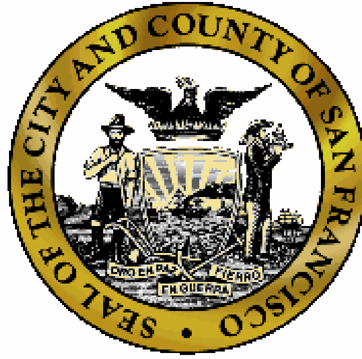

Report on Families With Children Living In Single Room Occupancy Hotels In San Francisco

Presented to

Honorable Willie L. Brown, Mayor

City and County of San Francisco Board of Supervisors

Honorable Tom Ammiano, President
Economic Vitality, Small Business and Social Policy Supervisors: Gerardo Sandoval, Gavin Newsom , Sophie Maxwell
Supervisors Chris Daly, Matt Gonzalez, Tony Hall, Mark Leno, Jake McGoldrick, Aaron Peskin, Leland Yee

San Francisco Department and Agency Directors

Trent Rhorer, Director, Department of Human Services
Terence Hallinan, District Attorney, San Francisco Office of the District Attorney
Mario Treviño, Chief of Department, San Francisco Fire Department
Mitch Katz, M.D., Director of Health, Department of Public Health
Darryl Higashi, Director, Mayor's Office of Housing
Lucien G. Canton, Director, Mayor's Office of Emergency Services
Louise H. Renne, City Attorney, Office of the City Attorney
Marcia Rosen, Executive Director, Redevelopment Agency
Gregg Fortner, Acting Executive Director, San Francisco Housing Authority
George Smith, Director, Mayor's Office on Homelessness
Fred Lau, Chief, San Francisco Police Department
Frank Y. Chiu, Director, Department of Building Inspections
Elizabeth Goldstein, Director, San Francisco Recreation and Park Department
Deborah Alvarez, Director, Department of Children, Youth, and Families
Arlene Ackerman, Superintendent, San Francisco Unified School District

by

San Francisco Board of Supervisor's SRO Health and Safety Task Force and the Families in SROs Workgroup Subcommittee

May 15, 2001

Table of Contents

Executive Summary ....Pages 1 – 6

Introduction.............................Pages 7 – 9

Findings ....Pages 10 – 20

Recommendations ....Page 21
Overall ....Page 22
Goal 1 ....Pages 23 – 26
Goal 2 ....Pages 27 – 28
Goal 3 ....Pages 29 – 30
Goal 4 ....Pages 31 – 37

Acknowledgements................Pages 38 – 40

Attachments............................Page 41
Attachment 1: ....Page 42 – SRO Census Survey Form
Attachment 2: ....Page 43 – DPH Family Focused Care
Attachment 3: ....Page 44 – DPH Environmental Health Section's New Policy
Attachment 4: ....Page 45 – Notice regarding "211"

References ....Page 46 – 55

Related Articles ....Page 56
Washington Post, 11-27-00 ....Pages 57 – 63
SF Chronicle, 1-19-01 ....Pages 64 – 65
SF Chronicle, 2-16-01 ....Pages 66 – 68

Executive Summary

Executive Summary

Introduction

In 1999, SRO residents and advocates organized and asserted to City leaders that critical issues facing families with children were not being addressed. The City created a “Families in SRO Workgroup” to research the issue and to recommend legislative, policy, and program changes that will help families with children:

(1) move from SROs into stable housing,
(2) be preserved while residing in SROs,
(3) live in clean, safe conditions when residing in SROs, and
(4) improve their socioeconomic and health status while residing in SROs and until housing stability is achieved.

Scope of the Problem

Although no exact figures are known, a sample survey conducted in the late 90’s estimated that 500 families lived in SROs in Chinatown alone. Of the near 900 families served by the DHS family shelter placement program during the first 9 months of FY00-01, 25% identified Hotel/SROs as their prior living situation and 8% were noted as leaving to a Hotel/SRO. More comprehensive information will be available when the “Census of Families with Children Residing in SROs” is completed in July of 2001 (Attachment 1, page 42).

There are an estimated 457 SRO Hotels in San Francisco with over 16,000 residential units. When families reside in SROs, they live in the privately-owned SROs, not those operated by community based organizations. Most SROs are located in the Mission, Tenderloin, Chinatown, and South of Market and are usually situated in distressed, high crime areas within those neighborhoods. Rooms are large enough for a twin or bunk bed. Hotels do not have refrigerators, stoves, or proper storage areas to keep food. Families with children live in an 8’x10’ room and for these accommodations, pay hotel owners between $250 and $500 per week.

Findings

It is a well-known fact that unstable housing has a devastating impact on a family’s wellbeing, on their ability to stay intact, and the capacity of the caregiver to get and keep a job. Homeless parents use all of their paycheck, time and energy to find and maintain shelter for their families. Experts state that one month of living in the cycle of homelessness equates to one year of symptoms, including severe depression, suicidality, disturbed sleep and appetite, chronic refusal to come forward, sense of not being entitled, and emotional exhaustion.

Families get separated. It is the policy of the San Francisco Department of Human Services' Family and Children Services to not remove children from parents simply due to the fact a family is "homeless." Staff state, however, that well over 50% of their families are faced with inadequate or unstable housing, which greatly exacerbates other issues for their families.

Families live in unhealthy, unsafe environments. According to a report published by the San Francisco TB & Homelessness Task Force[53]: "Homeless shelters and SROs are among the most likely places where TB can be transmitted in San Francisco. TB incidence and census tract measures indicate high TB rates in the Tenderloin, South of Market, Chinatown and the Mission District similar to those found in Sub-Saharan Africa. One in three hotel tenants is infected with the TB germ." Families may share unclean bathrooms or be subjected to living with lead, rodents, roaches, mold, garbage and sewage, broken glass, exposed sockets, no window or stair guards, and dirty syringes. SROs are fire hazards. During the 1990s, nearly a thousand units were lost in 12 SROs to fires in San Francisco. SROs are often surrounded by liquor stores and individuals engaged in prostitution, violence, drug selling and public drug using and drunkenness.

Families are unable to meet their nutritional needs. Lack of adequate cooking, cleaning and storage space leave families dependent on fast-food outlet. Food stamps only cover about two weeks of the month's food bills. Thus the rest of the month they bridge their nutritional gaps with use of soup kitchens and emergency food pantries.

Children's physical developments are impaired. A child living in an SRO is at high risk of having:

a) Difficulty breathing due to the presence of mold, little or no ventilation, and increased triggers such as pesticides, solvents, chemical fumes, pollution, and dust mites.
b) Physical exhaustion from interrupted sleep patterns.
c) Decreased development of gross and small motor movement due to small living space.
d) Difficulty consistently taking medications.
e) Exposure to more contagion (hap) infections, spread of infection and communicable diseases due to decreased ability to clean restroom and self and high rate of exposure to second-hand smoke, needles and used condoms.
f) Increased risk for malnutrition, increased weight and obesity, Vitamin D deficiency, rickets, diabetes, hypoglycemia (low blood sugar), and hypertension due to poor nutrition and reduced activity. "Iron deficiency anemia is found to be two to three times more common in homeless children than in children who are not homeless" [25] "Deficiency anemia is a disease that is associated with behavioral problems and decreased cognitive development." [41]
g) Decreased physical development due to lack of produce and dairy.
h) Increased likelihood of urinary tract infections due to "holding going to bathroom".
i) Decreased immune systems.

"Common acute problems in homeless children include upper respiratory tract infections, scabies, lice, tooth decay, ear infections, skin infections, diaper rash, and conjunctivitis." [21] "In addition, the incidence of trauma-related injuries…and chronic disease, e.g., sinusitis, anemia, asthma, bowel dysfunction, eczema, visual deficits, and neurological deficits is notably higher for homeless children than for others." [22] "One of the preventable problems in children is injuries. In one survey of homeless mothers, 20% responded that their child needed to be seen at an ER for an injury or fall." [44]

Children's psychological developments are impaired. Even the most resilient family faces a large number of stressors in the realm of social and psychological health simply due to the environment in which they live. Lack of a stable, safe housing environment can easily lead to extreme anxiety and depression for parents. As a child lives in squalid conditions, he or she may identify with such, and feel increasingly distressed. The lack of open space and decreased personal space results in intense personification of objects and individuals with whom children share their space. They may also become disassociated from, or not aware of, space and personal space. Even such concrete developmental tasks as walking may theoretically be impeded due to lack of space. The school-age child especially needs space and facilities in which to play. The very fact that there are not sufficient facilities to do homework or to carry out appropriate grooming routines, may lead to decreased feelings of self-worth. Children living in SROs are less likely to meet normal developmental milestones. When this occurs, the child may become depressed, anxious and face an increased risk for a host of psychological and psychiatric disorders.

Children's abilities to learn and achieve are impaired. "Perhaps the most disturbing of the effects homelessness has on children are the delays in their development, like walking, talking and playing." [42] The simple lack of open space and poor nutrition result in difficulty learning, lower attention span, and poor brain development. As a result, speech, language, memory, cognition, physical dexterity and balancing are impaired. "The rate of developmental problems is two to three times higher in homeless children than in poor children who are not homeless. [24]

Families have less access to needed services. Families in SROs must "lay low", be "invisible" and not annoy hotel managers, because until they establish tenancy rights, they can be asked and forced to leave the SRO. They are often not aware of rights or entitlements available to them. It is difficult, if not impossible, for healthcare providers to reach families for follow-up care. Families in SROs are not singled-out or tracked in City Departments as they are either not identified as living in an SRO, or are not "institutionally" considered "homeless" or "at risk." "Families are so often relocating that there is no opportunity to develop an ongoing relationship with a health care provider. When there is an acute problem, hospital emergency rooms, visiting public health nurses, and clinics usually are relied on to provide episodic and fragmented care. Continuity of care is nonexistent and care is rarely comprehensive, resulting in high rates of under-immunization and other unmet health needs." [26]

Immigrant families have distinct challenges. Many families with children residing in SROs are immigrant families. If undocumented, they are automatically not eligible for

federally funded low-income housing. Immigrant families are even more at risk of the above due to language barriers, inexperience in working the "system," cultural prejudices of institutions and fear of repercussions (e.g., deportation or not being able to attain citizenship).

Recommendations

Institutionalize a continuous improvement process between departments, families living in SROs, and their advocates. The objectives would be to address the findings and recommendations for each goal outlined in this report, to routinely assess the progress made, and to continually improve the situation. These collaborations would (1) have a lead department that staffs and coordinates the workgroup, (2) adopt the goals as outlined in this report, (3) aggregate City-wide data regarding the number of homeless families, and (4) give routine status reports to City leadership and Board of Supervisors.

Goal 1: Families with children move from SROs into stable housing.

1. Assure parents residing in SROs and their advocates sit on all housing committees so that they may influence housing advocates, non-profit housing development agencies, the State of California and and the City and County of San Francisco when housing policies are being developed and to assure that they adopt child- and family-focused planning priorities.
2. Expand the number of permanent housing units planned for "very low income" families and add supportive services onsite.
3. Assure "very low income" families living in SROs can compete in the low-income housing market.
4. Develop housing policies to support economic stability and development of families.

Goal 2: Families are preserved while residing in SROs.

1. Child Protective Services collaborate with Family Resource Centers, SRO Collaboratives, SRO management and families to develop prevention policies and practices where the family is given appropriate support and intervention and the least negative impact results.
2. Develop Family Respite Programs.

Goal 3: Children live in clean, safe conditions when residing in SROs.

1. Increase responsiveness and accountability of SRO hotel owners.
2. Increase responsiveness and accountability of City inspectors, planners, and enforcement. Note: A policy change was developed with and agreed to by DPH Environmental Health Section and the Mission and Chinatown SRO Collaboratives to address chronic problems in SROs that house families with children (Attachment 3, page 44).
3. Develop and fund an SRO Collaborative for the South of Market / Tenderloin neighborhood, similar to the Mission and Chinatown Collaboratives.

Goal 4: Families with children improve their socioeconomic and health status while residing in SROs and until housing stability is achieved.

1. Standardize "homeless" definition to include families living in SROs even if they have tenancy rights.
2. Implore the public education system to respond to the distinct needs of children living SROs.
3. Educate service providers on the issues facing families living in SROs and assure that their services are family focused and responsive (Attachment 2, page 43).
4. Develop and fund multidisciplinary SRO Family Outreach Teams (including Public Health RN, Psychiatric Social Worker, Case Manager, and Peer Parent) for each neighborhood to help families with children move from SROs into stable housing and to stabilize and support families while they reside in SROs. One team should be housed in each of the three target communities: Chinatown, Tenderloin/South of Market, and Mission.
5. Other Ways City Departments can help:
   a. Provide cell phones to families
   b. Support the development of "211" line for families to utilize when homelessness and/or hunger appear eminent (Attachment 4, page 45).
   c. Relocate families in SROs together.
   d. Prioritize "homeless" families and children on waiting lists for programs offering services.
   e. Fund sufficient childcare services.
   f. Link gyms and churches to SROs.
   g. Allocate resources for Department of Recreation and Parks to open more sites.

Introduction

Background

Over the years, tenant's advocates have seen a rise in the number of families with children residing in Single Room Occupancy Hotels (SROs). Daily, they witnessed how inadequate, inappropriate and risky SROs were for families with children to live.

In 1999, SRO residents and advocates organized and asserted to City leaders that issues facing families in SROs were not being addressed by City agencies, the treatment system, the homeless advocacy community or the children's advocacy community – and that the problem was rising to a critical level.

Under the direction of the San Francisco Department of Children, Youth, and Families, three focus groups occurred where resident families and advocates outlined the problems, concerns, and needs of families residing in SROs.

In Spring of 2000, a Citywide workgroup, chaired by the Department of Public Health and comprised of advocates, residents, providers, and staff from the Mayor's Office on Homelessness, Department of Human Services, and Board of Supervisors was formed to address the issues facing families living in SROs.

The "San Francisco Families in SRO Workgroup" was then adopted as a formal subcommittee of the San Francisco Board of Supervisors' SRO Task Force (formed to deal with a wide array of SRO issues).

The goals of the Workgroup are that families with children:
(1) move from SROs into stable housing,
(2) are preserved while residing in SROs,
(3) live in clean, safe conditions when residing in SROs, and
(4) improve their socioeconomic and health status while residing in SROs and until housing stability is achieved.

The workgroup was charged with recommending legislative, policy, and program changes that will help the City achieve these goals. Over the course of 14 months, the Workgroup met monthly, conducted focus groups and research, and met with individuals in the community and in City departments to discuss and develop the findings and recommendations included in this report.

This report will be submitted to the San Francisco SRO Task Force and to City Department leadership. The SRO Task Force will incorporate this report with their summary report to the San Francisco Board of Supervisors on May 15, 2001, at a special hearing held by the "Economic Vitality, Small Business, and Social Policy" Committee of the San Francisco Board of Supervisors.

Scope of the Problem

Although no exact figures are known, a sample survey conducted in the late 90's estimated that 500 families lived in SROs in Chinatown alone.

Having served nearly 900 families in the first nine months of FY00-01, the Department of Human Service (DHS) estimates that the number of homeless families their shelter placement program will serve this fiscal year will be 20-25% greater than last year. The "wait list for shelter" currently averages 100 families at any given time.

Scope of the Problem continued

Statistics from their shelter placement program noted that "25% of families completing an intake identified 'Hotel/SRO' as their prior living situation. 34% said they had stayed in a shelter before. 8% exiting were noted as leaving to a 'Hotel/SRO.' "

Currently, the San Francisco Housing Authority has over 13,000 families waiting for a unit. The number of homeless families promises to rise with the increase of Ellis Act evictions, San Francisco's expansion of the condo conversion ordinance, and the movement to restrict Hotel Conversion violations. Also expected to increase the number of homeless families is the national changes to Housing Authority regulations, including the "one-strike" regulation, evictions subsequent to loss of subsidies to the undocumented, and the constraint of increasing the number of housing vouchers instead of housing units.

In April of 2001, the Department of Public Health funded a "Census of Families with Children Residing in SROs" project. The census is to be conducted in four neighborhoods: Mission, Chinatown, South of Market, and Tenderloin. Coordinated by the Mission SRO Collaborative, 16 SRO residents will be trained and mentored in peer outreach and advocacy. They, along with staff from nine community based organizations, will:

1. Conduct a comprehensive point-in-time count of families with children residing in 400 SROs located within each of the 4 targeted neighborhoods (The Franciscan in Bayview Hunter's Point will also be surveyed).
2. Conduct 200 in-depth interviews with randomly selected families residing in SROs throughout the 4 neighborhoods (Attachment 1, page 42). Surveyors will also provide information about tenant's rights and relevant community and government resources.

An analysis and summary report profiling families with children residing in SROs in San Francisco will be published for use by community organizations and City departments to plan, design and develop services and low income housing for this population. It is expected that the census/interviews will be completed by July 2001.

How Families are Defined

Families encompass all nationalities, races, ethnic backgrounds, genders and sexual orientations. Primary caregivers include, but are not limited to, biological parent(s), grandparents, adopted parents, legal guardians, and extended family members who have children in their immediate care. For the sake of simplicity, this document will refer to primary caregivers as "parents."

Parent(s) fall into one or more of the following categories:

a. Individual(s) who has actual custody of, and is responsible for the care of, at least one child under the age of 18,
b. a pregnant woman,
c. individual(s) in the process of securing legal custody of any person who has not attained the age of 18 years,
d. individual(s) with a dependent child over the age of 18 who is mentally or physically disabled.

Findings

Overview

With the high rate of owner-move-in evictions, severe housing shortage, soaring rents, and limited space and services in family emergency shelters, more and more San Francisco low-income parents are turning to Single Room Occupancy Hotels (SROs) to put a roof over their families' heads.

Most SROs are located in the Mission, Tenderloin, Chinatown, and South of Market and are usually situated in distressed, high crime areas within those neighborhoods. Built and geared toward very low-income single adults, SROs are typically dark, unventilated and overcrowded. Rooms are large enough for a twin or bunk bed. Windows typically are off of light wells and often do not open.

There are SROs where up to 30 tenants are expected to share one bathroom. Floors are often covered with tattered, dirty and smelly carpets. Common areas – if available – do not have refrigerators, stoves, or proper storage areas to keep food. Tenants typically do not have personal mailboxes in the hotel. Most hotels do not have telephones in the hotel.

Families with children live in an 8' x 10' room and for these accommodations, pay hotel owners $250 to $500 per week.

Many of these families cycle in and out and between SROs, friends and relatives, shelters, and their cars...never gaining residency rights or stability. Families have been victimized by the so-called "musical rooms" – a practice whereby hotel managers evict residents every 21 days for 48 hours to ensure they do not gain tenancy rights.

Families who live in seriously distressed neighborhoods generally experience greater jeopardy and fewer supports to help them reach or sustain a healthy living. Families living in SROs state they feel isolated from their neighboring communities, have complex and distinct needs, and experience an even higher degree of jeopardy with even fewer supports.

There are an estimated 457 SRO Hotels in San Francisco with over 16,000 residential units. Twenty-seven of these hotels are master-leased by the City or are contracted out to community based organizations for management; and as such, are routinely monitored for compliance to environmental health standards. Some have on-site health and human supportive services available to its residents as well. Families do not reside in these 27 SROs. They live in the privately-owned SROs.

The San Francisco Department of Public Health's definition of Homelessness includes "any family with children staying in a Single Room Occupancy (SRO) hotel room – whether or not they have tenancy rights." However, there are families, in Chinatown for example, who have lived many years, sometimes generations, in their cramped, but stable SRO Hotels they call "home." Although many families residing in SROs would not consider themselves homeless, most of the issues outlined in this report apply to their situation.

Families are unable to "get ahead."

It is a well-known fact that unstable housing has a devastating impact on a family's wellbeing, on their ability to stay intact, and the capacity of the caregiver to get and keep a job. Homeless parents use all of their paycheck, time and energy to find and maintain shelter for their families. They are more likely to lose TANF benefits as it is difficult to comply with their CalWORKs welfare-to-work plans. Many of these families are also faced with the social prejudices and bureaucratic demands resulting from their immigration status.

"Without affordable, decent housing, people cannot keep their jobs and they cannot remain healthy. A recent longitudinal study of poor and homeless families in New York City found that regardless of social disorders, 80% of formerly homeless families who received subsidized housing stayed stably housed, i.e. lived in their own residence for the previous 12 months (Shinn and Weitzman, 1998). In contrast, only 18% of the families who did not receive subsidized housing were stable at the end of the study. As this study and others demonstrate, affordable housing is a key component to resolving family homelessness." [49]

"Some studies have suggested that residential instability, either from homelessness or other housing problems put children at twice the risk to becoming homeless adults, perpetuating the cycle." [39]

Experts state that one month of living in the cycle of homelessness equates to one year of symptoms, including severe depression, suicidality, disturbed sleep and appetite, chronic refusal to come forward, sense of not being entitled, and emotional exhaustion.

Families get separated.

"Homelessness frequently breaks up families. (It may be) …caused by placement of children into foster care when their parents become homeless. In addition, parents may leave their children with relatives and friends in order to save them from the ordeal of homelessness or to permit them to continue attending their regular school.

It is the policy of the San Francisco Department of Human Services' Family and Children Services to not remove children from parents simply due to the fact a family is "homeless." Staff state, however, that well over 50% of their families are faced with inadequate or unstable housing, which greatly exacerbates other issues for their families.

While we do not have data about San Francisco single adult shelter residents and their children, "the break-up of families is a well-documented phenomenon: in New York City, 60% of residents in shelters for single adults had children who were not with them; in Maryland, only 43% of parents living in shelters had children with them; and in Chicago, 54% of a combined street and shelter homeless sample were parents, but 91% did not have children with them." [48]

For those lucky enough to have kept their families intact by the time they move into an SRO, they will experience a good deal of loss of independence and, against their wishes, may get separated by institutional requirements.

Families live in unhealthy, unsafe environments.

1. Children co-habituate in overcrowded spaces with neighbors who have risky lifestyles and communicable diseases. According to a report published by the San Francisco TB & Homelessness Task Force[53]:

   "Homeless shelters and SROs are among the most likely places where TB can be transmitted in San Francisco. TB incidence and census tract measures indicate high TB rates in the Tenderloin, South of Market, Chinatown and the Mission District similar to those found in Sub-Saharan Africa.

   "One in three hotel tenants is infected with the TB germ. This represents the high potential for future TB disease and transmission in this population.

   "Overcrowding can increase TB transmission in the hotel population. Poor building ventilation and high rates of susceptible individuals (i.e. HIV infected individuals) also contribute to the spread of TB in hotels.

   "Tenants who stay in SROs often face multiple obstacles in ensuring an adequate quality of life. UCSF research indicates that SRO tenants in the Tenderloin/South of Market areas also suffer from high rates of recent or current hospitalizations for all causes (30%), current or past substance abuse (30%), and mental illness. These factors greatly contribute to persistent poverty and chronic health problems leading to TB exposure and disease."

2. Hotels may be non-compliant with safety codes, for example, families may share unclean bathrooms or be subjected to living with lead, rodents, roaches, mold, garbage and sewage, broken glass, exposed sockets, no window or stair guards, and dirty syringes.

3. SRO Hotels are fire hazards. During the 1990s, nearly a thousand units were lost in 12 SROs to fires in San Francisco. Since January 2000, there have been three large hotel fires in the City, resulting in a loss of 160 units. The third hotel fire happened on the weekend of April 14 at the Raymond Hotel (70 Units) on Howard and 6th. It is unknown how many smaller fires there might have been, resulting in the loss of a unit here or there.

4. SROs are often surrounded by liquor stores and individuals engaged in prostitution, violence, drug selling and public drug using and drunkenness.

Families are unable to meet their nutritional needs.

Families in SROs face many challenges to feeding themselves adequately, including:

- Low discretionary income, i.e., once housing needs are met, there is little money for food.
- Lack of access to cooking or cleaning facilities.
- Lack of access to fresh produce markets, especially in Tenderloin and South of Market.
- Inability to keep food safe, i.e., no refrigeration or access to rodent- and vermin-proof containers.

Families are unable to meet their nutritional needs.
continued

All of the above leave families dependent on fast-food outlets that may meet caloric needs, but are excessive in carbohydrates and fats and fail to provide the nutritional quality needed to enhance health and prevent infection and chronic diseases.

Advocates working with these families state food stamps only cover about two weeks of the month's food bills. Thus the rest of the month families bridge their nutritional gaps with use of soup kitchens and emergency food pantries – automatically classifying them as "food insecure" (unable to meet their nutritional needs through regular channels).

Children's physical developments are impaired.

Failure to thrive, impaired physical development, and developmental delays in children occur; for example, a child living in an SRO is at high risk of having:

a) Difficulty breathing due to the presence of mold, little or no ventilation, and increased triggers such as pesticides, solvents, chemical fumes, pollution, and dust mites.
b) Physical exhaustion from interrupted sleep patterns.
c) Decreased development of gross and small motor movement due to small living space.
d) Difficulty consistently taking medications.
e) Exposure to more contagion (hap) infections, spread of infection and communicable diseases due to decreased ability to clean restroom and self and high rate of exposure to second-hand smoke, needles and used condoms.
f) Increased risk for malnutrition, increased weight and obesity, Vitamin D deficiency, rickets, diabetes, hypoglycemia (low blood sugar), and hypertension due to poor nutrition and reduced activity. "Iron deficiency anemia is found to be two to three times more common in homeless children than in children who are not homeless" [25] "Deficiency anemia is a disease that is associated with behavioral problems and decreased cognitive development." [41]
g) Decreased physical development due to lack of produce and dairy.
h) Increased likelihood of urinary tract infections due to "holding going to bathroom".
i) Decreased immune systems.

"Common acute problems in homeless children include upper respiratory tract infections, scabies, lice, tooth decay, ear infections, skin infections, diaper rash, and conjunctivitis." [21] "In addition, the incidence of trauma-related injuries…and chronic disease, e.g., sinusitis, anemia, asthma, bowel dysfunction, eczema, visual deficits, and neurological deficits is notably higher for homeless children than for others." [22]

"In one study, homeless children had a 42% chance of having an upper respiratory infection over a given period of time, compared to 22% for the general population of children. Multiple respiratory and ear infections can lead to hearing problems, language delays and even poor school performance. Other contagious infections, such as diarrhea, have been shown to be 5 times more frequent in children in shelters than compared to other children in the same area. Homeless children can even contract more serious infections like tuberculosis, a lung infection which requires months of expensive medicines and can affect the entire body if it goes untreated." [40]

Children's physical developments are impaired.
continued

"This has many results, the most frightening of which is lack of immunizations against such deadly diseases such as polio, whooping cough, and meningitis. Children in shelters have shown as high as a 70% rate of delay in immunizations in comparison to 22% among poor, housed children.[43] It should be noted that if an SRO family resides in a San Francisco family emergency shelter, 85-100% of the children in the program are fully immunized by the time they exit. However, families residing in SROs alone do not receive this type of intervention.

"One of the preventable problems in children is injuries. In one survey of homeless mothers, 20% responded that their child needed to be seen at an ER for an injury or fall. Six percent of children reported either a fracture or a fall (being "knocked unconscious") and 14% report having a burn serious enough for a scar to form. These injuries put homeless children at needless endangerment of life and limb." [44]

"Baby walkers are a common cause of injuries in young children in which children in walkers fall down stairs or off porches. Falls resulting in severe or fatal injuries are usually due to falls from second story or higher windows. The mean height for a fatal injury is 5-6 stories. Window screens are made to pop out for safety reasons, and do not serve as a barrier to prevent children from falling out of windows." [50]

The Center on Disease Control published a report on the correlation between infant mortality and poverty, and found that "in 1988, the infant mortality rate was 60% higher and the post neonatal mortality rate was twice as high as those for women living above poverty level." [6]

Children's psychological developments are impaired.

Certainly many families residing in SROs have the inner-resourcefulness and fortitude to make the best of a bad situation. However, even the most resilient family faces a large number of stressors in the realm of social and psychological health simply due to the environment in which they live. Lack of a stable, safe housing environment can easily lead to extreme anxiety and depression for parents.

Children living with depressed and stressed parents almost invariably are compromised in their own functioning. A parent or set of parents, who must move into a SRO from a previously stable housing situation, may feel shame and guilt. Even if a parent does his or her best to "carry on as usual," children tend to be very perceptive as to parental states of mind.

Sometimes, the parent is outwardly depressed with symptoms of sadness (dysphoria) and irritability. Children of various ages may act up or "act out" in an unconscious effort to distract the parent from his or her troubles. Such behavior is normally interpreted as the child being "bad," but in fact may be a way that the child, unconsciously, is caring for the parent. The child's behavior may cause the parent to become focused on tending to the child's and family's needs.

The issues that overwhelm some families involve a combination of mental health and substance abuse as well as family violence problems. This means that not only do the children not have a place to play, and decent food to eat, but they also are not able to get consistent attention and adequate parenting.

Children's psychological developments are impaired.
continued

Parents are simply overwhelmed by the tasks of finding work and shelter and this creates or exacerbates mental health and substance abuse issues for them.

"One study of homeless and low-income housed families found that both groups experienced higher rates of depressive disorders than the overall female population, and that one-third of homeless mothers (compared to one-fourth of poor housed mothers) had made at least one suicide attempt (Bassuk et al., 1996). In both groups, over one-third of the sample had a chronic health condition." [47]

In other studies, it was found that "53% percent of homeless families are headed by young, single women, 89% of homeless mothers had been physically or sexually abused and 67% during childhood, and a significant percentage had also abused alcohol or drugs." [20]

"A report by Dr. Stephanie Riger, of the University of Illinois at Chicago, cited a recent study which found that 63% of 436 homeless and low income housed mothers had been victimized by domestic abuse. The report points out that this is in contrast to 9% of women in the general population, according to the National Crime Victimization Survey." [8] "As well, many studies demonstrate the contribution of domestic violence to homelessness, particularly among families with children. A 1990 Ford Foundation study found that 50% of homeless women and children were fleeing abuse." [14]

Children often feel guilty – both unconsciously and consciously – that they have caused an unwanted situation. Children very often misconstrue or misinterpret and take responsibility and feel guilt about events outside their control. Certainly children below the age of twelve, whose reasoning skills and cognitive development lags far below that of an adult, often assume responsibility for ills that befall themselves and their loved ones. Subsequently, children may behave in ways that will cause them to incur punishment – as they may feel that they don't deserve to be treated well.

Children experience alienation, reduced self-esteem, decreased hope and aspirations. They learn not to see their strengths, to be invisible; that is, "if I can't see myself, you can't either."

Parents may consciously or subconsciously blame the child for their own lack of privacy. Certainly in any instance when a parent has admonished them to "keep quiet because you'll disturb the manager" and if the family subsequently loses their "home," the child may feel responsible, even if reassured that it is not his or her fault.

At times the barriers to accomplishing developmental tasks are driven by the desire to be helpful and take responsibility beyond what is appropriate for their age. Children mature faster, "lose their childhood" and become "parentified", caring for younger siblings or for the parent him or herself, who may be depressed, involved with substances, or disorganized or overwhelmed. At times this "parentification" evolves at the behest of the parent who urges the child to become "more grown up" and help out in this difficult time. At other times, the child assumes duties due to his or her own internal process.

Children's psychological developments are impaired.
Continued

The very fact that there are not sufficient facilities to do homework or to carry out appropriate grooming routines, may lead to decreased feelings of self-worth. As a child lives in squalid conditions, he or she may identify with such, and feel increasingly distressed. The lack of open space and decreased personal space results in intense personification of objects and individuals with whom children share their space. They may also become disassociated from, or not aware of, space and personal space.

A child living in a SRO may also, as a result of crowded and unsafe conditions, regress and behave in a way typical of a younger child. For example, a toddler who has just started toilet training in his previously stable environment may balk at the unfamiliar bathroom. The parent may not have the energy or impetus to proceed with toilet training in the unsanitary and even unsafe conditions of the SRO. Even such concrete developmental tasks as walking may theoretically be impeded due to lack of space.

Study after study reveals that play is a necessary element for sound psychological development of all children. The school-age child especially needs space and facilities in which to play. The child living in a SRO, as opposed to a child living in a homeless shelter, has none of this space. The single room is much too crowded for the normally playful latency-aged child. The neighborhood is invariably too dangerous to play.

During adolescence, the child living in the SRO faces extreme stressors. Adolescence is a time when the individual becomes more aware of his or her body and sexual identity. Privacy is prized and necessary. The SRO offers virtually no time for the adolescent to be alone. What is appropriate modesty must be "unlearned" in order to function in the SRO.

As the adolescent seeks a separate identity from the parent, he or she usually turns to peers for support and encouragement. Within the SRO there is no safe place for the adolescent to be with peers. It is likely that the adolescent will "normalize" their neighbors' inappropriate behaviors and addictive coping skills and possibly adopt them.

Children living in SROs are less likely to meet normal developmental milestones. When this occurs, the child may become depressed, anxious and face an increased risk for a host of psychological and psychiatric disorders. The following are examples of why children living in SROs are likely to become hyper-vigilant, depressed and anxious:

a. there is an increased risk of domestic violence which is invariably witnessed by children,
b. while the parent may or may not be overtly sexually abusive to children while living at SRO, there is an increased risk that they will be exposed to inappropriate adult sexual interaction,
c. children are at risk for removal (by Child Protective Services) from parents while living at SRO,
d. children face daily threats to their lives in terms of unhealthy and unsanitary living conditions as well as from unsafe and crime-ridden neighborhoods in which the SROs are almost invariably located.

The necessity of always being "on guard" against one of the above conditions can cause extreme anxiety with the possibility of sleep and eating disorders as well as an overall decrease in functioning.

Children's psychological developments are impaired.
continued

In summary, children and parents living in SROs are at increased risk for psychiatric disorders including (but not limited to) Post Traumatic Stress Disorder (PTSD), Dysthmia (depression) Anxiety Disorder, increased symptoms of Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorders and others. PTSD (Post-Traumatic Stress Disorder) in parents leads to RTSD (Recurring Traumatic Stress Disorder) in children.

Children's abilities to learn and achieve are impaired.

For a child to gain age-appropriate vocabulary, he or she needs interaction with an attentive, verbal individual. Parents living in SROs, as mentioned above, may be depressed, stressed and otherwise unable to nurture the child's emotional and cognitive development.

"Perhaps the most disturbing of the effects homelessness has on children are the delays in their development, like walking, talking and playing." [42] The simple lack of open space and poor nutrition result in difficulty learning, lower attention span, and poor brain development. As a result, speech, language, memory, cognition, physical dexterity and balancing are impaired.

"It is estimated that 30% to 50% of the nation's school-age homeless children do not attend school. Of those in school, sporadic attendance, grade repetition, and below-average performance (designated as having special needs) are common. The rate of developmental problems is two to three times higher in homeless children than in poor children who are not homeless." [24]

"Dr. Yvonne Rafferty, of Pace University, wrote an article which compiled earlier research on the education of homeless children, including the following findings:

- 79% of 49 homeless children in NYC scored at or below the 10th percentile for children of the same age in the general population.
- 13% of 157 students in the 6th grade scored at or above grade level in reading ability, compared with 37% of all 5th graders taking the same test.
- 43% of children of 163 families were not attending school.
- 51% attendance rate for homeless students vs. 84% for general population.
- 15% of 368 homeless students were long-term absentee vs. 3.5% general population." [2]

"In one study, half of children in homeless shelters had one or more developmental delays. Similarly, 45% of school age children in homeless shelters were found to need special education evaluation, yet only 22% actually received this important testing or placement. Moreover, about half of children in shelters missed one week of school in 3 months and 20% missed over 3 weeks in three months, significantly more than poor housed children. Children who change shelters often must change schools too, disrupting continuity in learning." [42]

"According to the National Law Center on Poverty and Homelessness, a majority of service providers and shelter operators surveyed considered it a problem for homeless children … to participate in after-school events and extra curricular activities, to obtain counseling and psychological services, and to access before- and after-school care programs." [36]

Children's abilities to learn and achieve are impaired.
continued

"Families who become homeless are often forced to move frequently. Length-of-stay restrictions in shelters, short stays with friends and relatives, and/or relocation to seek employment make it difficult for homeless children to attend school regularly. In addition, guardianship requirements, delays in transfer of school records, lack of a permanent address and/or immunization records often prevent homeless children from enrolling in school." [38]

"Homeless children and youth who are able to enroll in school frequently face another obstacle: inability to get to their school because of lack of transportation. Homeless families may not have a family car or money for public transportation, and many shelters are unable to provide transportation. Children who miss school frequently fall behind very quickly. Without an opportunity to receive an education, homeless children are much less likely to acquire the skills they need to escape poverty as adults." [38]

Families have less access to needed services.

"Access to health care, particularly preventive health care, is impaired for homeless families. Health becomes a lower priority as parents struggle to meet the family's daily demands for food and shelter." [26]

"Families are so often relocating that there is no opportunity to develop an ongoing relationship with a health care provider. When there is an acute problem, hospital emergency rooms, visiting public health nurses, and clinics usually are relied on to provide episodic and fragmented care. Continuity of care is nonexistent and care is rarely comprehensive, resulting in high rates of under-immunization and other unmet health needs." [26]

Parents or children with chronic diseases and/or those who are post-surgery are especially at risk of relapse, being separated and re-institutionalized when stable and supportive housing is not available to the family.

"Many homeless families are unable to visit or even identify a regular clinic. In some homeless shelters, over 44% of families use the ER or clinics in hospitals as their only care." [43] "In a Los Angeles study, it was found that homeless families were more likely to use emergency services for preventive and sick care than were domiciled poor families. Moreover, access to care is a formidable barrier for such families." [23]

Families must "lay low", be "invisible" and not annoy hotel managers, because until they establish tenancy rights, they can be asked and forced to leave the SRO.

They are often not aware of rights or entitlements available to them. It is difficult, if not impossible, for healthcare providers to reach families to remind them of the need for routine checkups, or missed appointments, or to give them findings from diagnostic tests or directions for follow-up care, etc.

Families in SROs often fall between the cracks. They do not get the homeless wrap-around services they might otherwise receive in a homeless shelter. They are not singled-out or tracked in City Departments as they are either not identified as living in an SRO, or are not "institutionally" considered "homeless" or "at risk."

Immigrant families have distinct challenges.

Many families with children residing in SROs are immigrant families. If undocumented, they are automatically not eligible for federally funded low-income housing. Immigrant families are even more at risk of the above due to language barriers, inexperience in working the "system," institutional prejudices and fear of repercussions (e.g., deportation or not being able to attain citizenship).