COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT

Suffolk, ss. No. SJC 6970

MASSACHUSETTS COALITION FOR THE HOMELESS et al.,

Plaintiffs, Appellants

and

Michele BENNETT et al.

Plaintiff-Intervenors, Appellants

v.

Gerald WHITBURN, Secretary of the Executive Office of Human Services, et al.,

Defendants, Appellees.

BRIEF FOR THE SECTION ON COMMUNITY PEDIATRICS AND CHILD ADVOCACY, BOSTON CITY HOSPITAL DEPARTMENT OF PEDIATRICS, AMICUS CURIAE.

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MEDICAL LITERATURE

We intend in this brief to summarize the current state of the medical and academic literature with respect to the deleterious effects of homelessness on children's health and development. We believe that a medical perspective may assist the Court in delimiting the proper scope of judicial discretion and authority with respect to the Commonwealth's statutory duties to assist homeless children and their families.

ARGUMENT

I. DEFENDANT SHOULD NOT HAVE THE DISCRETION TO PLACE CHILDREN IN WELFARE MOTELS AND EMERGENCY SHELTERS WHICH EXPOSE THEM TO SUBSTANTIALLY HEIGHTENED HEALTH AND SAFETY RISKS.

A. CHAPTER 118, § 2 IMPOSES A LEGAL DUTY ON THE DEFENDANT TO ASSURE THAT CHILDREN ARE RAISED "PROPERLY IN THEIR OWN HOMES" RATHER THAN IN EMERGENCY SHELTERS OR WELFARE MOTELS.

The state enabling statute for the Aid to Families with Dependent Children (AFDC) program provides that AFDC benefits "shall be sufficient to enable... [parents] to bring up... [each dependent child] properly in his or her own home." G.L. c. 118, § 2. With respect to homeless AFDC recipients, the Supreme Judicial Court previously remanded this case to the Trial Court for further consideration of the Department of Public Welfare's

> "obligation under G.L. c. 118, § 2, to provide aid sufficient to permit AFDC parents to live in a home, and not simply to provide accommodations to AFDC parents. The furnishing of accommodations in hotels, motels and emergency shelters does not fulfill the department's duty under § 2."

Massachusetts Coalition for the Homeless v. Secretary of Human Services, 400 Mass. 806, 825 (1987) [hereafter cited as "MCH at __"].

Of particular concern, the Supreme Judicial Court explicitly recognized that G.L. c. 118, § 2 "places a duty on the department to prevent, as far as reasonably possible, the use of transient housing by AFDC families..." MCH at 822. Plaintiffs have subsequently argued that, at a minimum, the Trial Court should consider whether the state has maximized its use of appropriated Emergency Assistance funds in order to provide "home-like" temporary accommodations.[1] Nevertheless, the trial court ruled that it "must defer to defendants' judgment regarding how they choose to fulfill their obligations." Trial Court opinion at 12 (emphasis added).

The doctrines of judicial deference and administrative discretion require courts to engage in a difficult balancing process. On the one hand, "[a] court... may not properly exercise the functions of the executive branch of State government." Matter of McKnight, 406 Mass. 787, 792 (1990). "On the other hand, a court has the right to order the department to do what it has a legal obligation to do." Id. (citing Attorney Gen. v. Sheriff of Suffolk County, 394 Mass. 624, 629-30 (1985)).

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[1] In particular, plaintiffs have recommended that defendants should increase the use of less-costly apartment-style temporary shelters, consider the implementation of a transitional subsidy program and optimize the use of subsidized housing resources by homeless families. Each of these requests is motivated by a concern that the defendants' current practice of sheltering families in congregate shelters or crowded motel rooms does not meet its obligation to homeless families.

Given the department's unfulfilled obligation to provide "home-like" environments for children, the lower court's complete abdication is both inappropriate and an error of law. In the first place, the court should not simply ignore an ongoing, substantial violation of statutory duties by the executive. Contrary to the court's opinion that it "must defer to the defendants' judgment," the court abused its discretion by failing to order the executive to correct these violations.[2] As suggested in McKnight, the court is well within its authority to order the executive to comply with its statutory mandate, even when it does not have the right to order more precise relief. McKnight, 406 Mass. at 798.

Second, due to the distressing nature of the issues involved, the lower court should have made some attempt to ascertain whether a precise, specific order was warranted in this case. Thus, it is troubling that facts were irrelevant to the lower court's decision, especially because the effects of homelessness on children are so pernicious. Had the court considered the data more carefully, it might well have found that the only means of fulfilling statutory obligations was placement in "home-like" environments, thus satisfying the McKnight standard.[3] See Attorney Gen. v. Sheriff of Suffolk

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[2] The precise scope of such corrective action(s) should have been the subject of the lower court proceedings upon remand, as previously recommended by the Supreme Judicial Court. Undoubtedly, the defendants should have been given the initial opportunity to create a shelter scheme which does not unduly rely upon long-term hotel/motel and congregate shelter placements.

[3] "Only when... there is but one way in which that obligation may properly be fulfilled, is a judge warranted in telling a public agency precisely how it must fulfill its legal obligation." Mcknight, 406 Mass. at 792.

County, 394 Mass. 624 (1985) (ordering new jail built); Perez v. Boston Hous. Auth., 379 Mass. 703 (1980) (ordering receiver appointed); Blaney v. Commissioner of Correction, 374 Mass. 337, 342 (1978) (ordering changes in state's protective custody implementation).

Medical studies clearly indicate the substantial, long-term harm which children suffer from such shelter placements. It seems ironic to allow the executive branch to implement a shelter policy which injures the precise class of people the enabling legislation was designed to protect. As physicians, we are guided by the principle "do no harm." Surely, the Commonwealth bears a similar obligation to homeless children?

Much of the medical literature regarding the effects on children of homelessness in general, and shelter placements in particular, has been published since the Supreme Judicial Court's earlier decision.[4] The findings are cause for extreme concern. Homeless children are sicker, and have less access to care. In the remainder of this section, we intend to summarize the current state of scientific knowledge with respect to the substantial, detrimental consequences of homelessness on children's health and development. The lower court should have considered this type of information before rendering its opinion.

B. HOMELESS CHILDREN HAVE A SIGNIFICANTLY HIGHER INCIDENCE OF ACUTE AND CHRONIC

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[4] Accord MCH at 821, notes 15-16 (discussing ways in which emergency shelters disrupt family life and expose children to numerous health and safety risks).

MEDICAL PROBLEMS THAN THEIR HOUSED COUNTERPARTS

Homeless children suffer significantly elevated rates of certain acute and chronic medical problems when compared to the general pediatric population and/or to children from the same socio-economic level. The medical community has conducted extensive studies on the health effects of homelessness and has published significant medical data on homeless children's susceptibility to respiratory and gastro-intestinal infections and low birth weight. The studies and data strongly demonstrate the serious health costs of placing homeless children in shelters.

1. Substantially Higher Rates of Respiratory Illnesses, Including Tuberculosis and Asthma, Result from Increased Exposure to Infected Individuals, Crowded Living Conditions, and Lack of Control Over the Living Environment.

A medical study which compared homeless children to the general pediatric population found that homeless children had twice the rate for upper respiratory infections.[5] Increased exposure to infected individuals, crowded living conditions, lack of control over the living environment, and malnutrition all result in higher rates of respiratory illnesses, in particular, tuberculosis and asthma. In general, homeless people are twenty-five times more likely to contract tuberculosis than the general population.[6]

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[5] Rafferty & Shinn, *The Impact of Homelessness on Children,* 46 Am. Psychologist 1170 (1991). Homeless children had a 42% probability of contracting an infection, while the general child population had a 22% probability.

[6] J. Wright & E. Weber, HOMELESSNESS AND HEALTH (1987) (citing a study by the Center for Disease control).

Homeless children may be at an even greater health risk than homeless adults. In one study, eleven out of thirteen tuberculosis cases that resulted from an exposure to a tuberculosis-infected, homeless adult were children.[7] An additional eight children were identified with latent infection.[8] Tuberculosis infection is life threatening to newborns, with a high incidence of active disseminated disease among exposed infants.[9]

Similarly, homeless children are two to three times more likely to manifest asthma symptoms than are children from low income families that have housing.[10] This probability is highly significant because asthma is the most common chronic respiratory disease in childhood, and the most frequent cause for pediatric hospitalization.[11] The higher incidence of asthma among

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[7] Leonhardt et al., *A Cluster of Tuberculosis Among Crack House Contacts in San Mateo County, California,* 84 Am. J. Pub. Health 1834 (1994). A total of 89 people were exposed to the infection. 42 of the 89 were children.

[8] Id. A child with a "latent" infection, if left untreated, can later develop an active "full blown" case of tuberculosis. Regardless, the latent child acts as a carrier of the infection to others.

[9] Bass et al., *Pediatric Problems in a Suburban Shelter For Homeless Families,* 85 Pediatrics 668 (1988). It should also be noted that tuberculosis is expensive. An outbreak among Boston's homeless of more than 60 cases of multiple drug resistant tuberculosis identified the probable index case as a single homeless alcoholic adult. The health care expense to the state was more than $1 million.

[10] Wood, Valdez, Hayashi & Shen, *Health of Homeless Children and Housed, Poor Children,* 86 Pediatrics 858 (1990).

[11] Brown & Weiss, *The Influence of Lower Respiratory Illness on Childhood Asthma: Defining Risk and Susceptibility,* 6 Seminar Respiratory Infection 225 (1991).

these children is related to the inability of homeless families to control their environment. Viral respiratory infections, smoking, dust mites, cockroaches and mice urine are medically proven asthma triggers. Most Boston shelters contain these asthma triggers because they are crowded, transitory in nature, and not necessarily designed to serve the asthmatic child.[12] The current structure of Boston's shelter system enhances the health risks to the individual homeless child and to society as a whole by placing the child's health at risk and increasing the chances of an tuberculosis outbreak.

2. Gastrointestinal Problems, Including Giardia Outbreaks and Chronic Diarrhea, are Common in Homeless Shelters Due to Shared Bathroom and Kitchen Facilities

The communal bathrooms and kitchens in many shelters, and the ability of common parasites to survive for prolonged periods on communal surfaces, enhance the transmission of gastrointestinal infections among homeless children. Gastrointestinal disorders are more frequently diagnosed in homeless children than in the general pediatric population,[13] with one

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[12] For example, entire families frequently occupy one room. Families cannot control whether smoking is allowed in the shelter. As previously mentioned, children are at increased risk of exposure to respiratory illnesses from other resident. If the room contains carpeting, it is extremely difficult to eliminate the dust mites which reside in the fibers of the carpet.

It should be mentioned that no formal process exists for a physician to request a particular type of accommodation for a chronically ill child. One of our sickest asthma patients (hospitalized 17 times in a four year period) was placed, despite repeated requests, in a shelter in Framingham which permitted smoking by residents, contained shag carpeting, and used forced hot air heat. He spent 17 days in our Pediatric Intensive Care Unit during this period.

[13] J. Wright, supra note 6 (finding 15% diagnosis in the homeless population versus 4% in the pediatric population).

study citing the frequency of diarrhea among homeless children as 5 times the rate compared to the general population in Los Angeles.[14] Nationally, 12% of shelters for battered women and their children surveyed reported outbreaks of diarrhea affecting 10 or more individuals.[15] Screening for intestinal parasites in a suburban shelter in Massachusetts found that randomly-tested juvenile residents were twice as likely to have giardia infections,[16] as samples from symptomatic individuals tested by the Massachusetts State Diagnostic Laboratories.[17]

3. Pregnant Homeless Women Have a Substantially Increased Risk of Delivering a Premature Infant

A New York City study compared the reproductive experience of three groups of women: homeless, low income housed, and the general population.[18] It found that homeless women were more than twice as likely

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[14] Wood, supra note 10.

[15] Gross & Rosenberg, *Shelters for Battered Women and Their Children: an Under-recognized Source of Communicable Disease Transmission,* 77 Am. J. Pub. Health 1198 (1987).

[16] Bass, supra note 9 (13%).

[17] Keppus et al., *Results of Testing for Intestinal Parasites by State Diagnostic Laboratories, US, 1987,* 40 MMWR 25 (1991) (6.3%).

[18] Chavkin et al., *The Reproductive Experience of Women Living in Hotels for the Homeless in New York City,* 87 NY State J. Med. 10 (1987).

to deliver a premature infant than the general population. Even when compared to women of equal socio-economic status, low birth weights are 43% higher among homeless mothers.[19] Low birth weight is associated with numerous health risks to the infant. These risks include immature respiratory drive, and increased susceptibility for aspiration and pneumonia.[20] These findings probably reflect decreased access to prenatal care, increased stress, increased exposure to ill individuals.

B. HOMELESS CHILDREN HAVE POOR ACCESS TO PREVENTATIVE MEDICAL CARE AND SUFFER FROM A DISPROPORTIONATE NUMBER OF PREVENTABLE CONDITIONS.

1. Children in Shelters Have Less Access to Medical Care, Do Not Receive Routine Care, and Receive Care in Inappropriate Settings

It is ironic, yet not surprising, that given the large number of health problems facing homeless children, they are often without health insurance or a source of primary care services. The most disturbing results were obtained in a Seattle study.[21] Nearly 33% of families surveyed could not identify a usual site of care. Another study found that almost twice as many homeless families had no regular source of medical care compared to their housed, low-

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[19] Id. The study found that low birthweight rates were 163 per 1000 (homeless) vs 114 per 1000 (poor) vs 74 per 1000 (all mothers).

[20] Bor & Epstein, *Pathogenesis of Respiratory Infection in the Disadvantaged,* 6 Seminar Respiratory Infection 225 (1991).

[21] Miller & Lin, *Children in Sheltered Homeless Families: Reported Health Status and Use of Health Services,* 81 Pediatrics 668 (1988).

income counterparts.[22] Families who do utilize care often go to inappropriate settings. Thus, a Philadelphia study found that forty-four percent of those who identified a regular source of care used the emergency room or hospital clinics.[23] Consequently, homeless children are more likely to get sick with preventable illnesses, and less likely to receive appropriate follow-up medical care. This can be a serious, and sometimes deadly, combination.

Immunization rates are an important indicator of access to preventative care. In a study performed in New York City, homeless children attending a hospital clinic were compared to the other predominantly low-income children in the practice.[24] Twenty-seven percent of the homeless children had delayed immunizations, compared to 8% in the low-income control group. Investigators obtained even more dramatic results comparing homeless and domiciled children attending a different pediatric clinic in New York City.[25] Seventy percent of homeless children had delayed immunizations, compared

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[22] Roth & Fox, *Children of Homeless Families: Health Status and Access to Health Care,* 15 J. Community Health 275 (1990).

[23] Parker, Rescorla, Finkelstein, Barnes, Holmes & Stolley, *A Survey of the Health of Homeless Children in Philadelphia Shelters,* 145 Am. J. Diseases Children 520 (1991).

[24] Alperstein, Rappaport & Flanigan, *Health Problems of Homeless Children in New York City,* 78 Am. J. Pub. Health 1232 (1988).

[25] Fierman, Dreyer, Acker, and Legano, *Status of Immunization and Iron Nutrition in New York City Homeless Children,* Clinical Pediatrics 155 (1993).

to 22% in the domiciled group. Similar studies in Los Angeles,[26] Seattle,[27] and Washington, DC[28] show delayed immunization rates approximately 2.5 to 5 times higher than housed, low income counterparts.

Dental disease, although not strictly part of pediatrics, is another marker of the lack of preventive care and is of concern itself. According to Roth and Fox,[29] 51.4% of homeless children had not had a dental examination during the past year, compared to 24.9% of children staying at home. In a separate study, two-thirds of the homeless children surveyed did not seek dental care during the previous year when the parent thought it might be needed because of problems with insurance or family finances. Thirty-six percent were reported to have dental problems such as cavities, crooked teeth or pain.[30]

One reason for lack of care is lack of health insurance. Roth and Fox explored the issue of insurance coverage and found that 31.2% of homeless families surveyed had no insurance. This was two times

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[26] Murata, Mace, Strehlow and Shuler, *Disease Patterns in Homeless Children: A Comparison with National Data,* 7 J. Pediatric Nursing 196 (1992).

[27] Miller & Lin, supra note 21.

[28] Orenstein, Boenning, Engh, & Zimmerman, *Emergency Care of Children in Shelters,* 8 Pediatric Emergency Care 313 (1992).

[29] Roth & Fox, supra note 22.

[30] Miller & Lin, supra note 21.

the rate for low income families surveyed.[31] A similar report confirmed high rates of homeless families who identify as "self pay" compared to low income controls -- 46% compared to 20%.[32]

2. Homeless Children Are At An Increased Risk Injuries Requiring Medical Treatment.

Lack of access to medical care is especially troubling because homeless children often need it. The Philadelphia study reports high rates of accidents in the homeless population of children surveyed.[33] Twenty percent of children had been seen in the emergency room during the past year for an injury or fall. Six percent had a fracture in the past year. Fourteen percent had burns severe enough to result in scar formation. Six percent of homeless children surveyed had an episode of having been "knocked unconsciousness" because of trauma within the past year. Seven percent had a poison or pill ingestion requiring emergency treatment. Finally, 8% of homeless children surveyed had been admitted to the hospital for treatment of injury.

When comparing homeless children to a sample from the general population, Los Angeles investigators found that the homeless

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[31] Roth & Fox, supra note 22.

[32] Orenstein, supra note 28.

[33] Parker, Rescorla, et al, supra note 23.

children had significantly higher rates of open wounds and lacerations.[34] Injuries are a major cause of morbidity and mortality in children in general. It appears that homeless children are at an even increased risk for injuries and accidents. While the causal connection is not completely understood, it is clear that access to medical care becomes that much more important for these children.

C. CHILDREN IN TRANSIENT HOUSING HAVE POOR NUTRITION RESULTING FROM BARRIERS TO FOOD ACQUISITION AND PREPARATION.

Another serious threat to the health and development of homeless children is their inadequate diet and consequential growth problems. It is axiomatic in the medical literature that poor nutrition leads to poor growth, both physically and mentally. Tragically, the result is a decreased realization of childrens' ultimate potential in adulthood.

It is often difficult to sort out the effects of poverty versus the effects of homelessness since the two are intertwined in the majority of families. This is particularly true in the arena of nutrition where poverty so significantly limits families' choices about food. However, it is clear that homelessness itself creates new and additional burdens

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[34] Murata, supra note 26.

on families beyond those imposed by poverty. The struggle to maintain an adequate and nutritionally balanced diet while living in a welfare motel was described by a study completed in New York City.[35] Overall, 92% of families had no refrigerator in the hotel room, 100% had no stove, 80% reported eating less food and food of lesser quality than they previously had, and 67% said they "felt hungrier" since moving to the hotel. A Los Angeles study found that 21% of homeless children did not get enough to eat because of lack of money 4 days or more in the last month.[36]

Living in the constant chaos of shelter life, where food availability and access to food preparation facilities are severely limited, restricts families' nutritional choices and the consequent quality of the families' diet. One survey of 96 single mothers and their 192 dependent children in two temporary housing shelters in Kansas City Missouri during the twelve months from January 1989 to January 1990, showed the extremely poor nutritional status of these families.[37] A nutrient analysis found that the study subjects in all age groups were consuming less than 50% of the 1989 Recommended Dietary

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[35] J. Simpson, M. Kilduffm and C.D. Blewett, STRUGGLING TO SURVIVE IN A WELFARE MOTEL (1984).

[36] Wood, supra note 10.

[37] Drake, *The Nutritional Status and Dietary Adequacy of Single Homeless Women and Their Children in Shelters* 107 Pub. Health Rep. 312 (1992).

Allowances (RDA) for iron, magnesium, zinc and folic acid. Without these essential nutrients, children simply stop growing.

Homeless children also garner a disproportionate share of their caloric intake from sugars; major sources include soft drinks, candy, cookies and sweetened cereals.[38] Mothers reported that they "treated" their children to sweets because they could not afford the toys their children requested and because these foods are nonperishable and easy to store.

In addition to the challenges of food acquisition and preparation, homeless families are frequently cut off from nutrition "safety net" programs.[39] Homeless families were less likely to be receiving food stamps or WIC versus housed poor families (62% versus 81% respectively). They are also more likely to have their welfare cases closed and benefits reduced; 43% of the 196 homeless families surveyed reported losing benefits during the past year, resulting in loss of disposable income for food purchases. Like access to medical care (see Section I.B) or schools (Section I.D), homeless families face transportation and bureaucratic barriers in accessing family support

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[38] Taylor & Koblinsky, *Dietary Intake and Growth Status of Young Homeless Children,* 93 J. Am. Dietetic A. 464 (1993).

[39] Wood, Valdez, Hayashi, & Shen, *Homeless and Housed Families in Los Angeles: A Study Comparing Demographic, Economic and Family Function Characteristics,* 80 Am. J. Pub. H. 1049 (1990).

benefits. Children who eat poorly, or don't eat at all, suffer from a host of poor health and development outcomes including growth delay, neurological impairments, shortened attention spans and behavioral/emotional problems.

D. HOMELESS CHILDREN ARE AT AN INCREASED OF BEHAVIORAL DISORDERS AND POOR CHILD DEVELOPMENT OUTCOMES

No one has ever contested the fact that homelessness has a deleterious effect on children's psychological well-being.[40] However, only recently has scientific research detailed just how pernicious those effects are, especially with regard to children's behavioral and developmental functioning. Developmental theory posits optimal developmental and behavioral outcomes in children to be dependent upon a healthy interaction between the child and his or her environment. Those outcomes are significantly affected by the nature of the environment in which the child lives[41] and the child's ability to achieve a sense of mastery over that environment, two factors particularly disrupted by the experience of homelessness.

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[40] Rafferty, supra note 5.

[41] A. Sameroff & M. Chandler, *Reproductive Risk and the Continuum of Caretaking Casualty*, Rev. Child Dev. Res. 187 (F. Horowitz, M. Hetherington, S. Scarr-Salanatek et. al. eds.) (1975).

1. Homeless Children are Exposed to a Heightened Level of Environmental Stress

Homelessness precludes a stable, consistent environment, and presents a myriad of stressors for children. It is probably self-evident that homeless children live in places that are frequently inappropriate, chaotic, unpredictable and unsafe. In a Massachusetts study of homeless families, for example, the families had experienced an average of 6.6 moves in the five years prior to the current homelessness episode and 3.6 moves in the year before becoming homeless. Most of the families had long histories of residential instability and two thirds of the mothers had experienced a major family disruption.[42]

Such environmental instability precludes children from attaining a sense of control over their environments and promotes what psychologists have termed "learned helplessness" and depression. For example, in one study, preschoolers who were placed in shelter settings demonstrated short attention spans, withdrawal, aggression, speech delays, and regressive behavior.[43] Left unchecked, these behaviors ultimately preclude normal cognitive and behavioral development.

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[42] Bassuk, Rubin & Lauriat, *Characteristics of Sheltered Homeless Families,* 76 Am. J. Pub. Health 1097 (1986).

[43] J. Molnar, HOME IS WHERE THE HEART IS: THE CRISIS OF HOMELESS CHILDREN AND FAMILIES IN NEW YORK CITY (1988).

2. Homelessness Impedes a Child's Relationship with His or Her Parent(s) Resulting in Poor Attachment and Consequent Emotional Problems

At the center of this critical interplay between the child and his or her environment is the relationship with a caretaker. A stable, supportive parent is essential to help a child cope with the stresses of being homeless. However, studies have demonstrated that homelessness deprives parents of a sense of security and fulfillment of their basic needs so that they become mistrustful, apathetic, despairing and depressed.[44]

Maternal depression in turn interferes with the mother's ability to nurture her child, resulting in impaired parent-child attachments and interactions, and greatly increasing the prevalence of subsequent emotional, behavioral, and developmental problems in the child. Thus, parents -- the mainstays of support for homeless children -- are themselves victims of its pernicious effects and often not able to meet the child's heightened emotional and developmental needs. This vicious cycle has devastating effects on children.

3. Homeless Children Suffer Disproportionately from Developmental Delays and School Failure, in Part Because of Disrupted Access to Schools

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[44] Eddowes & Hranitz, *Childhood Education: Infancy Through Early Adolescence,* 65 J. A. Childhood Educ. Int'l. 197 (1989).

functioning at the fifth percentile for age in psychomotor ability and 38% demonstrated emotional and behavioral problems.[47]

In two studies that compared homeless children to housed, but equally poor children, homeless preschoolers had significantly more developmental delays.[48] [49] Significantly, a Boston study demonstrated that only a small percentage of children had abnormal or questionable developmental screening results at the time of entry to a homeless shelter. This finding lends support to the contention that it is homelessness, and not simply poverty, that is a major cause of developmental delay in children.[50]

The effects of homelessness on children's emotional state can be just as devastating and distressingly common. For example, a full 50% of the children in the Massachusetts study demonstrated anxiety and depression, possibly reflecting the current shelter experience, the

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[47] Fox, Barnett, Davies & Bird, *Psychopathology and Developmental Delay in Homeless Children: A Pilot Study,* 29 J. Am. Acad. Child Adolescent Psychiatry 732 (1990).

[48] Rescorla, Parker & Stolley, *Ability, Achievement, and Adjustment in Homeless Children,* 61 Am. J. Orthopsychiatry 210 (1991).

[49] Bassuk, supra note 45.

[50] Lewis & Meyers, *The Growth and Development Status of Homeless Children Entering Shelters in Boston,* 104 Pub. Health Rep. 247 (1989).

chaotic environment, and the lack of privacy.[51] When compared to housed children of the same socioeconomic status, homeless children demonstrate more behavior problems (especially aggressiveness, irritability and temper tantrums) than housed children.[52] [53]

Homelessness in older children has been shown to be linked to academic difficulties, school absenteeism, and ultimate school failure. A 1990 study compared 196 homeless families to 194 poor, but housed families in Los Angeles. It found that homeless children had more school failure, developmental delay, and behavior problems. Homeless children missed school much more often than housed children, and almost half missed school because their families were in transition.[54]

These studies confirm the devastating effects of homelessness on children's development. The long-term consequences are both profound and chilling: impaired development leads to poor school achievement, school failure and a high drop out rate. Given the links between educational attainment and economic well-being, an early

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[51] Bassuk, supra note 42.

[52] Wood, supra note 10.

[53] Masten, Miliotis, Graham-Bermann, & Ramirez, *Mental Health and Development,* 61 J. Consulting Clinical Psychology 335 (1993).

[54] Wood, supra note 10.

experience of homelessness may well contribute to the inter-generational transmission of poverty.

II. A FAMILY DOES NOT HAVE "FEASIBLE ALTERNATIVE HOUSING" IF A SUBSTANTIAL PORTION OF ITS AFDC GRANT IS UTILIZED TO MEET HOUSING EXPENSES BECAUSE IT WILL FOREGO OTHER NECESSARY EXPENDITURES INCLUDING FOOD.

A. GENERAL LAWS C. 18, § 2(D)(d) REQUIRES THE DEPARTMENT OF TRANSITIONAL ASSISTANCE TO FURNISH "TEMPORARY SHELTER" WHEN A HOMELESS FAMILY DOES NOT POSSESS "FEASIBLE ALTERNATIVE HOUSING."

The second issue in this case is whether a family receiving shelter benefits through the Emergency Assistance (EA) program can be required to spend up to 99% of its AFDC grant on rent for private market housing. The statute governing the administration of the EA program is found at G.L. c. 18, § 2(D). Under the statute, benefits include "temporary shelter as necessary to alleviate homelessness when such family has no feasible alternative housing available..." G.L. c. 18, § 2(D)(d). As argued supra, defendants, who administers the EA program, have a concurrent responsibility to pay AFDC benefits sufficient to enable "[parents] to bring up... [each dependent child] properly in his or her own home." G.L. c. 118, § 2. Of course, defendants' implementation of the EA program must be consistent with the authorizing statute. See e.g., Williams v. Sec. of Exec. Office of

Human Svces., 414 Mass. 551, 566-7 (1993); see also Haley v. Comm'r of Public Welfare, 394 Mass. 466, 472-3 (1985).

In order to receive ongoing shelter benefits under the EA program, homeless families must comply with housing search regulations. 106 C.M.R. 309.040(B)(5)(d)(x). Defendants have interpreted this requirement to mean that homeless families must rent private market housing regardless of its cost. See e.g. App. 1074-77 ¶¶ 8-14; App. 1078-79 ¶¶ 8-10; App. 1084 ¶ 4; App. 1101 ¶ 16; App. 1105-6 ¶¶ 9-10; App. 1190 ¶ 6. Failure to rent such housing results in loss of the shelter benefit. 106 C.M.R. § 309.040(A)(1). In effect, defendants have determined that such high cost housing is "feasible alternative housing."

The health repercussions of forcing families to rent severely unaffordable housing are substantial and include the malnourishment of children. Defendant's practice, if maintained, would result in substantial harm to plaintiff children, who rely on their AFDC grants for necessaries other than shelter, including food, utilities, transportation, and clothing.[55] See Town of Cohasset v. Town of

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[55] As a "down to earth" example, under defendants' interpretation, parents would not be able to afford diapers for their infants. Diapers are expensive, approximately $5-8 per package of twenty diapers; the typical infant uses between 5 and 10 diapers per day. Cost thus ranges from approximately $40 to $150 per month. Diapers are not available through in-kind benefits programs like Food Stamps or Medicaid.

Scituate, 309 Mass. 402, 409 (1941) (stating that purpose of AFDC program broader than merely furnishing "food, shelter and necessities to a needy family..."). The remainder of this section considers the nutritional impact of high housing costs on low income children.

B. POOR FAMILIES UTILIZE A SUBSTANTIAL PERCENTAGE OF THEIR AFDC GRANTS TO PURCHASE FOOD.

Poor families in the United States are increasingly unable to afford the most basic of human necessities, including food and shelter. Often low-income families must choose which essential need to meet with their limited cash resources. Evidence is accumulating that for a substantial proportion of low-income families in the U.S., when the choice is made to preserve adequate shelter, food sufficiency is sacrificed, with resulting hunger and undernutrition which can be measured in their children.

Evidence derived from economic data permits the calculation of food resources available to low-income families. In 1989, researchers at the Massachusetts Department of Public Health Office of Nutrition replicated methodology employed by the U.S. General Accounting Office to study income, assistance program benefits, and expenses for

low-income families in Boston.[56] At the time of the study, the maximum AFDC benefit for a family consisting of a parent and two children was $491 per month, while monthly rental for a two-bedroom apartment averaged $944 (range $529 to $1260). They found that, even with maximal participation in food assistance programs, these programs (Food Stamps, the Special Supplemental Food Program for Women, Infants, and Children [WIC], and school meals) covered only 34-66% of food costs for poor families in Boston.[57] Therefore, AFDC benefits are needed to meet the remaining 34-66% of food costs not covered by in-kind nutrition programs. If families are forced to use AFDC benefits to pay for housing, these families will probably spend some time living with insufficient food to meet their basic needs.

C. FAMILIES WITH HIGH HOUSING COSTS HAVE LESS DISCRETIONARY INCOME WITH WHICH TO PURCHASE NECESSARY FOOD.

Direct evidence demonstrates that families with high housing costs are less able to afford to purchase enough food for an adequate

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[56] Wiecha & Palombo, *Multiple Program Participation: Comparison of Nutrition and Food Assistance Program Benefits with Food Costs in Boston, Massachusetts,* 79 Am. J. Pub. Health 591 (1989).

[57] Id.

diet. This evidence is provided by studies which report interview data, nutritional outcome data, or both.

The best measure of the nutritional status of a community is the growth of its young children. All national surveys in the U.S. to date have shown that poor children grow at a slower rate than non-poor children, manifested as a higher prevalence of short stature.[58] A recent study at Boston City Hospital (B.C.H.) shows that this growth effect is associated with housing costs.

Families on the waiting list for housing subsidies are financially similar to those families already receiving subsidies, except that the housing costs for subsidized families are capped as a percentage of their income; this theoretically leaves additional discretionary income available for food purchases. Therefore, the nutritional status of low-income children, as measured by growth parameters, will likely be better among children whose families receive housing subsidies compared to families who are on the waiting list for housing subsidies.

This hypothesis was tested in the Pediatric Emergency Department at B.C.H. Children were between 6 and 7 times (21.6%

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[58] Miller & Korenman, *Poverty and Children's Nutritional Status in the United States,* 140 Am. J. Epidemeology 233 (1994).

vs. 3.3%) as likely to have low growth parameters if their families were on the waiting list for housing assistance. The study concluded that receiving a housing subsidy is associated with improved growth in low-income children, an effect which is consistent with housing subsidies' having a protective effect against childhood undernutrition.[59]

Another study of growth data collected in the B.C.H. Pediatric Emergency Department over a continuous three-year period showed that the prevalence of undernutrition rose significantly following the three coldest months of winter.[60] There is no known biologic explanation for this observation. The study concluded that the most probable cause for this effect was the family's being forced to choose whether to spend their fixed, inadequate cash resources on utility bills (i.e. an additional shelter expense) to heat their home, or on adequate food.

National interview data, including studies of household economy and of measures of hunger, support these conclusions. Data from the Consumer Expenditure Survey of the U.S. Department of Labor,

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[59] Meyers, Frank, Roos, Peterson, Casey, Cupples & Levenson, *Housing Subsidies and Pediatric Undernutrition,* Archives of Pediatric Adolescent Med., forthcoming.

[60] Frank, Napoleone, Meyers & Peterson, *Seasonal Changes in Weight For Age in a Pediatric Emergency Room,* Presentation to the American Public Health Association annual meeting, Atlanta, GA (November 13, 1991).

Bureau of Labor Statistics show that rental-assistance households allocate 4.1% more of their total expenditures to food.[61] The major source of data on childhood hunger in the U.S. is the Community Childhood Hunger Identification Project (C.C.H.I.P.). A 1990 C.C.H.I.P. survey in Massachusetts found that 43% of children in surveyed families receiving Food Stamps were experiencing hunger,[62] and the 1995 multisite survey found that 19% of low-income families with at least on child under age 12 years were hungry during some part of one or more months during the prior year, and an additional 50% were at risk of hunger.[63] In this study, families reporting hunger spent an average 6.2% more of their income on shelter than did families not reporting hunger.

Studies of child nutritional status are consistent with the conclusions based on economic and interview data cited above. The most common nutritional deficiency in the U.S. and worldwide is iron deficiency. Iron deficiency correlates with poverty, and is three to four

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[61] U.S. Dept. of Labor, Bureau of Labor Statistics, *Consumer Expenditure Survey: Quarterly Data from the Interview Survey*, Rep. 859, Fourth Quarter (1992).

[62] Rosenberg, M., *Children are Hungry in Massachusetts*, Project Bread (May 1991).

[63] Wehler, Scott, Anderson, Summer, & Parker, *Community Childhood Hunger Identification Project: A Survey of Childhood Hunger in the United States,* Food Res. and Action Center (July 1995).

times more prevalent in children living in families with incomes below the federal poverty line than non-poor children.[64] Insufficient dietary iron has been demonstrated to cause developmental and cognitive impairment in children of all ages,[65] which may be irreversible if it occurs in early childhood, during the period of rapid brain growth and development.[66]

A retrospective analysis of blood iron levels from 580 children seen in the Boston City Hospital Pediatric Primary Care Clinic was conducted several years ago. It found that children whose families received housing subsidies were 60% less likely to be iron deficient than those children who could not be so classified.[67]

Taken together, the data cited above provide compelling evidence that many poor families live on the brink of food insufficiency, and that high housing costs, when unrelieved by subsidies, or when exacerbated by high heating costs, tip many families

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[64] Pilch & Senti, *Assessment of the Iron Nutritional Status of the U.S. Population Based on Data Collected in the Second National Health and Nutrition Examination Survey, 1976-1980*, Life Sci. Res. Off., FASEB (August 1984).

[65] J. Dobbing, ed., BRAIN, BEHAVIOR, AND IRON IN THE INFANT DIET, (1990).

[66] Lozoff, Jimenez & Wolf, *Long-term Developmental Outcome of Infants With Iron Deficiency,* 325 New Eng. J. Med. 687 (1991).

[67] Meyers, Rubin, Napoleone & Nichols, *Public housing Subsidies May Improve Poor Children's Nutrition,* 83 Am. J. Pub. Health 115 (1993).

into food insufficiency, with resultant growth deficiency, childhood hunger, and iron deficiency, all of which are well known detriments to child health, development, and well-being.

The phrase "feasible alternative housing" is certainly susceptible to administrative and judicial interpretation. It cannot possibly include housing which is so expensive that children regularly go to sleep hungry. There are clearly articulated standards for housing affordability, including those employed by the defendant in the annual report to the legislature mandated by MCH. We urge the court to place some ascertainable limit on the cost of housing which homeless families can be forced to accept.

CONCLUSION

From a medical perspective, homeless children are caught in a tragic trap. As the foregoing discussion makes clear, they have a substantially heightened risk of becoming sick due to a host of environmental factors. When they do become ill, their access to medical care is severely restricted.[68] The adverse impacts of homelessness and high housing costs on children are serious, quantifiable, and have long term consequences.

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[68] Parker, Greer & Zuckerman *Double Jeopardy: The Impact of Poverty on Early Child Development,* 35 Pediatric Clinic N. Am. 1227 (1988).

It is clear that specific decisions made by the administration exacerbate these effects. At a minimum, the medical data should be relevant to the lower court's decision. In light of this data, the Trial Court erred in summarily dismissing the plaintiffs claims. We strongly urge this court to reverse the Trial Court decision.

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annual report civil division LAF—

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Litigation - early designed to protect right greater rel. simplicity more check an arbitrary govt to prevent from taking away of rights

L.A. ~~4~~ Frustrating, without orders, gov. wouldn't have ~~significance~~ have done as much -

Without litigation, can't get anything else, but can't use just one forum - now can use just other avenues

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Advocates
other states -
impact of L.S. restrictions, funding cut -

gave up LRS, Boston, LS, CA, LAF LAS Chicago, Miami, D.C. neighborhood -

Legal resources ~~aff~~ available, may mean other issues -

4000 cases challenge, community based ed. -
to assert own right to same degree