

# Eviction and Household Health and Hardships in Families With Very Young Children

Diana B. Cutts, MD,<sup>a</sup> Stephanie Ettinger de Cuba, PhD, MPH,<sup>b</sup> Allison Bovell-Ammon, MDiv,<sup>c</sup> Chevaughn Wellington, MD, MS,<sup>c,d</sup> Sharon M. Coleman, MS, MPH,<sup>e</sup> Deborah A. Frank, MD,<sup>d</sup> Maureen M. Black, PhD,<sup>f,g</sup> Eduardo Ochoa, Jr., MD,<sup>h</sup> Mariana Chilton, PhD, MPH,<sup>i</sup> Félíce Lê-Scherban, PhD, MPH,<sup>j,k</sup> Timothy Heeren, PhD,<sup>e</sup> Lindsey J. Rateau, MPH,<sup>e</sup> Megan Sandel, MD, MPH<sup>d</sup>

abstract

**BACKGROUND:** Families with versus without children are at greater eviction risk. Eviction is a perinatal, pediatric, and adult health concern. Most studies evaluate only formal evictions.

**METHODS:** Using cross-sectional surveys of 26 441 caregiver or young child (<48 months) dyads from 2011 to 2019 in emergency departments (EDs) and primary care clinics, we investigated relationships of 5 year history of formal (court-involved) and informal (not court-involved) evictions with caregiver and child health, history of hospitalizations, hospital admission from the ED on the day of the interview, and housing-related and other material hardships.

**RESULTS:** 3.9% of 26 441 caregivers reported 5 year eviction history (eviction), of which 57.0% were formal evictions. After controlling for covariates, we found associations were minimally different between formal versus informal evictions and were, therefore, combined. Compared to no evictions, evictions were associated with 1.43 (95% CI: 1.17–1.73), 1.55 (95% confidence interval [CI]: 1.32–1.82), and 1.24 (95% CI: 1.01–1.53) times greater odds of child fair or poor health, developmental risk, and hospital admission from the ED, respectively, as well as adverse caregiver and hardship outcomes. Adjusting separately for household income and for housing-related hardships in sensitivity analyses did not significantly alter results, although odds ratios were attenuated. Hospital admission from the ED was no longer significant.

**CONCLUSIONS:** Demonstrated associations between eviction and health and hardships support broad initiatives, such as housing-specific policies, income-focused benefits, and social determinants of health screening and community connections in health care settings. Such multifaceted efforts may decrease formal and informal eviction incidence and mitigate potential harmful associations for very young children and their families.

Full article can be found online at [www.pediatrics.org/cgi/doi/10.1542/peds.2022-056692](http://www.pediatrics.org/cgi/doi/10.1542/peds.2022-056692)

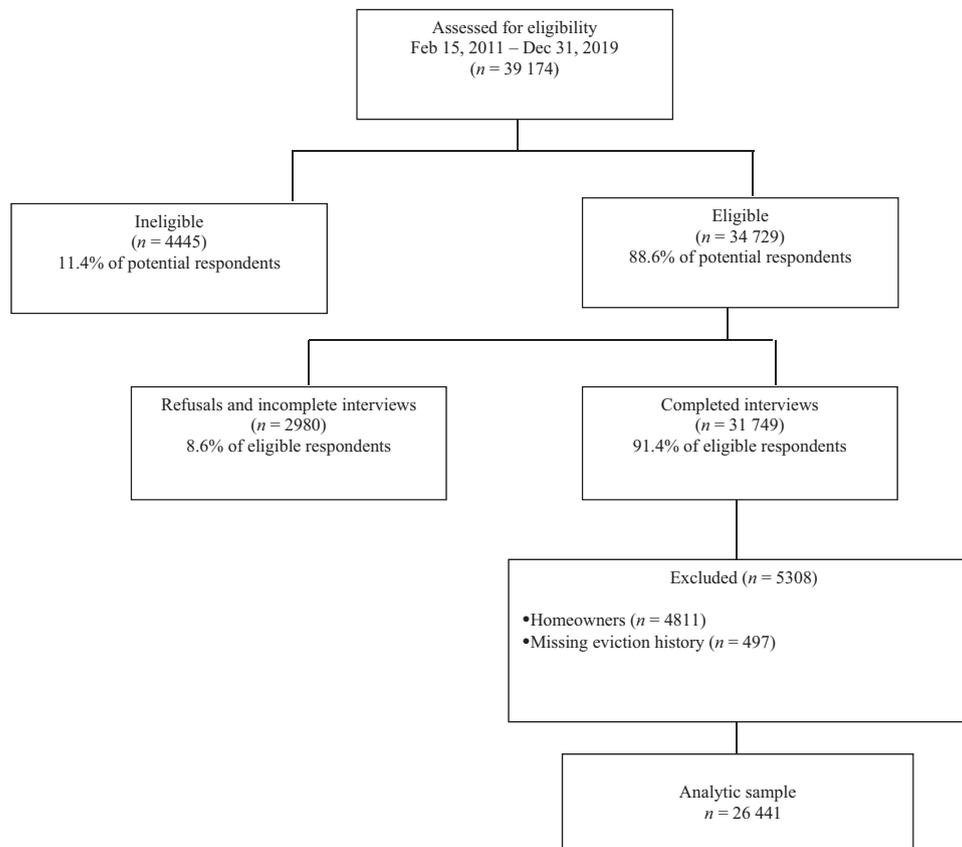
<sup>a</sup>Department of Pediatrics, Hennepin County Medical Center, Minneapolis, Minnesota; <sup>b</sup>Department of Pediatrics, Boston University School of Medicine, Boston, Massachusetts; <sup>c</sup>Children's HealthWatch, Boston Medical Center, Boston, Massachusetts; <sup>d</sup>Frank H. Netter M.D. School of Medicine, Quinnipiac University, North Haven, Connecticut; <sup>e</sup>Biostatistics and Epidemiology Data Analytics Center, Boston University School of Public Health, Boston, Massachusetts; <sup>f</sup>Department of Pediatrics, Growth and Nutrition Division, University of Maryland School of Medicine, Baltimore, Maryland; <sup>g</sup>RTI International, Research Triangle Park, North Carolina; <sup>h</sup>Department of Pediatrics, University of Arkansas for Medical Sciences, Little Rock, Arkansas; and <sup>i</sup>Departments of Health Management and Policy and <sup>j</sup>Epidemiology and Biostatistics, and <sup>k</sup>Urban Health Collaborative, Dornsife School of Public Health, Drexel University, Philadelphia, Pennsylvania

Drs Cutts and Ettinger de Cuba supervised data collection, conceptualized and designed the study, interpreted the data, and reviewed and revised the manuscript; Ms Bovell-Ammon supervised data collection, conceptualized and designed the study, interpreted the data, assisted in drafting the initial manuscript, and reviewed and revised the manuscript; Dr Wellington interpreted the data, assisted in drafting the initial manuscript, and reviewed and revised the manuscript; Drs Sandel, Frank, Black, Ochoa, Chilton, and Lê-Scherban supervised

**WHAT'S KNOWN ON THIS SUBJECT:** Eviction is a perinatal, childhood, and adult public health and health care concern. Most studies evaluate formal, court-involved evictions. Eviction's relationship to health appears bidirectional; poor child health may precipitate eviction, and eviction may shape poor childhood health.

**WHAT THIS STUDY ADDS:** Evaluation of formal and informal evictions among families with very young children revealed informal evictions were common. Risk of adverse child and caregiver health, child developmental delay, and previously underrecognized hardships were associated with both eviction types.

**To cite:** Cutts DB, Ettinger de Cuba S, Bovell-Ammon A, et al. Eviction and Household Health and Hardships in Families With Very Young Children. *Pediatrics*. 2022;150(4):e2022056692



**FIGURE 1**

Analytic sample selection diagram for analysis of associations of eviction history with child and adult health and family material hardships, February 2011 to December 2019.

Nearly 2 million United States households are evicted or involuntarily displaced annually.<sup>1</sup> Families with children are at elevated eviction risk, increasing with each additional child.<sup>2</sup> Multiple factors contribute to evictions, including lack of affordable housing, gentrification, and racial and ethnic discrimination.<sup>3</sup> Eviction is a pediatric and adult health concern.<sup>4,5</sup> Previous research demonstrates evictions among families are associated with poor child and adult physical health, maternal depression, and increased material hardships,<sup>6,7</sup> but little is known about the health-related consequences of eviction among infants and toddlers, a critical window of development.

After eviction, families may move frequently, live in poor-quality and/

or overcrowded housing, become homeless, lose social support, live in neighborhoods with few health care facilities, and experience hazardous environmental exposures, conditions associated with negative health outcomes.<sup>2,7-9</sup> Frequent and involuntary residential mobility is significantly associated with children's behavioral and emotional problems, adolescent depression, earlier illicit drug use, and teenage pregnancy.<sup>10</sup> Relationships between eviction and birth outcomes appear bidirectional; a prenatal threatened or actual eviction is linked to poor birth outcomes, and families with infants born preterm may have significant financial burden that precipitates eviction.<sup>11-15</sup>

Material hardships and adverse mental and physical health effects associated with eviction among

older children and parents are persistent evident 2 years posteviction.<sup>2</sup> Existing studies assess associations of eviction with a single or combined measure of economic hardship, without discernment of the multiple pathways by which eviction is associated with health.

Most studies on eviction and family health have focused on formal evictions: legal action to remove a tenant resulting in a 5 year court record.<sup>16</sup> Many families, however, experience informal evictions: landlord actions to force families to move without legal involvement.<sup>1</sup>

This study's primary research question is: How are formal and informal evictions related to caregiver or child health, pediatric health care utilization, and material well-being among families with

infants and toddlers? Although 3 studies have examined eviction's relationship to material hardship and neonatal, child, and caregiver health among families of children under age 5, none have assessed specific dimensions of multiple material hardships.<sup>6,7,11</sup> This study fills several gaps: (a) using data from an understudied population of families with infants and toddlers, (b) including 5 year formal and informal eviction history, (c) examining novel outcomes, including child health and health care utilization, caregiver physical and mental health, housing-related hardships, and other material hardships: food, energy, health care, and child care.

## METHODS

### Participants

Researchers conducted household-level surveys with caregivers and audited medical records from February 2011 through December 2019 in pediatric emergency departments (ED) (Baltimore, MD; Boston, MA; Little Rock, AR; and Philadelphia, PA) and primary care clinics (Minneapolis, MN and Baltimore, MD). Institutional review board approval was obtained for all sites and renewed annually. Study eligibility criteria included caregiver: consent, lived in the child's household, residency in the study site's state, and ability to speak English, Spanish, or Somali (in Minneapolis only), and the child's age <48 months. Of those screened, 34 729 caregivers (88.6%) were eligible, and 31 749 completed the interview. The sample was restricted to unique renter households (homeowners excluded  $n = 4811$ ) and nonmissing eviction history data (missing  $n = 497$ ) with a final sample of 26 441.

### Demographics

The survey included questions about the caregivers' race and ethnicity,

country of birth, marital status, highest level of education, age, and employment status; number of children in household; and children's insurance type, breastfeeding history, and birth weight. Self-reported household income data were collected starting in 2013 with a question about monthly income from all sources, excluding noncash benefits, in categorical ranges of \$1000. The birth mothers' race, a social construct, and ethnicity were self-identified using questions from the US Census and combined into the following categories: Hispanic, all races; Black non-Hispanic; White non-Hispanic; other or multiple races non-Hispanic (composed of caregivers identifying multiple races or groups too small in this sample to analyze independently including Asian, Native American). Child age, sex, weight, and length and height on the visit date were abstracted from medical records.

### Predictor

Eviction history is based on a validated measure (Milwaukee Area Renters Study) defined by answers to the following question: "An eviction is when your landlord or a government or bank official forces you to move when you don't want to. In the past 5 years, have you ever been evicted?"<sup>1</sup> The question identifies any eviction experience (any versus none). If eviction was affirmed, caregivers were asked about an eviction order in court and a ruling in the landlord's favor to determine a formal eviction. Caregivers were divided into 3 groups based on their 5-year history: no eviction, eviction history-formal, eviction history-informal.

### Measures

#### Health outcomes

Child and caregiver health: Caregivers evaluated their own and

their child's health on the basis of the validated question from the third National Health and Nutrition Examination Survey. Responses were dichotomized into fair or poor versus good or excellent.

Child hospitalizations: The child's lifetime history of hospitalizations excluding birth reported by the caregiver (any versus none).<sup>17</sup>

Developmental Risk: Children's developmental risk was defined by 1 or more concerns on the parent's evaluation of developmental status, approved by the American Academy of Pediatrics for child developmental screening tools for this age group.<sup>18</sup> Only children  $\geq 4$  months were included in developmental risk analysis because of improved parent's evaluation of developmental status specificity and sensitivity for those ages.<sup>18</sup>

Hospital admission from the ED: For ED sites only, admission to inpatient care on the visit date was abstracted from the medical record.

Child anthropometrics: The child's length and height and weight on the visit date were used to calculate weight-for-age and weight-for-length or height percentiles on the basis of World Health Organization or Centers for Disease Control and Prevention standards. Risk of underweight was defined as weight-for-age <5<sup>th</sup> percentile or weight-for-length or height <10<sup>th</sup> percentile.<sup>19</sup> Obesity risk was defined as weight-for-age  $\geq 90^{\text{th}}$  percentile.<sup>20</sup>

Maternal depressive symptoms: Endorsement of 2 of 3 questions on a validated maternal depression screener<sup>21</sup> was used to determine evidence of depressive symptoms.

### Housing-Related Hardships

Four measures of housing-related hardship were evaluated: behind on

rent in the previous year, 2 or more moves in the previous year, homelessness in the child's lifetime,<sup>22</sup> and current homelessness defined as living in a shelter, hotel or motel, or having no steady place to sleep.

### Household Hardships

**Food insecurity:** The 18-question US Household Food Security Survey Module asks about the previous 12 months.<sup>23</sup> Household food insecurity was defined as endorsement (sometimes or often true) of 3 or more of 10 household questions and child food insecurity as endorsement of 2 or more of 8 child-specific questions.

**Energy insecurity:** Families were classified as energy insecure if any of 4 validated questions were affirmed<sup>24</sup>: threatened or actual utility shutoff, unheated or uncooled days, or heating with a cooking stove.

**Health care hardship:** Health care hardship was defined by: forgone health care, in which a household member needed care or prescriptions that were not received because of cost and/or health cost sacrifices; or struggling with payment of basic needs including food, housing, or utilities as a consequence of medical expenses.

**Child care constraints:** Child care constraints were defined if caregivers reported challenges obtaining child care made it difficult to work or attend school.

### Statistical Analysis

$\chi^2$  analyses or Student's *t* test were used to describe family characteristics, stratified by 3-category eviction history (no eviction, formal, or informal) and combined eviction history (no eviction versus either formal or informal). An initial set of multivariable logistic regression

analyses examined informal and formal eviction separately and compared associations across eviction type on child, caregiver, and hardship outcomes. If associations of informal and formal eviction were similar using multivariable logistic regression, we planned to rerun the analysis with a combined eviction history variable to increase precision. Adjusted multivariable logistic regression analyses were fit to evaluate the association between eviction history groups and outcomes. Covariates were chosen based on significant association with eviction history or health outcomes or on previous research demonstrating associations, including well-documented findings of racism and racial inequities as a significant contributor to increased risk of eviction and poor health outcomes.<sup>2</sup> Analyses were adjusted for study site, caregiver: age, place of birth (United States-born or foreign-born), race and ethnicity (as a proxy for experienced racism), marital status, employment, education; and child: insurance type, age, breastfeeding history; and number of children in the household. For child health outcomes, low birth weight (LBW) was included as a covariate on the basis of evidence linking LBW with adverse child health outcomes. No history of eviction was the referent group for all analyses. Sensitivity analyses adjusting for (1) household income (2) housing-related hardships and (3) limiting the sample to children with public or no insurance were performed to examine whether these factors were drivers of observed relationships.

For all models, we report adjusted odds ratios (aOR) and corresponding 95% confidence intervals (95% confidence interval [CI]). All analyses were conducted using 2-sided tests and a significance level of 0.05. Statistical

analyses were performed by using SAS software (version 9.4; SAS Institute, NC, USA).

## RESULTS

### Sample Characteristics

Of the 26 441 caregivers, 92.5% (24 457) were birth mothers. 3.9% reported an eviction in the previous 5 years (Table 1). More caregivers reported formal than informal evictions (57.0% vs 43.0%). Compared to the no eviction group, a greater proportion of caregivers in the formal and informal eviction group were Black, non-Hispanic, United States-born, older and had an education beyond high school. Of caregivers with an eviction history, whether informal or formal, the greatest proportion came from Baltimore, Philadelphia, and Boston. Children in the informal and formal eviction versus no eviction group had higher rates of public insurance (93.6%, 95.2% vs 90.8%, respectively) and lower rates of breastfeeding history (63.3%, 59.5% vs 65.9%, respectively). Rates of current housing subsidy receipt (17.3%) were lowest in the formal eviction versus informal and no eviction groups (26.0% and 21.3%, respectively). Notably, a greater proportion of both the informal and formal eviction versus no eviction group reported having subsidized housing rescinded in the past 2 years (5.0%, 5.9% vs 1.0%). Rates of LBW did not differ between groups.

There were higher rates of fair or poor child and caregiver health, child developmental risk, and maternal depressive symptoms in both the informal and formal eviction versus no eviction group and no differences between groups in child weight or health care utilization rates. All household hardships rates were higher in the informal and formal eviction versus no eviction group. (Table 2)

**TABLE 1** Characteristics of Sample by Eviction History, February 2011 to December 2019 Eviction History Groups

Characteristic	Overall Sample, N (%)	No Eviction History, N (%)	Informal Eviction History, N (%)	Formal Eviction History, N (%)	P
	26441	25421 (95.2)	439 (1.7)	581 (2.2)	— c
Site					
Baltimore	5295 (20.0)	4973 (19.6)	147 (33.5)	175 (30.1)	
Boston	5778 (21.9)	5525 (21.7)	119 (27.1)	134 (23.1)	
Little Rock	5351 (20.2)	5209 (20.5)	66 (15.0)	76 (13.1)	
Minneapolis	3569 (13.5)	3481 (13.7)	23 (5.2)	65 (11.2)	
Philadelphia	6448 (24.4)	6233 (24.5)	84 (19.1)	131 (22.5)	
Mother place of birth					c
US-born	19914 (75.6)	19008 (75.0)	378 (86.1)	528 (91.0)	
Foreign-born	6438 (24.4)	6325 (25.0)	61 (13.9)	52 (9.0)	
Maternal race and ethnicity					c
Hispanic	8557 (32.8)	8387 (33.4)	93 (21.2)	77 (13.5)	
Black or Non-Hispanic	13 303 (51.0)	12 649 (50.4)	256 (58.3)	398 (69.6)	
White or Non-Hispanic	3277 (12.6)	3139 (12.5)	63 (14.4)	75 (13.1)	
Other or multiple races	949 (3.6)	900 (3.6)	27 (6.2)	22 (3.8)	
Caregiver age in years, mean (SD)	27.4 (5.9)	27.3 (5.9)	27.5 (5.5)	28.4 (5.4)	c
Married or partnered	7915 (30.0)	7678 (30.3)	120 (27.3)	117 (20.2)	c
Caregiver education attainment					
Less than high school degree	6239 (23.7)	6032 (23.8)	97 (22.2)	110 (18.9)	
High school or GED completion	10 463 (39.7)	10 085 (39.8)	173 (39.6)	205 (35.3)	
Education beyond high school	9674 (36.7)	9241 (36.4)	167 (38.2)	266 (45.8)	
Caregiver employed	12 443 (47.2)	12 009 (47.3)	167 (38.0)	267 (46.0)	b c
Monthly household income					c
>\$1000	7098 (26.8)	6685 (26.3)	179 (40.8)	234 (40.3)	
\$1000–\$1999	5865 (22.2)	5607 (22.1)	102 (23.2)	156 (26.9)	
\$2000–\$2999	2851 (10.8)	2756 (10.8)	42 (9.6)	53 (9.1)	
\$3000–\$3999	1017 (3.8)	978 (3.8)	19 (4.3)	20 (3.4)	
\$4000 or more	1035 (3.9)	1011 (4.0)	6 (1.4)	18 (3.1)	
Child sex: female	12 331 (46.6)	11 860 (46.7)	197 (44.9)	274 (47.2)	
Child age in months, mean (SD)	19.9 (13.9)	19.9 (14.0)	19.1 (12.9)	20.7 (13.8)	
Child breastfed	17 342 (65.8)	16 719 (65.9)	278 (63.3)	345 (59.5)	
Child insurance					c
Public	23 971 (90.9)	23 010 (90.8)	410 (93.6)	551 (95.2)	
No insurance	1049 (4.0)	1015 (4.0)	20 (4.6)	14 (2.4)	
Private	1346 (5.1)	1324 (5.2)	8 (1.8)	14 (2.4)	
Low birth weight	3734 (14.5)	3578 (14.4)	64 (14.8)	92 (16.2)	
Number of children in household, mean (SD)	2.3 (1.3)	2.3 (1.3)	2.5 (1.4)	2.6 (1.5)	c
Current subsidized housing	5350 (21.3)	5159 (21.3)	102 (26.0)	89 (17.3)	a
Subsidized housing loss (2-y)	304 (1.2)	248 (1.0)	22 (5.0)	34 (5.9)	c

<sup>a</sup>  $P < .05$ .

<sup>b</sup>  $P < .001$ .

<sup>c</sup>  $P \leq .0001$ .

### Comparison of Informal and Formal Eviction History

Treating informal and formal eviction as separate exposures showed little difference in the associations of informal and formal eviction compared with no eviction for child health, caregiver health, and hardship outcomes (Table 3). Two outcomes differed by type of eviction. Admission from the ED showed greater odds among the formal compared to informal eviction group. Household food insecurity had greater odds among

the informal compared to the formal eviction group. Informal and formal eviction groups were combined for subsequent analyses.

### Child and Caregiver Health Outcomes

In adjusted analyses (Table 4), compared to the no eviction group, the eviction group children were more likely to be in fair or poor health (aOR: 1.43, [95% CI: 1.17–1.73]), at developmental risk (aOR: 1.55, [95% CI: 1.32–1.82]) and to have been admitted from the

ED (aOR: 1.24 [95% CI: 1.01–1.53]). Groups did not differ in odds of lifetime hospitalizations, risk of underweight, and obesity risk.

Eviction group caregivers were more likely to be in fair or poor health (aOR: 1.96 [95% CI: 1.72–2.25]) and to report depressive symptoms (aOR: 2.71 [95% CI: 2.37–3.11]), than no eviction group caregivers.

### Household Hardships

Compared to the no eviction group, the eviction group was more likely

**TABLE 2** Crude (Unadjusted) Prevalence Between No, Informal, and Formal Eviction History and Child Health and Health Care Utilization, Caregiver Health, and Household Hardships, February 2011 to December 2019

Outcome	Overall Sample, N (%)	Eviction History Groups			P
		No Eviction, N (%)	Informal Eviction History, N (%)	Formal Eviction History, N (%)	
	26 441	25 421 (95.2)	439 (1.7)	581 (2.2)	—
Lifetime hospitalizations	7285 (27.7)	6983 (27.6)	135 (30.8)	167 (28.9)	—
Child health fair or poor	2608 (9.9)	2469 (9.7)	50 (11.4)	89 (15.3)	<sup>a</sup>
Developmental risk (child ≥4 mo) n = 22 553	4499 (20.0)	4252 (19.6)	96 (25.1)	151 (29.8)	<sup>a</sup>
At risk for underweight	3339 (12.9)	3213 (12.9)	51 (11.9)	75 (13.2)	—
Obesity risk (wt-for-age >90%)	4167 (16.1)	4008 (16.1)	67 (15.7)	92 (16.1)	—
Hospital admission from emergency department n = 24 733	2634 (10.6)	2519 (10.6)	45 (10.8)	70 (12.9)	—
Caregiver health fair/poor	6064 (23.3)	5685 (22.7)	164 (38.3)	215 (37.5)	<sup>a</sup>
Maternal depressive symptoms	5679 (22.7)	5237 (21.8)	199 (47.8)	243 (43.7)	<sup>a</sup>
Multiple moves	1415 (5.4)	1242 (4.9)	76 (17.4)	97 (16.8)	<sup>a</sup>
Behind on rent	5694 (22.6)	5234 (21.5)	185 (47.4)	275 (54.2)	<sup>a</sup>
Homeless in child's lifetime	2252 (8.5)	1958 (7.7)	119 (27.1)	175 (30.2)	<sup>a</sup>
Current homelessness	1140 (4.3)	1008 (4.0)	53 (12.1)	79 (13.6)	<sup>a</sup>
Household food insecurity	6973 (26.4)	6461 (25.4)	235 (53.5)	277 (47.7)	<sup>a</sup>
Child food insecurity	3354 (12.7)	3080 (12.1)	116 (26.4)	158 (27.2)	<sup>a</sup>
Energy insecurity	5676 (22.1)	5275 (21.3)	174 (42.0)	227 (41.1)	<sup>a</sup>
Health care hardship	6075 (23.0)	5671 (22.3)	180 (41.0)	224 (38.6)	<sup>a</sup>
Child care constraints	7574 (29.5)	7073 (28.6)	204 (47.0)	297 (52.3)	<sup>a</sup>

<sup>a</sup>  $P \leq .0001$ .

—, not significantly different across groups.

to have multiple moves (aOR: 4.01, [95% CI: 3.33–4.82]), be behind on rent in the past year (aOR: 3.83, [95% CI: 3.33–4.41]), have homelessness in the child's lifetime (aOR: 5.48 [95% CI: 4.63–6.49]), and be homeless currently (aOR: 3.66 [95% CI: 2.93–4.57]). The eviction group was more likely to experience all material hardships measured: household food insecurity (aOR: 3.07 [95% CI: 2.69–3.50]), child food insecurity (aOR: 2.75 [95% CI: 2.36–3.20]), energy insecurity (aOR: 2.18 [95% CI: 1.90–2.50]), health care hardship (aOR: 2.43 [95% CI: 2.11–2.78]), and child care constraints (aOR: 2.63 [95% CI: 2.30–2.99]).

Sensitivity analyses controlling for household income did not change the significance of the health and hardship associations but attenuated the odds (Table 5). Exceptions were fair or poor child health and admission from the ED, which did not achieve significance after adjusting for household income

(aOR: 1.23 [95% CI: 0.99–1.53]) and (aOR: 1.23 [95% CI: 0.98–1.56]), respectively). Adjusting for housing-related hardships, odds ratios for all health and other hardships were attenuated but remained significant with the exception of admission from the ED (aOR: 1.23 [95% CI: 0.99–1.53]) (Table 5). Limiting the sample to children with public or no insurance to ensure a more uniformly low-income sample resulted in highly consistent findings with no changes in significance and nearly identical odds ratios for many outcomes. (Table 5)

## DISCUSSION

This study found a 5 year history of formal or informal eviction was associated with increased odds of young children's developmental risk and hospital admission from the ED (acute health concerns requiring inpatient care), child and caregiver fair or poor health, housing-related hardships and 4 household hardship dimensions: food, utilities, health

care, and child care. Additionally, there were few differences in outcomes differentiated by formal versus informal evictions. Sensitivity analyses accounting for income and other housing hardships likewise demonstrated few differences. These results are consistent with a small but growing body of evidence on associations between eviction history and adverse health and hardship conditions among young children.<sup>6,7</sup> Longitudinal data has also documented eviction's association with health and material hardship among families with young children, finding poor child and caregiver health, and elevated risks for both maternal depression and a composite measure of material hardships for 2 years posteviction.<sup>6</sup> Our study expands these findings and includes specific household hardship dimensions among families with very young children, useful for targeting policy solutions. Evictions during this

**TABLE 3** Adjusted Associations Between Informal and Formal Eviction History and Child Health and Health Care Utilization, Caregiver Health, and Family Hardships (February 2011 to December 2019)

Outcome	No Eviction	Odds Ratios:		<i>P</i> , Comparison of Formal to Informal Evictions
		Informal Eviction	Odds Ratios: Formal Eviction	
<i>N</i> (%)	25 421 (95.2%)	439 (1.7%)	581 (2.2%)	
Child and caregiver health				
Child health fair or poor	1.00	1.22 (0.89–1.66)	1.59 (1.25–2.04) <sup>a</sup>	.17
Developmental risk	1.00	1.39 (1.08–1.78) <sup>a</sup>	1.68 (1.36–2.07) <sup>c</sup>	.24
At risk for being underweight	1.00	0.83 (0.61–1.13)	0.99 (0.76–1.28)	.39
Obesity risk (wt-for-age >90%)	1.00	0.99 (0.76–1.30)	0.99 (0.78–1.25)	.97
Lifetime hospitalizations	1.00	1.19 (0.96–1.47)	0.99 (0.81–1.20)	.21
Hospital admission from emergency department	1.00	0.96 (0.69–1.34)	1.50 (1.15–1.96) <sup>a</sup>	.04
Caregiver health fair or poor	1.00	2.06 (1.68–2.52) <sup>c</sup>	1.90 (1.59–2.26) <sup>c</sup>	.54
Maternal depressive symptoms	1.00	2.93 (2.39–3.59) <sup>c</sup>	2.55 (2.13–3.06) <sup>c</sup>	.31
Housing-related hardships				
Multiple moves	1.00	4.00 (3.06–5.22) <sup>c</sup>	4.02 (3.15–5.12) <sup>c</sup>	.97
Behind on rent	1.00	3.31 (2.69–4.07) <sup>c</sup>	4.30 (3.58–5.17) <sup>c</sup>	.06
Homeless in child's lifetime	1.00	4.96 (3.86–6.36) <sup>c</sup>	5.91 (4.76–7.34) <sup>c</sup>	.28
Current homelessness	1.00	3.17 (2.27–4.42) <sup>c</sup>	4.09 (3.08–5.44) <sup>c</sup>	.24
Other household hardships				
Household food insecurity	1.00	3.55 (2.92–4.33) <sup>c</sup>	2.75 (2.31–3.27) <sup>c</sup>	.05
Child food insecurity	1.00	2.70 (2.15–3.38) <sup>c</sup>	2.78 (2.29–3.39) <sup>c</sup>	.83
Energy insecurity	1.00	2.26 (1.84–2.78) <sup>c</sup>	2.12 (1.77–2.54) <sup>c</sup>	.64
Health care hardship	1.00	2.46 (2.01–3.01) <sup>c</sup>	2.40 (2.01–2.87) <sup>c</sup>	.87
Child care constraints	1.00	2.34 (1.92–2.84) <sup>c</sup>	2.87 (2.42–3.41) <sup>c</sup>	.12

Footnoted *P* values compare to no eviction referent group. *P* values in the far-right column use multivariable logistic regression to compare between informal and formal eviction and are based on maximum likelihood estimation. All models adjusted for: site, maternal place of birth and race and ethnicity; caregiver marital status, employment, education, age, child insurance status, breastfeeding history, age, and number of children in the household; low birth weight included as an additional covariate for child health.

<sup>a</sup> *P* < .05.

<sup>b</sup> *P* < .01.

<sup>c</sup> *P* < .0001.

sensitive developmental period place children at risk for lasting harm.<sup>5,7</sup>

This study also includes informal evictions, which are often excluded from other studies. Similar associations between health outcomes and formal and informal evictions suggest a shared detrimental effect, although possibly through different mechanisms. Informal evictions, like formal evictions, increase parental stress and can lead to residential displacement resulting in loss of social connections, school, and other support systems for families and children. Unlike like formal evictions, which involve an arduous and often lengthy legal process, informal evictions may cause sudden displacement that is catastrophic for families, leading them to accept whatever housing is available, regardless of location or

quality. Although informal evictions are not recorded in court, most landlords request previous landlord references, which may have a detrimental effect on future rental opportunities for families.

Food insecurity, housing instability, energy insecurity, and health care hardship are independently associated with adverse health outcomes among adults and children.<sup>22,24–27</sup> Emerging data show that child care constraints are associated with worse child and adult health.<sup>28</sup> Regardless of the temporality of hardships and eviction, these associations undermine children and families' health and wellbeing.

### Policy and Public Health Implications

Eviction rates in this sample (3.9%) were approximately double the national average of formal evictions

among renters (2.3% in 2016), again revealing that households with children are at elevated eviction risk.<sup>2,29,30</sup> There are many drivers of eviction rates, including economic downturns, income shocks, and neighborhood gentrification, which is independently associated with poor child mental health outcomes.<sup>31</sup> Previous research also demonstrates adverse health conditions may contribute to increased risk of eviction<sup>15</sup> among families with young children. Despite city, state, and federal eviction moratoria during the coronavirus disease 2019 pandemic, varying widely by state and locality, an estimated 1 out of 5 families with children were at risk for eviction in May 2021.<sup>32,33</sup>

To advance health equity, eviction's root causes, including discrimination against children, systemic racism, xenophobia, wage and wealth

**TABLE 4** Adjusted Associations Between Eviction History and Child Health and Health Care Utilization, Caregiver Health, and Household Hardship, February 2011 to December 2019

Outcome	Eviction aOR (95% CI)
No eviction	Ref.
Child and caregiver health	
Child health fair or poor	1.43 (1.17–1.73) <sup>b</sup>
Developmental risk	1.55 (1.32–1.82) <sup>c</sup>
At risk for being underweight	0.92 (0.75–1.12)
Obesity risk (wt-for-age >90%)	0.99 (0.83–1.19)
Lifetime hospitalizations	1.07 (0.93–1.24)
Hospital admission from emergency department	1.24 (1.01–1.53) <sup>a</sup>
Caregiver health fair or poor	1.96 (1.72–2.25) <sup>c</sup>
Maternal depressive symptoms	2.71 (2.37–3.11) <sup>c</sup>
Housing-related hardships	
Multiple moves	4.01 (3.33–4.82) <sup>c</sup>
Behind on rent or mortgage	3.83 (3.33–4.41) <sup>c</sup>
Homeless in child's lifetime	5.48 (4.63–6.49) <sup>c</sup>
Current homelessness	3.66 (2.93–4.57) <sup>c</sup>
Other household hardships	
Household food insecurity	3.07 (2.69–3.50) <sup>c</sup>
Child food insecurity	2.75 (2.36–3.20) <sup>c</sup>
Energy insecurity	2.18 (1.90–2.50) <sup>b</sup>
Health care hardship	2.43 (2.11–2.78) <sup>c</sup>
Child care constraints	2.63 (2.30–2.99) <sup>c</sup>

All models adjusted for: site, maternal place of birth and race and ethnicity; caregiver marital status, employment, education, age, child insurance status, breastfeeding history, age, and number of children in the household; low birth weight included as an additional covariate for child health correlates. Ref., reference.

<sup>a</sup>  $P < .05$ .

<sup>b</sup>  $P < .01$ .

<sup>c</sup>  $P < .0001$ .

disparities by race and sex, and health inequities, must be addressed.<sup>3,34–37</sup> This sample had complex variations in maternal racial and ethnic and nativity based on eviction history. Although the current study does not focus on racial and ethnic and nativity differences, future research should specifically and intersectionally address eviction rates by race and ethnicity, nativity, and associated health inequities. Research differentiating relationships of state and local policies with eviction incidence and inequities and the bidirectional nature of evictions and health can identify protective policies for family health. Research examining protective effects of housing and other assistance programs against eviction would be informative.<sup>38,39</sup>

Formal evictions remain on record for ~5 years and can have ramifications on housing access,

employment, and credit scores, perhaps partially explaining associations with material hardships in this and other studies.<sup>6,40</sup> A report from the National Academies of Science, Engineering, and Medicine highlights the coronavirus disease 2019 pandemic's impact on evictions and inequities, providing recommendations for addressing the current eviction crisis.<sup>36</sup> Policies that provide tenant protections, increase housing affordability, and promote racial and socioeconomic equity vary widely by state or locality and are critical to mitigate the effect and decrease the eviction incidence.<sup>41</sup> Policy solutions for formal evictions include procedural changes requiring legal representation and, when needed, interpreters for tenants to decrease landlord-tenant power imbalance. Preventing informal evictions may require skilled

community-based advocacy to reduce tensions between landlords and tenants. Upstream prevention may include increasing access to rental assistance and affordable housing, especially for families with infants and young children, such as permanently authorizing an emergency assistance fund to pay rent arrears and other income-boosting policies. Recognizing the bidirectional nature of eviction and adverse health outcomes, increasing access to health care services, and improving health-related social needs that support optimal health are important. Expanding Medicaid helps to cover medical expenses, provides access to care that could ameliorate illness, and has been shown to reduce the number and rate of evictions as well as eviction filings.<sup>15,37,38</sup> Providing assistance with health care costs may also present the opportunity for household spending to be distributed to other necessities, such as food, rent, utilities, and child care.<sup>15</sup>

Although policy solutions are necessary for reducing evictions, clinical and public health practice provides an opportunity to address underlying causes of evictions and mitigate their harms.<sup>42</sup> Health care providers could screen patients and families for housing-related hardship.<sup>5,22,43</sup> Partnering with community organizations and connecting patients at risk with resources including housing-specific case management, financial assistance, and affordable housing may prevent evictions and improve health.<sup>36,44</sup> Responses could vary depending on the specific hardships identified, thus screening for and connecting patients to resources to address and alleviate food, utility, child care, and health care costs are also critical.

**TABLE 5** Sensitivity Analyses: Adjusted Associations Child and Caregiver Health, Material Hardships and Eviction in past 5 Years With Additional Covariates (Model 1: Income; Model 2: Housing-Related Hardships) and a Restricted Sample (Model 3: Children With Public or No Insurance)

Outcomes	No Eviction	Model 1: Eviction aOR (95% CI), Using Subset With Nonmissing Income Variable, <i>n</i> = 18 069, February 2011 to December 2019	Model 2: Eviction aOR (95% CI) Main Model Covariates With Additional Adjustment for Housing- Related Hardships, February 2011 to December 2019	Model 3: Eviction aOR (95% CI), Excluding Children With Private Insurance, <i>n</i> = 25 020, February 2011 to December 2019
<b>Child and caregiver health outcomes</b>				
Child health fair or poor	1.00	1.19 (0.98–1.45)	1.25 (1.03–1.53) <sup>b</sup>	1.44 (1.18–1.75) <sup>b</sup>
Developmental risk	1.00	1.36 (1.16–1.60) <sup>b</sup>	1.40 (1.19–1.65) <sup>c</sup>	1.56 (1.32–1.83) <sup>c</sup>
At risk for being underweight	1.00	1.02 (0.83–1.24)	0.95 (0.77–1.16)	0.93 (0.76–1.14)
Obesity risk (wt-for-age >90%)	1.00	1.04 (0.87–1.24)	0.97 (0.81–1.17)	1.00 (0.84–1.21)
Lifetime hospitalizations (yes/no)	1.00	1.02 (0.89–1.18)	1.00 (0.86–1.16)	1.06 (0.92–1.23)
Admit from ED	1.00	1.12 (0.90–1.39)	1.23 (0.99–1.53)	1.26 (1.02–1.55) <sup>a</sup>
Caregiver health fair or poor	1.00	1.75 (1.53–2.01) <sup>c</sup>	1.59 (1.38–2.82) <sup>c</sup>	1.97 (1.72–2.26) <sup>c</sup>
Maternal depressive symptoms	1.00	2.36 (2.06–2.70) <sup>c</sup>	1.91 (1.66–2.21) <sup>c</sup>	2.70 (2.35–3.10) <sup>c</sup>
<b>Housing-related hardships</b>				
Multiple moves	1.00	3.20 (2.65–3.86) <sup>c</sup>	n/a	3.99 (3.31–4.81) <sup>c</sup>
Homeless in child lifetime	1.00	4.70 (3.96–5.56) <sup>c</sup>	n/a	5.42 (4.57–6.43) <sup>c</sup>
Current homelessness	1.00	3.44 (2.77–4.26) <sup>c</sup>	n/a	3.63 (2.91–4.54) <sup>c</sup>
Behind on rent or mortgage	1.00	3.28 (2.85–3.78) <sup>c</sup>	n/a	3.71 (3.22–4.28) <sup>c</sup>
<b>Other household hardships</b>				
Household food insecurity	1.00	2.70 (2.37–3.09) <sup>c</sup>	1.94 (1.68–2.23) <sup>c</sup>	3.00 (2.62–3.42) <sup>c</sup>
Child food insecurity	1.00	2.27 (1.95–2.65) <sup>c</sup>	1.78 (1.52–2.08) <sup>c</sup>	2.67 (2.29–3.11) <sup>c</sup>
energy insecurity	1.00	1.87 (1.63–2.14) <sup>c</sup>	1.44 (1.25–1.67) <sup>c</sup>	2.15 (1.87–2.48) <sup>c</sup>
Health care hardship	1.00	2.05 (1.79–2.36) <sup>c</sup>	1.66 (1.44–1.91) <sup>c</sup>	2.44 (2.13–2.80) <sup>c</sup>
Child care constraints	1.00	2.37 (2.08–2.70) <sup>c</sup>	2.08 (1.82–2.38) <sup>c</sup>	2.63 (2.31–3.01) <sup>c</sup>

Model 1 adjusted for: site, maternal place of birth and race and ethnicity; caregiver marital status, employment, education, age, child insurance status, breastfeeding history, age, number of children in the household, and household income; low birth weight included as an additional covariate for child health correlates. Model 2 adjusted for: site, maternal place of birth and race and ethnicity; caregiver marital status, employment, education, age, child insurance status, breastfeeding history, age, number of children in the household, and housing-related hardships; low birth weight included as an additional covariate for child health correlates. Model 3 adjusted for: site, maternal place of birth and race and ethnicity; caregiver marital status, employment, education, age, child insurance status, breastfeeding history, age, and number of children in the household. n/a, not available.

<sup>a</sup> *P* < .05.

<sup>b</sup> *P* < .01.

<sup>c</sup> *P* < .0001.

### Study Strengths and Limitations

This study's strengths include its focus on a large, geographically and racially and ethnically diverse sample of families with young children and information about informal evictions, often missing in eviction research because of a reliance on court filings. This study population is not nationally representative but rather a sentinel sample, primarily composed of families with low incomes accessing urban hospitals with a high proportion of both caregivers of color and immigrant caregivers, compared to national statistics. The sentinel sample is both a strength and a limitation as a dynamic form of data collection designed to signal early trends and identify and monitor policy effects and disease

burdens before they become widely prevalent. Although limited in generalizability, it helps identify emerging health impacts promptly so that timely interventions can be developed.<sup>45</sup> The cross-sectional study design reflects association, not causation, within unknown eviction timing. Caregivers were asked about evictions in the previous 5 years, whereas most hardship questions use a 1 year retrospective period. Therefore, eviction's proximity to interview date, hardship report, and youngest children's lifetime is unknown. Some families may have experienced >1 eviction, but multiple incidents of eviction, which is rare in a 5 year window, were not captured in this study. Future studies may consider exploring health outcomes among those who have had multiple evictions

compared to 1 or none. Regardless, maternal hardships experienced prenatally have implications for child health<sup>46,47</sup> and, conversely, child health can precipitate evictions.<sup>15</sup> As a result, a relentless cycle can occur between poor health and evictions. Additionally, many variables in this study were self-reported and subject to reporting bias. The eviction history question is validated to identify formal and informal evictions common among low-income renters missed by court record data,<sup>1</sup> and self-reported health and material hardship measures used have been validated in national surveys.<sup>17–24,47</sup> Finally, there may be other unmeasured confounders, such as exposure to discrimination, neighborhood

location, and city-specific tenant protections.

## CONCLUSIONS

Considering evidence on the health and socioeconomic impact of evictions, this research elucidates associations between family history of eviction and infant and toddler health and development. Although eviction's causes and consequences may be complex and varied, findings suggest reduction of eviction incidence, formal and informal, may address health disparities and the needs of young families.

Policymakers, community organizations, and health professionals have important roles in designing evidence-based policy solutions to reduce evictions and improve opportunities for families to meet their basic needs.

## ACKNOWLEDGMENTS

We thank Nayab Ahmad, BA, Yasmeen Alsaif, and Mikalia Jackson, BS, for their assistance in the preparation of this manuscript. We also thank the families who shared their time and information with us.

An earlier version of this analysis was presented at the Pediatric Academic Societies meeting in Baltimore in April 2019.

## ABBREVIATIONS

aOR: adjusted odds ratio  
CI: confidence interval  
ED: emergency department  
LBW: low birth weight

data collection, interpreted the data, and reviewed and revised the manuscript; Ms Coleman and Rateau conducted the analyses and reviewed and revised the manuscript; Dr Heeren provided statistical oversight, interpreted the data, and reviewed and revised the manuscript. and all authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

**DOI:** <https://doi.org/10.1542/peds.2022-056692>

Accepted for publication Jun 6, 2022

Address correspondence to Stephanie Ettinger de Cuba, PhD, MPH, Department of Pediatrics, Boston University School of Medicine, 801 Albany St, 3<sup>rd</sup> floor, Boston, MA 02119. E-mail: sedc@bu.edu

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

Copyright © 2022 by the American Academy of Pediatrics

**FUNDING:** No external funding.

**CONFLICT OF INTEREST DISCLOSURES:** Dr Sandel is an unpaid board member of Enterprise Community Partners, a nonprofit charitable organization promoting affordable housing. The other authors have no conflicts of interest to disclose.

## REFERENCES

1. Desmond M, Shollenberger T. Forced displacement from rental housing: prevalence and neighborhood consequences. *Demography*. 2015;52(5):1751–1772
2. Desmond M, Gershenson C. Who gets evicted? Assessing individual, neighborhood, and network factors. *Soc Sci Res*. 2017;62:362–377
3. Desmond M. Eviction and the reproduction of urban poverty. *Am J Sociol*. 2012;118(1):88–133
4. Fowler KA, Gladden RM, Vagi KJ, Barnes J, Frazier L. Increase in suicides associated with home eviction and foreclosure during the US housing crisis: findings from 16 National Violent Death Reporting System States, 2005–2010. *Am J Public Health*. 2015;105(2):311–316
5. Goplerud DK, Leifheit KM, Pollack CE. The health impact of evictions. *Pediatrics*. 2021;148(5):e2021052892
6. Desmond M, Kimbro RT. Eviction's fallout: Housing, hardship, and health. *Soc Forces*. 2015;9(1):295–324
7. Leifheit KM, Schwartz GL, Pollack CE, et al. Eviction in early childhood and neighborhood poverty, food security, and obesity in later childhood and adolescence: Evidence from a longitudinal birth cohort. *SSM Popul Health*. 2020;11:100575
8. Gove WR, Hughes M, Galle OR. Overcrowding in the home: an empirical investigation of its possible pathological consequences. *Am Sociol Rev*. 1979;44(1):59–80
9. Hoke MK, Boen CE. The health impacts of eviction: Evidence from the national longitudinal study of adolescent to adult health. *Soc Sci & Med*. 2021;273:113742
10. Jelleman T, Spencer N. Residential mobility in childhood and health outcomes: a systematic review. *J Epidemiol Community Health*. 2008;62(7):584–592
11. Himmelstein G, Desmond M. Association of eviction with adverse birth outcomes among women in Georgia, 2000 to 2016. *JAMA Pediatr*. 2021;175(5):494–500
12. Hazekamp C, Yousuf S, Day K, Daly MK, Sheehan K. Eviction and pediatric health outcomes in Chicago. *J Comm Health*. 2020;45(5):891–899

13. Khadka A, Fink G, Gromis A, McConnell M. In utero exposure to threat of evictions and preterm birth: Evidence from the United States. *Health Serv Res.* 2020;55(Suppl 2):823–832
14. Leifheit KM, Schwartz GL, Pollack CE, et al. Severe housing insecurity during pregnancy: association with adverse birth and infant outcomes. *Int J Environ Res Public Health.* 2020;17(22):8659
15. Schwartz GL, Leifheit KM, Berkman LF, Chen JT, Arcaya MC. Health selection into eviction: adverse birth outcomes and children's risk of eviction through age 5 years. *Am J Epidemiol.* 2021; 190(7):1260–1269
16. National Consumer Law Center. Salt in the wound: how eviction records and back rent haunt tenant screening reports and credit scores. Available at: [https://www.nclc.org/images/pdf/special\\_projects/covid-19/IB\\_Salt\\_in\\_the\\_Wound.pdf](https://www.nclc.org/images/pdf/special_projects/covid-19/IB_Salt_in_the_Wound.pdf). Accessed August 2, 2022
17. O'Hara B, Caswell K. Health Status, Health Insurance, and Medical Services Utilization: 2010. Household Economic Studies. Washington, DC: US Census Bureau; July 2013. Available at: <https://www.census.gov/library/publications/2013/demo/p70-133.html>. Accessed August 17, 2022
18. Glascoe FP. Evidence-based approach to developmental and behavioural surveillance using parents' concerns. *Child Care Health Dev.* 2000;26(2):137–149
19. Frank DA, Casey PH, Black MM, et al. Cumulative hardship and wellness of low-income, young children: multisite surveillance study. *Pediatrics.* 2010;125(5):e1115–e1123
20. Gamliel A, Ziv-Baran T, Siegel RM, Fogelman Y, Dubnov-Raz G. Using weight-for-age percentiles to screen for overweight and obese children and adolescents. *Prev Med.* 2015;81:174–179
21. Kemper KJ, Babonis TR. Screening for maternal depression in pediatric clinics. *Am J Dis Child.* 1992;146(7): 876–878
22. Sandel M, Sheward R, Ettinger de Cuba S, et al. Unstable housing and caregiver and child health in renter families. *Pediatrics.* 2018;141(2):e20172199
23. Coleman-Jensen A, Rabbitt M, Gregory C, Singh A. *Household food security in the United States in 2013*, ERR-173, US Department of Agriculture, Economic Research Service, September 2014. Available at: [https://www.ers.usda.gov/webdocs/publications/45265/48787\\_err173.pdf](https://www.ers.usda.gov/webdocs/publications/45265/48787_err173.pdf). Accessed August 2, 2022
24. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics.* 2008;122(4):e867–e875
25. Shankar P, Chung R, Frank DA. Association of food insecurity with children's behavioral, emotional, and academic outcomes: a systematic review. *J Dev Behav Pediatr.* 2017;38(2):135–150
26. Gundersen C, Ziliak JP. Food insecurity and health outcomes. *Health Aff (Millwood).* 2015;34(11):1830–1839
27. Newacheck PW, Hughes DC, Hung YY, Wong S, Stoddard JJ. The unmet health needs of America's children. *Pediatrics.* 2000;105(4 Pt 2):989–997
28. Bruce C, Bovell-Ammon A, Ettinger de Cuba S, et al. Access to high-quality, affordable child care: strategies to improve health. Available at: <https://childrenshealthwatch.org/wp-content/uploads/CHW-Childcare-Report-final-web-2.pdf>. Accessed August 2, 2022
29. Eviction Lab. National estimates: eviction in America. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6358494/>. Accessed January 7, 2020
30. Lundberg I, Donnelly L. A research note on the prevalence of housing eviction among children born in U.S. Cities. *Demography.* 2019;56(1):391–404
31. Dragan KL, Ellen IG, Glied SA. Gentrification and the health of low-income children in New York City. *Health Aff (Millwood).* 2019;38(9):1425–1432
32. Semuels A. Renters are being forced from their homes despite eviction moratoriums meant to protect them. Available at: <https://time.com/5820634/evictions-coronavirus/>. Accessed August 2, 2022
33. McCarty M, Carpenter D. CARES Act eviction moratorium. Available at: <https://crsreports.congress.gov/product/pdf/IN/IN11320>. Accessed August 2, 2022
34. Desmond M. *Evicted: Poverty and Profit in the American City*. Broadway Books; 2016
35. Phojanakong P, Brown Weida E, Grimaldi G, Lê-Scherban F, Chilton M. Experiences of racial and ethnic discrimination are associated with food insecurity and poor health. *Int J Environ Res Public Health.* 2019;16(22): E4369
36. National Academies of Sciences Engineering, and Medicine. *Rental Eviction and the COVID-19 Pandemic: Averting a Looming Crisis*. Washington, DC: The National Academies Press; 2021:69
37. Green KA, Bovell-Ammon A, Sandel M. Housing and neighborhoods as root causes of child poverty. *Acad Pediatr.* 2021;21(8S 8s):S194–S199
38. Allen HL, Eliason E, Zewde N, Gross T. Can Medicaid expansion prevent housing evictions? *Health Aff.* 2019;38(9):1451–1457
39. Zewde N, Eliason E, Allen H, Gross T. The effects of the ACA Medicaid expansion on nationwide home evictions and eviction-court initiations: United States, 2000–2016. *Am J Pub Health.* 2019;109(10):1379–1383
40. Duke A, Park A. *Evicted for Life: How Eviction Court Records Are Creating a New Barrier to Housing*. Massachusetts Law Reform Institute; 2019
41. Bovell-Ammon A, Yentel D, Koprowski M, Wilkinson C, Sandel M. Housing is health: A renewed call for federal housing investments in affordable housing for families with children. *Acad Pediatr.* 2021;21(1):19–23
42. Sandel M, Hansen M, Kahn R, et al. Medical-legal partnerships: transforming primary care by addressing the legal needs of vulnerable populations. *Health Aff (Millwood).* 2010;29(9): 1697–1705
43. Billieux A, Verlander K, Anthony S, Alley D. *Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool*. NAM Perspectives; 2017

44. Bovell-Ammon A, Mansilla C, Poblacion A, et al. Housing intervention for medically complex families associated with improved family health: pilot randomized trial. *Health Aff (Millwood)*. 2020;39(4):613–621
45. Erwin PC; Sentinel Public Health Practitioner Surveillance group. Tracking the impact of policy changes on public health practice. *Am J Public Health*. 2017;107(5):653–654
46. Sandel M, Sheward R, Ettinger de Cuba S, et al. Timing and duration of pre- and postnatal homelessness and the health of young children. *Pediatr*. 2018;142(4):e20174254
47. Cutts DB, Coleman S, Black MM, et al. Homelessness during pregnancy: a unique, time-dependent risk factor of birth outcomes. *Matern Child Health J*. 2015;19(6):1276–1283