prevent future outbreaks of tuberculosis. Damp, mouldy and cold housing has been proven to increase the risk of respiratory ailments such as asthma and the common cold (Butler, Williams, Tukuitonga and Paterson, 2003). Viruses, bacteria, fungi and dust mites, all known allergy triggers thrive in damp conditions. These New Zealand results are borne out by international studies which indicate that low-income families in public housing are four to five times more likely to suffer from asthma (Rauh, Landrigan and Claudio, 2008). For children environmental toxins can lead to time away from schooling, ongoing sub-optimal health, educational underachievement and therefore limit future employment opportunities. The term “fuel poverty” has been coined to describe the dilemma of choosing whether to spend limited finances on heating or food (Howden-Chapman and Chapman, 2012). In addition the cost required to visit a general practitioner and pay for resulting prescriptions can prove prohibitive. Howden-Chapman's research has shown that the elderly are most at risk from fuel poverty. Links have also been identified between inadequate housing and rheumatic fever (Pearson, Barnard, Pearce, Kingham and Howden-Chapman, 2014).

As outlined above in Te Whare Tapa Wha health is not only a physical reality. Mental and family / social health are also significantly impacted by homelessness. People who are homeless (or living in severe housing deprivation) have been shown to be at greater risk of family violence, social isolation and theft. Butler et al., (2003) noted the relationship between living in damp, cold accommodation and the development of post-natal depression in new mothers. Participants interviewed in my 1998 research spoke of friction developing between them and their extended families when it was necessary to seek accommodation in the homes of relatives. One couple spoke of having to cut ties with their extended family due to the cultural expectation that they provide a meal for guests, while they had not enough money left over from rent expenses to feed their own children.

Simply having accommodation or temporary housing may not enable people to feel that they have a home. It is possible to be housed yet remain homeless. Security of tenure, the ability to personalise their living space or to effect necessary repairs, to offer hospitality, to set household rules and to live in the area of their choice were all identified as contributing to a sense of home. When these elements were not found in their accommodation families experienced a sense of dis-ease and stress as opposed to security and well-being.

While the connection between housing and health is complicated and multifactorial it undoubtedly exists. Access to adequate accommodation is accepted by the United Nations as a basic human right under Article 11(1) of the International Covenant on Economic, Social and Cultural Rights. This international covenant signed by New Zealand in 1978 states ‘... the right of everyone to an adequate standard of living for himself [sic] and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions’. The crisis of homelessness currently faced by many New Zealanders is a human rights issue. Homelessness is a “whole-of-society issue” (McLoughlin and Carey, 2013), and its causes are multifactorial; however as housing is a basic human right it is essential Government policies address strategies to ensure affordable, health-promoting housing for all New Zealanders.

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