HEALTH EFFECTS OF HOUSING STATUS ON CHILDREN: A HOUSE IS NOT A HOME*

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"A home is not a mere transient shelter: its essence lies in its permanence, in its capacity for accretion and solidification, in its quality of representing, in all its details, the personalities of the people who live in it."
[H.L. Mencken. Prejudices: Fifth Series (1926) 11.]

DOUBTLESS, we would all agree that homelessness is one of the great social crises of our city. The solution, undoubtedly, is to build new homes or to renovate existing buildings, to provide decent housing for all who live here. For the homeless children who live on our streets or in city-run shelters or in welfare hotels, that solution, the provision of new homes, will not be enough. These children have suffered long-lasting psychic and physical damage that will take a long time to heal. Their lives have been severely disrupted in a way that will interfere with normal development.

These children have suffered a social catastrophe comparable to the events of wartime: loss of home, of possessions, of familiar surroundings, of supportive friends and relations, of stability, of family life. Anna Freud studied the effects of World War II on the small children of London. When we read her accounts of the effects of bombing and evacuation on children and their families, we can only think that the homeless children of New York are suffering in the same way. Freud wrote: "War conditions, through the inevitable breaking-up of family life, deprive children of the natural background for their emotional and mental development. The present generation of children has, therefore, little chance to build up its future psychological health and normality which will be needed for the reconstruction of the world after the war. To counteract these deficiencies, war-time care of children has

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to be more elaborate and more carefully thought out than in ordinary times of peace.''[1]

Our homeless children have suffered similar damage. They need, not the minimum in food and shelter, but a ''more elaborate and more carefully thought out'' care than children who have lived their lives in the nurturing atmosphere of their own homes.

For the purpose of this paper, ''house'' is defined as a building that serves as living quarters for one or a few families, dwelling place, or place that provides shelter. ''Home'' is defined as a family's place of residence, a social unit, formed by a family living together; a restful or congenial environment; a place where one likes to be. Structurally, a house as defined should have privacy, which includes adequate sleeping facilities for each member of the family as well as toilet facilities; a living room and cooking and dining facilities. Important elements of the ''home environment'' are physical, social, and cognitive. The physical environment includes such items as appropriate toys and learning materials, the level of sensory input, the extent to which the environment is organized and safe, as well as the amount of physical restriction. The social environment refers to a child's contact with members of the household as well as the emotional climate, which includes how warm and nurturing the parents are as well as their disciplinary approach. Cognitive aspects of the home environment include the quantity and quality of language used, emphasis placed on intellectuality, the variety of sensory and communicative experiences available, and the extent to which parents encourage achievement.[2]

HOMELESSNESS

The number of individuals deprived of access to conventional housing has increased in every region of the United States. It has been reported that the homeless in the country vary between 250,000 and 3 million.[3,4] In New York State 50,000 are estimated to be homeless, of whom 85% are reported to be concentrated in New York City.[5] These numbers are controversial as they probably exclude those living in the streets, abandoned buildings and the runaway and ''throwaway'' adolescents. It has been estimated that 10,000 ''runaway'' adolescents are living predominantly in the streets in New York City. Ninety percent of these runaway adolescents are from minority ethnic groups, from troubled families, and have abusive parents.[6]

''Homeless'' people now residing in streets, abandoned buildings, or subways can be placed or find refuge in temporary shelters, namely, welfare hotels and Tier I and Tier II shelters. Shelter living is always congregate

living; some are more communal than others, but always congregate. The Tier I shelter environment is described by the Citizens Committee for Children as follows:

> Families live long periods of time in crowded conditions which provide no privacy for sleeping, dressing or using the bathroom facilities. The most personal aspects of life must be carried out in view of strangers of both sexes; parents cannot prevent their children from witnessing all manner of behavior and activity. The environment is essentially an affront to personal dignity, and violates the integrity of family life.

The shelters' sleeping rooms have up to 125 beds. Chaos and noise occur at all hours. Unsanitary bathrooms and showers, which often lack doors or curtains, are crowded. The bathrooms are also the only places to change clothes. At one shelter the bathrooms are co-ed. The dining rooms are crowded and disorganized. Three meals a day are provided at all shelters through a contact with Automatique, a food service. Food is only available at certain hours. If a child is hungry later in the evening, food is not available and is not supposed to be brought into the shelter if bought outside.

Basic parenting responsibilities, such as trying to toilet train or feed a toddler, change a diaper or bathe an infant are extremely difficult to carry out in a chaotic, crowded environment.

> Infestation by mice, cockroaches and flies, as well as lack of heat during the winter time, were some of the conditions children endured in the shelters.
>
> The damaging effects upon children of living in crowded conditions are immediate and intense. Parents watch their children become wild and aggressive. At the same time, parents are closely scrutinized by staff and guards and are afraid to do something for which their children can be taken away.[7]

Tier II shelters, on the other hand, have partitions to separate family units, but all families in shelters share bathroom and dining areas. A family is separated from other families but the members are not separated from each other. Most shelters lack storage facilities for family belongings and usually fail to provide separate recreational or lounge areas.

Welfare hotels or motels have single rooms for all members of a family and lack kitchen and dining facilities. Families have the advantage of walls that provide privacy from other families in these facilities but do not have privacy from each other. Absence of kitchen facilities means no refrigeration for milk, formula, juice, or perishable food, which greatly compromises nutrition and sanitation. Hallways and lobbies of these welfare hotels are "infested" with prostitutes or drug dealers. As a result, families and children lock themselves in their rooms, preventing children from play, exercise, or receiving appropriate physical and social stimulation. In addition, welfare hotels are located in commercial neighborhoods that are unsuitable for children.

"The American Public Health Association has adopted the need for privacy as one of the basic principles of healthful housing:

"The essential concept of a home involves the possibility of that isolation from the world which every human being sometimes craves and needs. Especially in cities, the home is a needed refuge from the noise and tension of the street and marketplace. The same principle applies within the home itself. When the dwelling is crowded, frequent personal contacts may be the cause of nervous irritation, as detrimental to mental health as is the more obvious influence of contact infection upon physical health."[8]

Another group, the "hidden homeless," are families doubled or tripled up with friends or relations. An estimated 40% of 1.3 million available public housing units nationwide are housing two or more families per unit.[9] In New York 35,000 individuals are living doubled up illegally in city housing[10] and an estimated 50,000–2,000,000 additional individuals are doubled in private housing.[11]

In 1952 J.M. Mackintosh wrote about the effects of overcrowded, inadequate housing on families and children: "Psychological study indicates that mental health in adult life is largely determined in its early stages by the child's reaction to the people immediately around it. The attitude of the family to the child and the child's response to that attitude determine to a great extent what his approach to life will be. Perhaps in its effect on health the home plays its largest part as the background to that vital family interplay. No one would suggest that a bad house prevents good family relationships inside it. Yet certain conditions of good family relations are made extremely difficult when the housing environment is really bad. The idea of happy motherhood may be a mockery in the case of the woman whose whole life is a losing physical battle against unequal odds provided by a dirty and dilapidated house in slum surroundings. Sheer lack of space and privacy throw the different members of the family so hard against one another that the perpetual state of friction and quarreling may be common. The family circle in such conditions ceases to be the place where the child learns confidence in the world through love. Instead it may teach a bitter lesson of mistrust and hatred. Antisocial traits are an inevitable result. In an atmosphere crowded by irritation and worry there is no room for normal family relationships to be developed or maintained."[8]

Nurses and physicians providing health care for children who live in congregate shelters or in hotel and motel rooms see the specific results of the disruption of family life and of normal routines. There is a great deal of regressive behavior: children revert to patterns previously outgrown; they go

back to thumb sucking or bedwetting. The latter is particularly difficult for parents to accept because coping with a chronic bedwetter in these circumstances is impossible. Sleep disturbances are common. It is difficult for anybody to sleep through the night in noisy, crowded conditions. Many children have recurring nightmares. Eating habits are disrupted when children are forced to conform to the mass feeding of congregate dining rooms or when a mother is trying to feed her family without facilities for the safe storage or cooking of food.

Parents must teach their children the opposite of normal social behavior. Instead of learning trust, the children are taught to be suspicious of all adults. Male physicians find that they cannot examine little girls who have been taught by their mothers to "never let a man touch you."

Confined to such limited living spaces, children have little opportunity to develop gross motor skills. They have little chance to acquire the responsibility or related skills that children normally develop as they learn to perform the household tasks that are part of family life in a real home.

The fastest growing segment of the homeless population are families, specifically single mothers with two or three children, who now comprise 40 to 45% of the homeless population in New York City.[12] These families comprise more than 33% of the homeless population in 26 major cities.[13]

The number of homeless families remained more or less stable at 600, and the number of children were similarly stable at 1,400 during the 1960s.[14] By the early 1980s, it began to increase steadily so that by spring of 1984, these numbers rose to 7,000 homeless children.[15] By August 1988 there were 5,213 homeless families with 10,771 children in New York City.[16] The average number of children per family has been reported as 2.6; about 50% of the childen are younger than five years of age and about 95% of these families are black or Hispanic.[17]

Mackintosh declared that pre-school age children were at the greatest risk: "At age 1–5 children are more exposed to the risks attending a bad home environment than in infancy or later, and the conclusion seems inevitable that the specially high association of their mortality rates with measures of overcrowding within the house is due to their high susceptibility to those dangers, whether they arise from the poverty which usually goes with overcrowding or from the insufficient room accommodation per se producing a higher intensity of "droplet" infection and other harmful effects. It seems fair to conclude that it is at these ages that the greatest benefits may be anticipated as the overcrowding evil is mitigated."[8]

The current crisis in homelessness among families is the result of a shift in the balance between the number of families and the low-income housing available.[18] Dolbeare (1986) estimated that about 8.1 million low-income households were competing for about 4.2 million low-cost housing units.[19] In 1984 Danziger reported that the number of families living below the poverty line increased by more than 25%.[20] Homelessness among families on a national scale was, therefore, inevitable, with less low-cost housing available and increasing numbers of poor families.[21] Most of the families became homeless as a result of eviction, fire, or an overcrowded, doubled-up situation.[22]

Families are supposed to stay in barrack-style shelters for only 21 days but, because of the lack of affordable housing, the average length of stay in temporary housing has been reported as 13 months.[23] Fourteen percent of all families have been in temporary housing for more than two years and about 40.5% for one or more, with some families moving in and out of the system.[17] Length of stay is usually correlated with the type of temporary housing facilities. The average length of stay is usually shorter for families in family centers and Tier II shelters operated by nonprofit organizations than for hotels. Tier II facilities and family centers provide social services and housing relocation assistance as well as more comfortable accommodations.

HEALTH STATUS OF THE HOMELESS

Although homeless families and poor children bring many problems with them to the welfare hotels and shelters, the homeless environment imposes additional stress in daily sustenance activities. Most homeless families are not housed in their originating neighborhoods, which interrupts schooling for children and often cuts the family off from social, familial, and such other community supports as day care and health care. Overcrowding and inadequate facilities for personal hygiene create a high-risk environment for contagion. Diarrhea, for example, is a serious problem in family congregate shelters. The Citizens Committee for Children[7] reported that 44% of families interviewed stated that one or more numbers had an illness or infection while in the shelter. In half of these cases, such illnesses as severe stomach ailments, high fever with convulsions, ear infections with high fever, pneumonia, influenza, and bronchitis were severe enough to require a trip to the hospital. Risks of the spread of disease through several modes of transmission, including person-to-person contact and airborne/droplet spread and fecal contamination, increase in congregate shelters. Outbreaks of shigella

dysentery[24] and measles have been reported in shelters in New York City.[6] There are, of course, no facilities to care for a sick child or adult in congregate shelters or in the one room that houses a family in a hotel. There is no way to provide isolation, special food, or extra liquids, nor to provide for the washing or toilet needs of a sick person.

Little is known and less has been published about the specific impact of homelessness on the health, developmental progress, behavior, and education of children. Since many homeless children come from families of low-socioeconomic status, it is expected that their health problems will resemble those of other poor children. However, data from several studies indicate that some of the medical and psychological problems of homeless children are more severe than those of poor children with homes. Poor access to primary care is exacerbated for poor families who have become homeless. Unfamiliar with their neighborhoods, lacking transportation and child care, and overwhelmed with frequent changes in shelters, daily searches for affordable food, and periodic attempts to find housing, homeless families are unable to seek medical attention except for emergency care. As a result, a high rate of immunization delay (27%[25,26] to 48%[27]) has been noted for homeless children as compared to 8% for domiciled children. The rate of low birth weight babies born to mothers living in shelters is 18% compared to 8.5% rate for the city's poor population living at home.[28] The reported infant mortality rate in the homeless population is 24.9 per 1,000,[28] which is nearly double that of New York City as a whole. Also, when admissions to hospitals from emergency records of homeless children and poor domiciled children were reviewed in New York City, the rate of admission to hospital for homeless children was 11.6 per 1,000 as compared to 7.5 per 1,000 for the domiciled children.[25] This finding is particularly significant when we consider that poor children are more likely to become ill and more likely to suffer adverse consequences from illness, and are 75% more likely to be admitted to a hospital in a given year.[29]

Families and children often enter temporary housing with medical conditions and special needs that are exacerbated in welfare hotels and shelter environments. Robert Wood Johnson-Pew Memorial Trust Health Care for the Homeless Project reports that the incidence of acute illness and prevalence of chronic medical problems in children is higher than the comparable domiciled group.[30] Again, overcrowding, inadequate ventilation, poor heating and sanitary conditions, lack of cooking facilities and refrigeration, and chronic stress all contribute to the higher than average prevalence of chronic health problems among the homeless.

Rampant use of illegal drugs has been a major problem for homeless families in welfare hotels, and "crack" (a cheap form of cocaine that can be smoked) is the primary drug of choice. For homeless adolescents, runaways, and throwaways, a high incidence of malnutrition, physical and sexual abuse, infectious disease, mental health problems, and suicide has been reported.[31] These adolescents are also at high risk for sexually transmitted diseases and diseases transmitted by sharing intravenous needles, e.g., hepatitis B and AIDS.

Increased child abuse and neglect is another damaging effect of chaotic and disorganized environments. A survey at a New York City hospital of reports of child abuse and neglect to Special Services for Children showed a rate of child abuse and neglect of 8.8 reports/1,000 children among the homeless group as compared to 2.3 reports/1,000 nonhomeless children of similar socioeconomic status living in the same health district.[25] In shelters and welfare hotels, families have no responsibility for shopping, planning, and cooking meals. Adults and children in welfare hotels depend on restaurant allowances, food stamps or WIC supplementation checks while families in shelters are served meals from a food service contracted by New York Human Resources Administration that does not take into consideration the kind of food appropriate for homeless families and children. A survey of homeless children in King County, Washington, where the children were measured for height and weight, showed a 36% incidence of >95 percentile for weight, a potential indicator of obesity.[26] A New York study reported a decreased growth in height among homeless children as compared to the domiciled children.[27]

In temporary housing, children witness such behavior as adult sexual activity, drug use, fighting, and cursing. Because shelters and hotels are not safe environments, parents are in constant fear that other people may harm their children. Numerous authors report substantial changes in the attitude and behavior of homeless children.[6,7,32-34] In a study of homeless families in Boston, nearly 50% of 151 homeless children had developmental lags, anxiety, depression, and learning difficulties.[32] In a survey of 61 families living in a welfare hotel in New York City, 66% reported behavioral and emotional problems in their children that developed while in the hotel.[33] A recent report of the Citizens Committee for Children[7] cited problems with children such as depression, antisocial behavior, difficulty in sleeping, and despondency. Older children and teens were reported as aggressive, acting out, cursing, and hitting. Furthermore, temporary housing has a destructive effect on homeless children's education.[35] Because of constant movement, parents are reluctant to register children in school. When homeless children attend school they are

not often prepared to function well in class. The disruptive environment of the temporary housing makes it difficult to get enough sleep at night and most have no place to do their homework. A report of 53 homeless families surveyed in New York City showed that 54% of the children had been kept back at least one grade in school.[36] Recent analyses of New York City Board of Education statistical data on the attendance and academic performance of 9,680 homeless school children and available overall data in all New York City students showed that the average attendance rate for homeless students in elementary school is 73.6% compared with 88.7% of all N.Y. City elementary school students, 63.6% compared with 85.5% for junior high school students and 50.9% compared with 83.9% for high school students. Forty-three percent of homeless students were reading at or above grade level compared with 68% of students citywide, and only 28% of homeless students scored at or above grade level in mathematics ability compared with 57% citywide.[37]

Health Services for the Homeless

Recognizing the need to provide health care to the shelter and hotel populations, the New York City Department of Health established the Homeless Health Initiative in the Spring of 1986. Up to that time, organized health care available to the homeless was minimal and consisted of emergency room visits and visits to the homeless by small outreach groups. Homeless Health Initiatives was established to identify the health problems of the homeless, improve their health care, implement policies to protect them from health hazards, and to develop a network among agencies serving the homeless. The Homeless Health Initiatives Program comprises three main parts: The Family Health Program, the Environmental Unit, and the Technical Support Unit. The Family Health Program is staffed mainly by public health nurses working at most of the long stay Human Resource Administration run hotels; 18–20 Public Health Nurses provide health assessment, referral, public health education, follow-up, and monitoring of general health concerns to the residents of the hotels. The approximate caseload per nurse is 200–250 families. Through the Family Health Program, certain hotels were specifically designated as residences for pregnant mothers and newborns where the health problems of this population are identified and appropriate referrals made. The Environmental Health Unit is designed to protect the homeless from environmental hazards. This program is responsible for inspecting all family and single city shelters. It is overseen by a supervising Public Health Sanitarian and staffed by two health sanitarians. Unfortunately, there is insufficient

follow-up and enforcement of recommendations made by the Environmental Health Unit to the funding agency, the Human Resources Administration. The Technical Support Unit was to have provided a networking system for the homeless health care program, but this unit has not yet been implemented.

The Human Resources Administration negotiated a joint contract with the New York City Department of Health and the New York City Health and Hospitals Corporation to improve and expand health care services for the homeless families in New York City. The first step in the program is Screening I, administered to every family member at an Emergency Assistance Unit (one in each borough) or shelter, by a nurse before they are given temporary housing. This screening allows the nurse to recommend appropriate housing for a family based on special medical circumstances such as pregnancy, a contagious illness, the need for immunization, or other special medical needs. Screening II takes place within 72 hours of placement. A medical history and physical examination allow the provider to determine the patient's health status and to recommend such follow-up treatment as family planning, help with substance abuse, mental health, child abuse problems, primary care, and enrollment in WIC, the federal government program that provides food for women, infants, and children. While in the shelters, the homeless receive ongoing care that includes basic health education, prompting to keep scheduled appointments, special services for contagious illnesses, and special services for pregnant mothers and newborns. Each shelter providing health services has a back-up medical facility for referrals, usually a New York City Health and Hospitals Corporation Neighborhood Family Care Center or Municipal Hospital Ambulatory Care Department.

The Human Resources Administration funds the health services and contracts with the Department of Health, the Health and Hospitals Corporation and several voluntary agencies to provide varying levels of health care in shelters and hotels. An example of a private agency's involvement in health services for the homeless are the Children's Aid Society health care clinics established in welfare hotels in Manhattan. The initial project of the Children's Aid Society was a summer camp for school-age children (six years to 12 years) who resided in the Carter Hotel in New York in 1983. While recruiting for camp participants, the Children's Aid Society staff became aware that the vast majority of children living in the hotel lacked primary care health providers, and that managing medical matters has a very low priority and for most of the families this was frequently ignored. Therefore, a pediatric nurse practitioner was sent to the Carter Hotel to deliver health care services on-site, which was accepted favorably by the hotel community. The

children are given complete physical examinations, updates of their immunizations, certifications for WIC, and attempts to address as many of their basic primary health care needs as possible. Referrals are made to neighboring hospitals for follow-up care.

The Children's Aid Society was active not only in the Carter Hotel, but services were expanded to meet the needs of other hotels. In 1986 a medical clinic was established by the Children's Aid Society in the Prince George Hotel (14 East 28th Street), the largest welfare hotel in the city, housing 450 families. In the Prince George Hotel, approximately 460 females were under 18 years and 500 males under 18 years. The average length of stay in the hotel was 12–14 months, so obviously this was not a transient population. A "community center," typical of other Children's Aid Society facilities, was developed within the hotel, as well as infant stimulation programs, head start, after school and teen programs, and the medical clinic. The medical clinic provided outreach, triage, and linkage to existing institutions near the hotel such as Bellevue Hospital and St. Vincent's Hospital; provided primary care to a limited group of hotel residents who would or could not take advantage of the available services of Bellevue and St. Vincent's Hospitals; and supported other in-house programs (WIC, public health nurse, crisis intervention, social service workers, and visiting nurse service) and provided thorough, expedient, and comprehensive back-up so hotel residents are not lost in the external referral system. Recently, dental services were added to the medical care provided to hotel residents.

Other services such as the New York Hospital Health Care Program for Homeless Families and Children living in welfare hotels through the Mobile Van Medical and Dental Services, the United Hospital Fund's project Comprehensive Health Care Program for the Homeless and efforts of others at St. Vincent Hospital, Bellevue Hospital, and other private agencies provide health services to the homeless.

CONCLUSION: A HOUSE IS NOT A HOME

It is well recognized that temporary housing provided by shelters and welfare hotels is not a home. The basic issue is to prevent homelessness by responding to the underlying causes of homelessness and to provide adequate and affordable housing for families and children presently residing in congregate shelters and hotels.[36] But housing is not at this point a simple solution to the problem of homelessness and we must consider as well the effect of homelessness on the behavior and development of children, that is, developmental delay and regression; behavior and learning problems due to intermit-

tent or lack of adequate schooling;[38] lack of facilities or programs for recreation as well as the lack of an environment conducive to learning and to sharing with other children.[39,40] We must also consider the effects of exposure to drug abuse, sexual and physical abuse, poor hygiene, and its effect on health.

Adequate health care services for homeless families and children are needed, but there is concern that the method of delivery of these services may further institutionalize such a health program in shelters and hotels only to compensate for the dangerous environment that exists within these facilities. Therefore, it is much safer, more humane, and cost effective simply to shelter families in apartment style units, temporarily or permanently. In addition, despite the greatest efforts of all concerned, it is not possible to ensure the health of children as long as they are homeless. Specifically, growth and development—including behavior, emotional development and education—cannot be adequately addressed.

Robert Coles[41] wrote about the experiences of children he interviewed in temporary shelters in Boston: One story is about an 11-year-old black girl who, when asked to draw a picture of her place of residence, states that she didn't want to draw the building where she lives because "the hotel is not anyone's home, it's where you stay if you don't have a home. Rats live there." Another child, five years old, asked her mother, both living in a temporary shelter: "How many times will we have to move until we stop?" When the mother did not reply, the child went on to say, "Only when we find a home can we catch our breath and be like everyone else." A mother of a sixth grader who has moved repeatedly and living in a crowded motel room responded to the same question: "Someday we might get a place to live, where we can stay put—when you are not wandering anymore. You can unpack and discover that all you own is the stuff you've been carrying around. You can be yourself and not someone waiting for the time to pass until you have your own place." These individuals of all ages, who cannot define themselves by the state, city or town, the neighborhood, and the house which they can call a home are what we call the "homeless people." They are disconnected from their permanent places of residence and have no reliable continuity in their lives. This growing number of homeless children in this country will be tomorrow's disadvantaged citizens because they lived most of their formative years in uncertainty and fear and they lack self-respect because they did not have a place that they could call a home.

Traditionally, pediatricians have been concerned about social conditions because they see the effects of these conditions on their patients. Tradi-

tionally, pediatricians have not hesitated to warn society about the dangers facing children. They warned about the perils of lead poisoning. Laws against child abuse were passed as a result of pressure by pediatricians. In the same way, pediatricians must find out in detail the effects of homelessness on children and use their influence to persuade society to provide decent housing and to provide the kinds of services that will help children and their families both survive the crisis of homelessness and help heal the scars left by the experience.

Traditionally, pediatricians have also advised parents how to assess and assist in the healthy physical, emotional, and cognitive development of their children. They must take the time to see that immunizations are done on time, to look at the nutritional status of the young children in shelters and hotels, and, above all, to take the time to sit with the parents, to talk with them and listen to their troubles, to give them the best advice possible about how to toilet train a two year old living in one room with two parents and three siblings, how to help children to avoid the dangers of drug and violence. And once those families are in their own apartments, we must help them to understand the residual damage: the continuing nightmares, the mistrust of adults, the problems in school.

Adults who lose their homes find homelessness difficult, impossible to forget, a source of continuing anxiety even after they regain a stable living situation. For young children, still struggling to establish an identity, to understand the world and the people around them, the devastation and loss is incomprehensible and the cause of permanent, perhaps irreparable, damage.

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