HELP USA

Building Better Lives

A Literature Review of Single-Room Occupancy (SRO) Supportive Housing Structures in the United States: An Assessment to Ascertain the Viability of SROs to Address the Needs of Homeless and Vulnerably Housed Populations in New York City

By Ashwin Parulkar and Daniel C. Farrell

Introduction

New York's single adult shelters were often overcrowded during the pandemic, underscoring how solutions to homelessness – which had begun rising significantly in the 2010s - must be found in new housing models, such as the repurposing of existing but often inequitable, housing, and residential-building stock (New York Housing Conference 2021). The city did convert hotels into temporary shelters for the homeless until mid-2021. The New York Housing Conference has recommended that policymakers convert this emergency response into a permanent policy of alternative housing for at least some contingent of the homeless and vulnerably housed population. They have specifically urged the New York City Housing Authority (NYCHA) to invest an additional $40 billion in building and apartment upgrades and the city to convert hotels in 'high opportunity' neighborhoods. into permanent supportive and affordable housing' models for rent-burdened and homeless people (NYHC 2021: 9). The federal government's recently announced *House America* policy also prioritizes the conversion of hotels as part of its $5 billion HOME Investment Partnerships (HOME-ARP) Program. It cites the success of 'non-congregate shelter settings' during the pandemic to both 'mitigate the spread of the virus' and enable 'many' residents to 't[ake] more advantage of services' (United States Interagency Council on Homelessness 2021).

New York City is acutely challenged by increasing homelessness and housing unaffordability. Its policymakers must therefore consider such housing innovations. The number of people in New York City shelters increased by 50% over the last decade - from about 38,000 in 2010 to just over 56,800 people in 2020 (Coalition for the Homeless 2021)[1]. Among this population, single adults in shelters alone increased from 7,700 in December 2009 to 18,700 in 2019 (Routhier 2020). Simultaneously, more than 900,000 households in the city pay more than 30% of their income on rent; 460,000 households[2] (Citizens Budget Commission New York 2018) and approximately 250,00 low-to-moderate income people spend more than 50% of their income on rent (Stern & Yager 2018a:2; Stern and Yager 2018b). The large 'rent-burdened' household and individual population indicates a perpetual vulnerability to homelessness.

[1] The total number of homeless New Yorkers is likely higher given that DHS does not account for shelters funded and managed by other institutions, including private and charitable organizations.

[2] NYU's Furman center estimated 250,000 low-to-moderate income people pay over 50% of their income on rent (Stern & Yager 2018a:2; Stern & Yager 2018b)

However, solutions are in our midst. In 2014, the city's approximately 177,000 studio and 30,000 SRO units could accommodate nearly 1.2 million renters living alone or with roommates (Stern & Yager 2018b: 2), which suggested that 'micro units and efficiencies with shared facilities may represent one way to provide affordable housing for some single-person, low-income households' (Stern & Yager 2018b:9).

Yet, we must also acknowledge that people are also driven into homelessness by social -- or 'individual' - 'factors' (Garcia & Kim 2019) that can be rooted in early life 'adverse experiences', such as the prolonged unemployment of parents, abuse, and deaths of parents and/or siblings (Padgett et al 2006, 2012). More than 6,000 people enter New York shelters from prisons, nursing homes, and psychiatric facilities each year (Routhier 2020). It is therefore essential to consider supportive housing models that provide social services for specific cohorts of homeless and vulnerably housed people in need.

In this context, this literature review attempts to ascertain: how viable may Single Room Occupancy (SROs) models, like converted hotels, be in potentially addressing needs of 'rent burdened' vulnerably housed and homeless New Yorkers, and particularly single adults in both populations? Again, we stress that the needs of the chronically homeless may be independent of or coincide with housing instability. Mental halth problems that may be associated with early life traumas.

This literature review provides an overview of:

- the evolution, decline and revitalization of SROs as part of America's housing stock and homelessness prevention system. This historical trajectory can be understood as:

  (1) the rise of SROs from the late 19th to mid 20th centuries to house transient, laboring poor classes, particularly between World Wars I and II,

  (2) the decline of SROs from the 1950s to 1980s due to urban renewal programs that eradicated SROs in Skid Rows across American cities to gentrify these areas

  and

  (3) attempts, this century, to revitalize SROs amid challenges, such as their diminished stocks and policy constraints that have carried over from the previous era. Recent federal social and municipal tax policies have ensured funds for SRO rehabilitation. Non-governmental organization (NGO), development firm and government agency partnerships have protected and modernized these housing options in North American cities for various poor and vulnerable Americans.

- emerging best practices from organizations that utilize the SRO housing model amid (i) increasing privatization of land and housing markets (Mitchell 2020) (ii) varying government and non-government partnerships that determine the scale and types of supportive housing models that can be implemented (Main 2017) and (iii) evolving social

services to address increasingly complex problems of substance abuse and unemployment in the homeless population.

- the impacts of SROs on crime rates and public health outcomes in neighborhoods where they are situated, particularly in context of their concentration and their housing quality in these areas. This section also examines how SRO residents integrate into or are excluded from their respective neighborhood.

The Evolution, Decline and Revitalization of SROs in the United States from the late-19th century to the early 21st century

In the mid to late 19th century, high-end and budget SRO hotel models catered to all classes of the nation's city dwellers, particularly on the east coast. Individual rooms lacked in-door cooking spaces. Quality, price and clientele were, instead, marked by bathroom-to-resident ratios: elite 'palace hotel' units had private bathrooms while boarding houses, used most by itinerant male laborers, provided one bathroom for every ten to twelve rooms (Bevil 2009:13, 17; Groth 1986)[3] In the early 20th century the 'inclusion of a kitchen…area' (Bevil 2009: 17) in new apartment models divided access to the housing market between elites who could afford these 'proper dwellings' and those who had to continue to rely on traditional SRO units. In response, 'SRO hotels develop[ed] their own unique landscape': restaurants and busses connected residents in upper class residential hotel districts like Madison Avenue to other parts of the city while low-cost saloons and discount stores catered to itinerant labors in districts like the Lower East Side, (Bevil 2009:20).

From the 1920s to the 1940s, however, SRO hotels generally adapted to the needs of the poor. In the 1920s, New York City 'landlords began (largely illegally) dividing larger SRO units into small ones to rent out to the unemployed and newly poor' (Sullivan & Burke 2013:120). The Great Depression in the 1930s generated both homelessness and middle-class flight. The Housing Act (1934) provided loans for houses on the outskirts of cities that were predominantly available to middle class white families. The large population of unemployed and transient laborers, immigrants and veterans increased the demand for SRO units. In response, 'landlords converted apartments, houses and hotels into small units leaving a bathroom and…kitchen to serve a number of separate tenants' (Haley 1989:6; Reynolds 1969). Competition for SRO units led to a rise in demand from 'new [ly identified] low-income group[s]' such as the elderly[4] and the disabled (Minkler & Ovrebo 1985). Still, New York City landlords 'accommodate[d] workers seeking jobs in the City's wartime munitions factories, *and then* returning soldiers, migrants from the South, and immigrants (largely from Puerto Rico) (Sullivan & Burke 2013: 120)

This posture of accommodation ended in the 1950s. Urban renewal programs reshaped American cities (Bahr 1967; Kasinitz 1984; Lee 1980; Rudel and Neaigus 1984; Minker & Ovrebo 1985; Mitchell 1997, 2020). Demolitions and zoning laws prohibited the existence of skid rows where

[3] Young professionals and families in mid-priced hotels shared bathrooms with a neighbor; low-income but salaried, and usually male, rooming house residents shared a bathroom with four other rooms

[4] Senior citizens comprised the largest subgroup of SRO residents by 1980 (Minkler & Ovrebo 1985)

SROs were located (ibid). In at least 41 cities, the population of these areas declined by 38% in the 1950s and 30% in the 1960s (Lee 1978; Minkler & Ovrebo 1985) Funding cuts, maintenance neglect, exclusionary zoning laws, and city ordinances that banned both the construction of new SROs and families from staying in existing units (an anti-immigrant bias) led to their overall demise (Bevin 2009; Sullivan & Burke 2013). This anti-SRO period[5] coincided with the increasing visibility of 'a transient labor force of men who were single or had left families behind to find work' (Shapiro 1971; Wallace 1965; Haley 1989: 6).

SRO stocks declined more rapidly in the 1960s and 1970s (Green 1982; Hopper and Hamburg 1986; Haley 1989) -- 16% nationally and 18% in central cities (Hull et al 1982; Minkler & Ovrebo 1985) - due to continued demolitions and increasing privatization of the housing market (Haley 1989). The national SRO stock decreased by 20% from 1976 to 1980 (376,000 to 307,00) while efficiency units[6] increased by 25% (Haley 1989:7). These units existed primarily in large buildings (more than 50 rooms). But their share in these structures declined from 28% to 25% during this period. The largest decline occurred in small buildings (10 to 19 units) (35% decrease). Moderately sized buildings (20 to 49 units) gained about 8 percent of the total share (58,000 units to 63,000 units).[7] SROs across all cities decreased by 13 percent with a 25% decrease among these metropolitan large buildings (Haley 1989:7) [move to endnote]. The practice of converting SRO units into high-end accommodations ('condo conversion') took root in New York City. In response to local demand for luxury apartments, landlords 'emptied and converted the most desirable buildings' while structures that were deemed unprofitable 'were left to rot' (Sullivan & Burke 2013:122)). By the mid-1970s one-fourth of New York's 'remaining SRO units (approximately 13,000) were vacant because they were uninhabitable. By the 1980s New York had eliminated and did not replace 100,000 units of affordable housing' (ibid).

By 1980 half of men entering shelters had lived in SROs before becoming homeless (Sullivan & Burke 2013:124). They were increasingly elderly, single (never married) and non-itinerant white males without high school diplomas and had incomes 20% below comparable non-SRO residents (Hull et al 1982; Minkler 1985). At this time, SROs were, generally, deemed supportive housing models for 'those…unable to survive in…the open setting of skid row or society in general' (Cohen and Sokolovsky; Minkler & Ovrebo 1985: 40). Yet these people were also stigmatized as 'the bottom rung of the housing ladder', which may have only hastened their 'deteriorating condition[s]' and lack of 'compliance with current health, safety and building codes' (Minkler & Ovrebo 1985).

In the 1980s, homelessness increased. It had previously declined from the Great Depression of the 1930's. While homelessness is ubiquitous throughout American history its shape and form continue to shift, the pervasiveness of homelessness throughout this country's history, beginning in the antebellum period, is well documented (Kuhlman, 1994; Kusmer, 2002). Beginning in the

[5] '…the term "Single Occupancy Room" (SRO) became a for a lifestyle associated with the skid-row subculture…' (Haley 1989:6)

[6] Defined as 'single rooms containing complete kitchens and bathrooms' (Haley 1989: 6)

[7] The author attributes the small rise in SRO units across moderately sized buildings as the result of practices of owners, in which 'new SRO units can be...created by closing off a room…and renting it on a long-term basis' (Haley 1989:7). The author does not specify causes for differences in rates of loss SRO units between large (statistically insignificant) and small (significant) units but asserts that demolitions and uninhabitability account for 'the greatest source of loss' across units in general (19%) (Haley 1989:9).

1950's and 1960's, the prototypical homeless person was a middle-aged white male who often suffered from alcoholism. The homeless person was economically destitute and usually drifted in and out of homelessness, occasionally staying at flophouses. The popular term that seemed to define homelessness in this time was the "skid-row aficionado" (Varcarolis, 1990). The "skid-row" homeless person was thought to be disaffiliated with society, defining disaffiliation as, "freedom from the restraints of stable affiliative ties" (Bahr, 1973, p. 13).

By the 1970's and 1980's, a new form of street homeless person had emerged. Rossi (1990) described the "new" homeless population as heterogeneous, suffering from economic destitution as well as co-occurring symptoms of severe mental illness and substance abuse. Many had a history of psychiatric hospitalization. Unlike their historical counterparts, the new homeless included women, as well as individuals of varying ethnic groups such as, African Americans, Hispanics, and Native Americans (Kusmer, 2002). The deinstitutionalization movement compounded the rise of the "new" homeless population. Deinstitutionalization, which began in earnest in the 1960's, was the term coined for the systematic discharge of long-term residents from state psychiatric institutions to the community. Between the early 1950's and the early 1980's there was a loss of approximately 450,000 psychiatric beds (Torrey, 1988). The loss of psychiatric beds coupled with the loss of SRO units directly led to an increase of homelessness among single adult, many of whom suffered severe and persistent mental illness.

In response to increasing homelessness and decreasing affordable housing options, national policies in the 1980s included SRO reforms. The Omnibus Reconciliation Act (1981) provided Section 8 subsidies for SRO rehabilitation. The Stewart B. McKinney – Vento Homelessness Act (1987) issued funds for hotel rehabilitation and relaxed ordinances against SROs in major cities, such as New York, San Diego, and San Francisco. Yet, these policies were undermined by other local and government efforts. Over time, the federal government reduced Section 8 funds. In New York, a municipal tax abatement ordinance intended to finance building restorations was undermined by widespread condo conversions (Werner and Bryson 1982; Minkler & Ovrebo 1985) and the city failed to enforce its own tenant anti-harassment laws (Sullivan & Burke 2013).

The homeless and housing unaffordability crises that followed ignited civic activism. Developers and politicians began to acknowledge the need to rehabilitate SRO hotels. By the 1990s and 2000s, local government and non-profit partnerships began to emerge. These networks availed historic preservation grants to refurbish buildings officially listed on the National Register[8]. Government and non-government housing and homeless service partnership have, since increasingly used the historical building preservation model to convert old buildings into modern SROs in Spokane, Washington, and San Francisco[9]. By 2014, Chicago had officially licensed 73 SRO buildings containing approximately 5,500 units. The city also passed the Single Room Occupancy and Residential Hotel Preservation Ordinance to establish a process for preserving affordable SRO buildings by providing opportunities to developers to secure properties for social purposes 'ahead of market-rate developers' – an outcome of the 2012 Emanual administration's Plan to End Homelessness (Enterprise & Landon Bone Baker 2018: 3).

[8] As of 2009, 1,242, palace, SRO and commercial transient hotels were listed on the National Register (Bevil 2009)
[9] Lower Nobb Hill Apartment Hotel District contained 297 buildings; Upper Tenderloin Historic District contained 410 buildings (Bevil 2009)

A prominent New York City example is Common Ground's Time Square project. This SRO program began in 1991 through Low Income Housing Tax Credit funds, a policy now credited with financing the renewal of Time Square overall. It is appropriate to end this section with the view of that organization's founder, Rosanne Haggerty[10], on impacts that location, services, and multi-stakeholder (i.e., the support of a local Community Board and Mayor Dinkins) arrangements had on community-building and well-being of diverse SRO residents:

'…there was a way to save this building by taking basically smart ideas from other places, around mixed-income housing, around integration jobs, around creating robust supports that people would need to get back on their feet, and that it was actually highly efficient economically to do this. And that there were other populations besides individuals who were homeless who were seeking and would benefit from affordable housing in the Times Square area…I had learned …how important it was also to also deal with linkages to jobs and a good access to transportation and that all these things really mattered in terms of the success of any community. And that there are other groups whose needs could be complementary to those of the homeless. For instance, low wage workers seeking affordable housing in the arts, or in the hotel industry, who were part of the Times Square economic ecosystem.' (Main 2017: 117)

Bests Practices: On-site Social Service and Policy/supply-side SRO initiatives that address dynamics of homelessness and housing affordability crises

This history of SROs highlights the need to examine the use of this model as a form of affordable housing for vulnerable communities that, in some instances, provides social services to the homeless. We now discuss best practices that have emerged in this context.

Social service practices intended to address the existing homeless population and associated risk factors

L.A.'s Skid Row Collaborative (2003-2007) (SRC)'s SRO provided 'intensive on-site…psychiatric' (Burt 2007:11) and case management services for chronically, mentally ill homeless people[11]. SRC's provision of high quality full and part-time nursing, psychiatric and social work staff (footnote ratio), even amid low salaries and limited experience, was credited for achieving high tenant retention. Skilled frontline medical and social worker personnel transformed pervious markers of exclusion from services, such as mental illness and chronic homelessness, into criterion for service provision. As one employee remarked, such criterion had previously been deemed 'flags' (to reject clients) under 'normal procedures. Once this was reversed, this employee was 'amaze[d]' that the organization 'had done better with harder people' (Burt 2007: 12).

SRC clients stayed an average 200 days longer[12] than the comparison group SRO[13]. The rate by which they completed one year of residence (75%) was also higher compared to the other group (63%). This 'housing plus services' SRO model was, therefore, recommended for other similarly vulnerable Skid Row locations.

[10] Quoted in and referred to as a 'Times Square renovation…policy entrepreneur' in Homelessness in New York City: Policymaking from Koch to De Blasio (Main 2017)
[11] Many suffered post-traumatic stress disorder (PTSD) (Burt et al 2007)
[12] 614 days (Burt et al 2007)
[13] Eligibility criteria included disability but not homelessness and mental illness (Burt et al 2007)

In the late 1990s, the Growth and Achievement Program (GAP)[14], implemented a case management, counseling[15], life skills[16] and skills training[17] module in a Minneapolis SRO (Shepard 1997). The program's objective was to 'reduce…becoming homeless by strengthening…self-determination [to] help [residents]…progress to…self-sufficient lifestyles' (ibid: 586). Program managers focused on establishing trust with clients 'through…discussion and social activities' to boost confidence 'to develop and act upon life goals (ibid:587). GAP clients did achieve measurable success through this approach. The increase in their monthly income ($94) was considerably higher than unenrolled SRO clients (who experienced a 3%7 drop)[18]. The percentage of GAP clients reliant on public assistance dropped by 20%, compared to 7% for the comparison group. These clients also had greater success on developing and implementing career plans and scored higher on job preparedness & job retention indicators. Shepard concluded that GAP 'demonstrate[d] that services to SRO residents [who are] often one step…from homelessness can be successful' and recommended small-scale versions of this model to enable social workers to engage closely with clients in an environment 'less constrained by regulations that restrict them in other settings' (Shepard 2017:591)

A set of studies on Pittsburgh SRO Wood Street Commons tracked impacts of the organization's evolving social service approach on tenant retention and well-being from the 1980s to 2000s (Arrigo 1994; Arrigo & Takashi 2006). Wood Street Commons initially relied on a 'needs-based' model. Deemed 'less participatory and more' hierarchical, clients were 'deferential to the social worker' because program managers believed 'that residents…required intensive…confrontative approach'. When this model failed to resolve retention problems the organization instituted a 'strength-focused strategy', which 'emphasized active resident participation and advocacy' through regular 'small group meetings…to discuss problems' (Arrigo 1994:99).

This community-based approach led to tenant retention, participation, and social activity engagement. For example, the decision to redesign the building into 'various floors [modeled after] city blocks that constituted a neighborhood' (Arrigo 1995:106) promoted 'community spirit' and continued engagement, among residents and between staff and residents. This led to the creation of new programs such as a Citywide Homeless Sports League, Performance Arts Collective, and cottage industries, which also trained and employed residents. Such activities were adopted by other low-income housing projects across Pittsburgh.

Follow up research in the mid 2000s (Arrigo and Takahashi 2006) found that this service philosophy enabled long-term positive transformations in the lives of tenants and in program activities that the authors characterized as identity formation (tenants), collective empowerment (among tenants and social workers) and structural reform (a progressive and evolving organizational culture). This process of forging identity was often led by 'reformed' tenants who sought to empower new residents through emphases on (i) mutual trust and social accord ('peacemaking', Fuller 1997) (ii) abandoning authoritarian structures for self-governance ('positive anarchism', Williams and Arrigo 2001) and (iii) storytelling and fluid realities (Ferrell

[14] Funded by the U.S. Department of Health and Human Services (Shepard 1997)
[15] Employment and individual counseling services (ibid)
[16] Nutrition and healthcare life skills modules (ibid)
[17] Financial aid and transportation (ibid)
[18] However, monthly income levels for both groups were low – i.e., $399 for GAP clients; $378 for the comparison group

and Sanders 1995; Ferrell 2001). This three-part approach led to a systematic, successful reintegration of formerly homeless SRO residents (Arrigo & Takahashi 2006).

Policy/supply-side practices to address housing affordability crisis

Chicago's Organization of the North East (ONE) – a consortium of 78 members from three neighborhoods - has lobbied the city to increase the number of SROs since the 1980s. SRO advocacy is one component of a larger campaign to increase affordable housing options amid the decline in housing stocks in areas affected by disinvestment (Levy, Comey & Padilla 2006; Enterprise & Landone Bone Baker Architects 2018). ONE facilitates transfers of SROs from the private to NGO sector. In partnership with other coalitions, the local government also passed legislation[19] that promised to preserve 700 SRO buildings (Enterprise & Landone 2018). These efforts have heightened local awareness of SROs as a potential solution to the housing affordability crisis. Enterprise & Landone Bone Baker Architects reviewed the supply-side best practices by Chicago's successful SROs. They found that such managing organizations (i) engage multiple stakeholders, including government, civil society and private sector actors 'early in the [project] timeline' and throughout ' intermediate milestone[s]' until completion; (ii) accurately identify and conduct rehabilitation efforts, from light modifications (i.e. upgrading safety and sanitation standards) to 'major restructuring [that] result[s] in a decreased number of rooms in interests of better quality standards'; (iii) fit rooms to client needs while meeting difficult zoning standards; (iv) avail government SRO tax credits and (v) conduct energy modeling and construct mechanical systems & required building insulation (Enterprise & Landone 2018).

In Vancouver, Canada, SROs were, historically, owned by the private sector. They are increasingly being managed by non-profit or government organizations. This shift has increased tenure security and affordability and has led to better resident living conditions and support structures (City of Vancouver 2017). These outcomes have been attributed to a multi-stakeholder SRO system of management, in which local and provincial governments align with civil society organizations to share responsibilities to address the city's housing affordability problem. The city government protected the existing housing stock while they increased new social housing models, including SROs, in partnership with other government agencies. The Vancouver government also passed legislation in 2003 that regulates the conversion and demolition of SROs, which protected SROs in areas that later became prime real estate targets. The provincial government purchased 24 private SRO buildings – about 1,500 rooms – and implemented a $143.3 million renovation program that ensured safety upgrades and new electrical and mechanical systems. In their role as SRO managers, non-profits have been credited for ensuring and protecting tenant housing security while advocacy groups have mobilized tenants in poorly managed private SROs to lobby for better living conditions (City of Vancouver 2017).

In San Francisco, SROs have historically been used to house the homeless, particularly after the city failed to invest in public housing after mental health facilities were 'de-institutionalized' in the 1970s and 1980s (Lamb 1984). The co-occurrence of mental illness and drug use among San Francisco's homeless population is, in part, a legacy of this policy history: 93% and 80% of supportive housing residents, respectively, have mental illness and substance abuse problems (Knight et al 2014). In this context, the San Francisco Department of Public Health created the

[19] Single Room Occupancy and Residential Hotel Preservation Ordinance (2014) (Enterprise & Landone 2018)

Housing and Urban Health (HUH) department, the first in the country to integrate housing and public health needs. HUH built new, government funded SROs. The objective was to create a positive built environment that could assuage traumas that afflict most tenants. Knight et al (2014) revealed that the rate of housing retention in old buildings – comprised of 'small, dirty' rooms with 'shared bathrooms' – was 30%, compared to a 70% retention rate among of residents in new HUH funded buildings (Knight et al 2014:3). The same case management team provided services to both building types. The study also reported that 'physical and social organization of specific SRO housing environments' impacted women's choices on either living in these housing options or the street (Knight et al 2014:4)

Neighborhood effects and risks: public health hazards, crime, and potentials for SRO resident integration into neighborhoods

The previous section established the positive impact of on-site services and building quality on community engagement and mental health outcomes. We now further examine local, or neighborhood, effects of SROs in context of varying degrees of private and public ownership and land management.

A study of San Francisco's 581 SROs examined impacts of zoning and building code violations[20] on public health hazards [21] in relevant neighborhoods[22] (SFDPH 2016). Two locations – Tenderloin and Nob Hill – recorded higher proportions of SROs with 20 or more violations in comparison to non-SRO neighborhoods. Neighborhood hospital and emergency admission rates for treatment of major burdens and diseases[23] associated with poor building construction were two and three times higher in these SRO neighborhoods than non-SRO neighborhoods. The concentration of SROs in neighborhoods and proximity of residence to SROs were factors in health outcomes. While 30% of public land and 50% of city residents live within one-quarter mile from an SRO, the density of neighborhood risks in SRO neighborhoods - i.e., health burdens, proportion of liquor stores, and insufficient access to quality and affordable food – is disproportionately higher compared to the city overall (SFDPH 2016: 30-32). The authors noted that several 'off-sale alcohol outlets….' in San Francisco 'are within ¼ mile of an SRO, with an alcohol outlet density twice that of the city as a whole [while] 69% of all [vehicular] injuries happen within ¼ mile of an SRO and the density per square mile is more than twice as high as the city average' (SFDPH 2016: 30).

In St. Petersburg, FL, a higher proportion of the city's SROs are built on commercial land and SRO neighborhoods also tend to be adjacent to neighborhoods with more commercial land use and SRO buildings (Krupe et al 2019). In this context, one study found that the presence of an SRO in a particular neighborhood ('the focal neighborhood') or in a nearby neighborhood ('the adjacent neighborhood) increases crime in 'the focal neighborhood' (Krupe et al 2019). Rates of physical assault in SRO neighborhoods were 1.48 times greater than in non-SRO neighborhoods (i.e., 48%

[20] Poor sanitation, mold, and faulty structural conditions (SFDPH 2016)

[21] The report discloses that 'specific health outcomes of SRO residents cannot be measured directly' (SFDPH 2016:30). We should therefore understand the report's analysis of neighborhood hospital and ER admission rates as indicators for *general* SRO residential and *specific* neighborhood-wide health status.

[22] Nearly 88% of San Francisco's SROs are concentrated in six zip codes (SFDPH 2016)

[23] Asthma and chronic obstructive pulmonary disease (COPD) (SFDPH. 2016)

higher; n=17). An average of 8 more prostitution incidents occurred in SRO neighborhoods than in non-SRO neighborhoods. Additionally focal neighborhoods next to SRO neighborhoods recorded higher rates of increase in theft (24%), drug crimes (25%) and prostitution (350%). The concentration of SROs and proximity to commercial land use were positively correlated with assault, theft, and drug-related crime. SROs may facilitate crime due to three factors. *Flexible eligibility criteria*, in which background checks are not required, may provide criminals easier access to housing, networks and havens for illicit activities. As former hotels or motels, the *physical structures* of these SROs 'facilitate…inconspicuousness through direct access to rooms and absentee management' (Krupe et al 2019: 18). Lastly, the *private ownership model* of the city's SROs marketizes incentives. The quality of SRO infrastructure and services is thus undermined by owners who are 'motivated by financial gain' instead of 'safe[ty] and secur[ity]'. Owners 'may…look the other way when the building is in disrepair or when guests act…criminally' (Krupe 2019:18).

A study on SRO residence (n=1813) and health status explored residents' connectivity to public institutions (hospitals for emergency department use), local black-market operations (illicit drug use) and criminal activities (physical assaults) (Shannon et al 2005). The authors found that SRO housing was positively correlated with HIV infection, HCV infection, and experiences of having been assaulted – findings that were confirmed by earlier SRO studies on drug use (Patrick et al 1997; Strathdee, Patrick Archibald et al 1997) and risk behaviors practiced in absence of social support structures (Coumans & Spreen 2003; Galea et al 2003; Wechsberg et al 2003). Risk behaviors among SRO residents in absence of social support also increased risks of the transmission of infectious disease in the surrounding area 'through …unsanitary cleaning of drug use paraphernalia and localized syringe sharing '(Shannon et al 2005:111). Additionally, 'squalid' and 'unhygienic living conditions' of SROs '…pushe[d] many residents to the streets to sustain even the most basic of daily needs,' which 'directly contribut[ed] to …open drug use…and public injecting'(ibid). In this context, public health linkages to SROs are required to mitigate disease transmission and ensure the well-being of their residents and neighborhoods at large.

Bowen & Mitchell (2016) examined how the ability to afford to live in an SRO[24] – measured by degrees of rent-burden[25] - impacted 'high risk-behaviors' of illicit drug use (other than marijuana)[26], problem drinking, multiple sexual partners, and sexual activity without a condom in Chicago (Bowen & Mitchell 2016: 3). The authors found that (i) rent burden was associated with all identified risk behaviors except problem drinking, (ii) there was 'no relationship between higher rent burden' and risk behavior', and (iii) non-burdened SRO residents 'varied significantly' from both groups. The authors identified three possibilities for these findings. First, income levels may have been so low that 'even a "moderate" rent burden beneath the 50% cut-off placed considerable strain on participants' resources" (Bowen & Mitchell: 2016: 8). Second, low-income non-rent burdened residents may have engaged in risk behaviors to 'cover non-housing expenses' - i.e., men and women seeking or feeling compelled to secure material support from sexual partners, as found

[24] The study included 162 SRO residents (Bowen & Mitchell 2016)

[25] Moderate-rent burden = spending more than 30% of one's income on SRO rent; severe-rent burden = spending more than 50% on SRO rent. According to the authors, The U.S. Department of Housing and Urban Development (HUD) guidelines list the maximum fair market rent for SROs at $545 (at 2014 prices and equivalent to 75% of studio apartment fair market prices) (Bowen & Mitchell 2016: 2)

[26] In acknowledgement of Shannon et al (2005) and Knight et al (2014)'s finding that SRO residency was correlated with HIV and other infectious disease risk

in Davey-Rothwell, Latimore, Hulbert, & Latkin, 2011. Third, living independently with no to limited income may itself have contributed to risk behaviors, such as drug use, or may have led to arrangements in which some participants 'informally rent[ed]…out their living spaces as drug-using zones' (Bowen et al 2016:8; Dickson-Gomez et al 2009).

In Ottawa, one study examined perceptions of younger and elderly SRO residents of their experiences and levels of integration into their neighborhoods. Residents reported above-range levels of psychological integration one year and two years after having moved into an SRO, respectively (designated FU1 and FU2) (Ecker and Aubry 2016). 60.6% (FU1) and 66% (FU2) deemed their neighborhoods safe, 42.7% (FU1) and 43.6% (FU2) perceived themselves to be like their non-SRO neighbors, 62.2% (FU1) and 63.5% (FU2) were confident they could depend on help from neighbors in an emergency, 40.1% (FU1) and 49.0%felt their neighbors cared about them and 36.1% (FU1) and 34.9% (FU2) disagreed that people in their neighborhood were not friendly. The authors found that housing quality and age was the most significant predicator of neighborhood integration. Respondents who reported their SROs to be high quality - particularly among the elderly -- had higher levels of psychological integration, a finding that is also confirmed by the broader literature. The elderly more commonly bond with neighbors through meal programs, drop-in centers and other activities organized around social support (Brodsky et al 1999; Prince & Prince 2002; Thompson, Pollio, Eyrich, Bradbury & North 2004; Kreindler & Coodin 2010; Townley & Kloos 2011; Ecker & Aubry 2016).

Conclusion

The loss of SRO units throughout the 20th century directly correlated to the increase of homelessness among single adults, primarily men. In response, recent programs in existing SROs like case management, skills training and community engagement activities have increased housing stability and job retention among homeless people. However, when chronically homeless people comprise a large proportion the tenants in a non-supportive SRO, serious challenges can occur. In recognition of the need for more SROs, innovative partnerships between government and non-governmental organizations have led to coordinated efforts in identifying sites to build new SROs in adequate numbers and to suitable living standards. Indeed, clean, and lively building environments have a positive impact on residents who suffer poor mental health and trauma. Concentrations of SROs in commercial areas - and/or in residential neighborhood – are associated with increased prostitution, drug use and theft. However, these negative effects are more powerful when SRO's lack on-site social services and suffer from poor management.

In conclusion, New York City policymakers should consider SROs as a housing model for the vulnerably housed and homeless under specific conditions. First, SROs should be considered in non-commercial districts, or in neighborhoods with relatively few SRO's. Secondly, ownership models should be multi-stakeholder arrangements, in which non-governmental organizations work with government partners to ensure the appropriate balance of management duties of buildings, social services and employment and recreational programs. Thirdly, SROs should ensure a balanced population, in which most tenants are not chronically homeless unless funding permits clinical services that meet supportive housing standards for this group. Lastly, background checks should be conducted for all prospective residents to screen applicants with felony convictions.

References

Arrigo, B. (1994). Rooms for the Misbegotten: Social Design and Social Deviance. *The Journal of Sociology & Social Welfare*. Vol 21 Iss 4: 85-113

Arrigo, B. & Takashi, Y. (2006). Recommunalization of the disenfranchised: A theoretical and critical criminological inquiry. *Theoretical Criminology*. Vol. 10(3): 307-336

Bahr, H. M. (1973). *Skid Row: An introduction to disaffiliation.* New York, NY: Oxford University Press.

Bahr. H. M. (1967). The gradual disappearance of skid row. *Social Problems. 15.* 41-45.

Bevil, A. (2009). *Preserving Single-Room Occupancy Hotels.* [Master's thesis, University of Georgia]

Bowen, E. & Mitchell, C.G. (2016). Housing as a Social Determinant of Health: Exploring the Relationships between Rent Burden and Risk Behaviors for Single Room Occupancy. *Social Work in Public Health*, 1-9

Brodsky, A.E. (1996). Resilient single mothers in risky neighborhoods: Negative psychological sense of community. Journal of Community Psychology, 24, 347–363.

Burt, M. (2007). The Skid Row Collaborative – 2003 – 2007, Urban Institute, p.1-25

Coalition for the Homeless, Homelessness Charts <https://www.coalitionforthehomeless.org/facts-about-homelessness/>

Citizens Budget Commission. (2018). Think Your Rent Is High? < https://cbcny.org/research/think-your-rent-high>

Cohen, C.I. & Sokolovsky, J., 1983. "Toward a concept of homelessness in aged men." Journal of Gerontology, 38(1), 8

Coumans, M., & Spreen, M. (2003). Drug use and the role of homeless- ness in the process of marginalization. *Substance Use and Misuse*, *38*(3–6), 311–338.

City of Vancouver. (2017). Single Room Occupancy (SRO) Revitalization Plan.
Ecker, J & Aubry, T. (2016). Individual, Housing and Neighborhood Predictors of Psychological Integration Among Vulnerably Housed and Homeless Individuals. *Am J Community Psychol* 58:111-122

Davey-Rothwell, M. A., Latimore, A., Hulbert, A., & Latkin, C. (2011). Sexual networks and housing stability. Journal of Urban Health, 88(4), 759–766

Dickson-Gomez, J., Hilario, H., Convey, M., Corbett, A. M., Weeks, M., & Martinez, M. (2009). The relationship between housing status and HIV risk among active drug users: A qualitative analysis. Substance Use & Misuse, 44(2), 139 – 162

Enterprise & Landone Bone Baker Architects. (2018). Next Generation SRO Housing in Chicago: Securing the future success and long-term stability of an endangered housing type, Enterprise Community Partners, pp 1-16

Ferrell, J. (2001) *Tearing Down the Streets: Adventures in Urban Anarchy*. New York: Palgrave Macmillan.

Ferrell, J. and C.R. Sanders (eds). (1995). *Cultural Criminology*. Boston, MA: Northeastern University Press.

Fuller, J.R. (1997). *Criminal Justice: A Peacemaking Perspective*. Boston, MA: Allyn & Bacon.

Galea, S., & Vlahov, D. (2002). Social determinants and the health of drug users: socioeconomic status, homelessness, and incarceration. *Public Health Report (Suppl.)*, *117*, 135–145.

Green. C. B. (1982). *Housing Single, Low-Income Individuals.* New York City: Columbia University Conservation of Human Resources and New York University Graduate School of Public Administration.

Groth, P. (1994). Living Downtown. Berkeley, CA: University of California Press

Haley, B.A. (1989). The Loss of Single Room Occupancy Housing in Metropolitan Areas. *Housing and Society*, 16:1, 5-15

Hopper, K. and Hamberg, J. (1986). The making of America's homeless: From skid row to new poor, 1945-1984. In R. G. Bratt, C. Hartman and A. Meyerson (Eds.l, *Critical Perspectives on Housing.* Philadelphia, PA: Temple University Press.

Hull, D.A., Haley, B.S. & Rothman, A.J. (1980). Single room occupancy research study: State of the art report. Volume 1. Washington, DC: US Department of Housing and Urban Development, Office of Policy and Development and Research, Division of Housing Management and Special Users

Garcia, I. & Kim, K. (2019). Homeless Again: Why Households Return to the Shelter? Quantitative Research, Metropolitan Research Center, University of Utah, p 1-53

Kasinitz. P. (1984). Gentrification and homelessness: The single room occupant and the inner-city revival. *Urban and Social Change Review,* 17 (I), 9-14.

Knight et al. (2014). Single room occupancy (SRO) hotels as mental health risk environments among impoverished women: The intersection of policy, drug use, trauma and urban space *International Journal of Drug Policy*, 1-6

Kreindler, S.A., & Coodin, S. (2010). Housing histories of Assertive Community Treatment clients: Program impacts, and factors associated with housing stability. *Canadian Journal of Psychiatry,* 55, 150–156.

Krupe et al. (2019). Noxious Housing: The Influence of Single Room Occupancy (SRO) Facilities in Neighborhood Crime. *Crime & Delinquency*, 00(0): 1-25

Kuhlman, T. L. (1994). Psychology on the streets. Mental health practice with homeless persons. New York, NY: John Wiley & Sons, Inc.

Kusmer, K. L. (2002). *Down and out, on the road. The homeless in American history.* New York, NY: Oxford University Press.

Lamb, R. (1984). Deinstitutionalization and the homeless, mentally ill. *Hospital and Community Psychiatry,* 35(9), 899-107

Lee, B. (1968). The disappearance of skid row: Some ecological evidence. *Journal of Housing,* 25 II}, 572-580.

Levy, Comey & Padilla. (2006). In the Fact of Gentrification: Case Studies of Local Efforts to Mitigate Displacement, Urban Institute, p. 1-86

Main, T.J. (2017) *Homelessness in New York City: Policymaking from Koch to de Blasio*. New York, NY: New York University Press

Minkler, M. & Ovrebo, B. (1985). The Vanishing Hotels for Low-Income Elders. *American Society of Aging,* Vol.9, No.3, pp.40-42

Mitchell, D. (1997). The Annihilation of Space by Law: The Roots and Implications of Anti-Homeless Laws in the United States. *Antipode*, 29:3, 303-335

Mitchell, D. (2020). *Mean Streets: Homelessness, Public Space and the Limits of Capital*. Athens, GA: University of Georgia Press

New York Housing Conference (2021). United for Housing – From the Ground Up: Affordable housing recommendations for New York City's next Mayor

Padgett, D.K., Hawkins, R.L., Abrams, C., Davis, A. (2006). In their own words: Trauma and substance abuse in the lives of formerly homeless women with serious mental illness. *American Journal of Orthopsychiatry*, 76, 461-467

Padgett, D.K., Smith, B.K., Henwood, B.F., Tiderington, E. (2012). Life Course Adversity in the Lives of Formerly Homeless Persons With Serious Mental Illness: Context and Meaning. *American Journal of Orthopsychiatry,* 82, 421-430

Patrick, D. M., Strathdee, S. A., Archibald, C. P., Ofner, M., Craib, K. J., Cornelisse, P. G., et al. (1997). Determinants of HIV seroconversion in injection drug users during a period of rising prevalence in Vancouver. *International Journal of STD & AIDS*, *8*(7), 437–445.

Prince, P.N., & Prince, C.R. (2002). Perceived stigma and community integration among clients of assertive community treatment. Psychiatric Rehabilitation Journal, 25, 323–331.

Reynolds, M T. (1969). *The Housing of the Poor in American Cities.* College Park, MD: McGroth Publishing.

Routhier, G. (2020). State of the Homeless 2020: Governor and Mayor to Blame as New York Enters Fifth Decade of Homelessness Crisis. Coalition for the Homeless, 2-59

Rudel, T. K. and Neaigus, A. (1984, May). Inflation, new homeowners and downgrading in the 1970s. *Urban Studies (Glasgow),* 21 (2), 129-138.

San Francisco Department of Public Health (SFDPH). (2016). Single Room Occupancy Hotels in San Francisco: A Health Impact Assessment, SFPDH, p 1-85

Shannon et al. (2005). The impact of unregulated single room occupancy hotels on the health status of illicit drug users in Vancouver. International Journal of Drug Policy, 17, 107-114

Shapiro, J. (1971). *Communities of the Alone.* New York City: Association Press.

Shepard, M. (1997). Site-based Services for Residents of Single-Room Occupancy Hotels. Social Work, Vol. 42, No.6, 585-591

Stern, E. & Yager, J. (2018a). 21st Century SROs: Can Small Housing Units Help Meet the Need for Affordable Housing in New York City, NYU Furman Center, p1-39

Stern, E. & Yager, J. (2018b). 21st Century SROs: Can Small Housing Units Help Meet the Need for Affordable Housing in New York City (POLICY BRIEF), NYU Furman Center, p1-11

Strathdee, S. A., Patrick, D. M., Archibald, C. P., Ofner, M., Cornelisse, P. G., Rekart, M., et al. (1997). Social determinants predict needle- sharing behaviour among injection drug users in Vancouver, Canada. *Addiction*, *92*(10), 1339–1347.

Sullivan, B.J. & Burke, J. (2013). Single-Room Occupancy Housing in New York City: The Origins and Dimensions of a Crisis, 17 CUNY L. Rev. 113-143

Thompson, S.J., Pollio, D.E., Eyrich, K., Bradbury, E., & North, C.S. (2004). Successfully exiting homelessness: Experiences of formerly homeless mentally ill individuals. Evaluation and Program Planning, 27, 423–431.

Torrey, E. F. (1988). *Nowhere to go: The tragic odyssey of the homeless mentally ill.* New York: Harper & Row.

Townley, G., & Kloos, B. (2011). Examining the psychological sense of community for individuals with serious mental illness residing in supported housing environments. *Community Mental Health Journal,* 47, 436–446.

United States Interagency Council on Homelessness. (2021). 10 Strategies to Reduce Homelessness With the American Rescue Plan

Varcarolis, B. (1990). *Psychiatric Mental Health Nursing.* Philadelphia, PA: W. B. Saunders Company.

Wallace. S. (1965). *Skid Row as a Way of Life.* Totowa. NJ: Bedminster Press.

Wechsberg, W. M., Lam, W. K., Zule, W., Hall, G., Middlesteadt, R., & Edwards, J. (2003). Violence, homelessness, and HIV risk among crack-using African American women. *Substance Use and Misuse*, *38*(3–6), 669–700.

Werner, F.E. & Bryson, D.B. (1982). A guide to the preservation and maintenance of single room (SRO) housing. Parts I-V. Clearninghouse Review: National Clearinghouse of Legal Services, 15(12), 999-1009 and 16(1), 1-25

Williams, C.R. and B.A. Arrigo (2001) Anarchaos and Order: On the Emergence of Social Justice', *Theoretical Criminology* 5(2): 223–52.