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Health and Care Utilization Among Youth With a History of Parental Incarceration and Homelessness

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Introduction: Despite widespread recognition of the health and social risks posed by parental incarceration (PI) and homelessness, these challenges are rarely considered in unison. We sought to (a) assess the experiences of homelessness among youth with and without a history of PI and (b) compare the health and healthcare utilization among youth with a combined history of PI and homelessness. **Method:** Examining data from eighth-, ninth-, and 11th-grade public school participants in the 2019 Minnesota Student Survey ($N = 110,904$), we calculated univariate and multivariate analyses to characterize the health status and care utilization of youth who have experienced PI, past-year homelessness, or both. **Results:** We observed higher prevalence of homelessness among youth with a history of PI compared to those without. The group with dual PI-homelessness experience had a higher proportion of youth that were younger, male, and non-White; and living in poverty or urban areas compared to youth with PI history only. Even after accounting for demographic factors, the dual PI-homelessness group evidenced higher expected odds for several physical health conditions (e.g., asthma, diabetes), and differences in care utilization indicators relative to individual PI and homelessness groups. **Discussion:** Findings suggest that PI may be overrepresented among recently homeless youth and that youth with such dual experience possess distinct, and often elevated, health service needs. Health, education, housing, and other systems may need intersectoral strategies to better identify and support this at-risk subset of youth through clinical and policy approaches.

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analysis and methodology. Andrew J. Barnes served in a supporting role for formal analysis and methodology. Rebecca Freese served as lead for data curation, formal analysis, and visualization and served in a supporting role for methodology and writing—review and editing. Julie Atella contributed equally to project administration and served in a supporting role for funding acquisition. Rebecca J. Shlafer served as lead for conceptualization, funding acquisition, resources, and supervision and served in a supporting role for formal analysis and methodology. Laurel Davis, Andrew J. Barnes, Julie Atella, and Rebecca J. Shlafer contributed equally to writing—review and editing.

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Public Significance Statement

This study found higher rates of recent homelessness among youth who have ever had a parent incarcerated. Both homelessness and parental incarceration tracked with worse health and use of health care services, with a potentially compounding effect. Understanding and acting upon multiple marginalization among youth is a critical task to achieve health equity.

Keywords: adolescent health, adverse childhood experiences, homelessness, parental incarceration, survey research

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For decades, the United States has held the unfortunate distinction of sustaining the highest incarceration rate in the world (Walmsley, 2018) with rates of prison and jail incarceration only plateauing in recent years (Carson, 2020). Criminal legal contact has been associated with significant social, economic, and health consequences, not only for affected individuals, but their surrounding families and communities as well (Maruschak et al., 2021). Indeed, national data show that more than five million U.S. children have experienced parental incarceration (PI; Murphey & Cooper, 2015) and that the majority of adults in prison are parents of children under 18 years old (Maruschak et al., 2021).

In tandem, the United States has also experienced dramatic increases in the prevalence of homelessness, with 1.3–1.5 million public school students (preschool through 12th grade) experiencing homelessness annually for the most recent years in which data are available (2016–2019; National Center for Homeless Education, 2021). Although several states have made marked progress on reducing rates of family homelessness in recent years, per 2020 point-in-time count estimates more than 150,000 individuals in families continued to experience homelessness on any given night. These data also identified approximately 35,000 unaccompanied homeless youth under the age of 18 living in sheltered or unsheltered locations (Henry et al., 2021). Similar to PI, children affected by family homelessness are subject to elevated risks for many physical, mental, and social health consequences (Grant et al., 2013).

Despite the threats posed by incarceration and homelessness on child and family development, research exploring their intersection is relatively nascent. In the context of the extant research on

cumulative psychosocial risk during childhood and adolescence, PI is well established as an adverse childhood experience (ACE), and a recent scoping review of the literature on ACEs notes that many investigators appropriately consider homelessness, inadequate housing, and housing instability to be an ACE as well (Karatekin et al., 2022). As such, PI and homelessness can be conceptualized as structural determinants of health inequities (Solar & Irwin, 2010). These two ACEs likely intersect and compound one another, with potentially cascading negative impacts on children and families. For example, being homeless can increase a family's visibility to police, which may lead to incarceration of adult caregivers; incarceration may consequently lead to disruptions in housing. Following release from incarceration, employment and housing policies limit opportunities for housing (Warner, 2015). In light of these entwined risks, this study aims to clarify the degree to which these ACEs affect child health both individually and jointly in order to inform social policy and prevention efforts.

Prior literature has explored the intersections between criminal legal contact and homelessness for families. For example, using longitudinal data from the Fragile Families and Child Wellbeing Study, Wildeman (2014) found that children with recently incarcerated mothers and fathers were more likely to be homeless than other children. Risk for homelessness was particularly high among Black children with incarcerated fathers. In addition, Casey et al. (2015) described notable overlap between young children's experiences of homelessness and PI. Among children currently living in homeless shelters, approximately one third had experienced PI. Families that had experienced PI were nearly twice as

likely to report experiencing eviction, compared to families with no history of PI. Finally, in a sample of currently incarcerated parents with young children, Muentner et al. (2019) found that parents in jail reported considerable residential instability. In the year before their incarceration, approximately 71% of parents in jail reported at least one change of residence—and nearly a quarter of parents reported four or more moves—not including their current incarceration. In addition, approximately 19% of the sample reported experiencing periods of homelessness.

While these studies demonstrate a clear intersection between children's experiences of PI and homelessness, we know little about how these experiences interact to influence children's outcomes. Several scholars have explored associations between children's health and PI (Heard-Garris et al., 2018; Hiolski et al., 2019; Lee et al., 2013) and children's health and homelessness (Barnes et al., 2021; Edidin et al., 2012; Gewirtz O'Brien, Edinburg, et al., 2020). These two separate literatures reflect a clear pattern—children with incarcerated parents and children experiencing homelessness and housing instability are at increased risk for poor health across a variety of indicators. Yet, we know very little about how these experiences interact. To fill this gap, the current study sought to examine the health and healthcare utilization of youth with and without the experiences of PI and/or homelessness. Specifically, we sought to characterize youth's experiences with health and healthcare utilization based on their experiences with PI and/or homelessness.

Method

Data Source and Study Design

Data were drawn from the 2019 Minnesota Student Survey (MSS), which used a cross-sectional design to examine children's experiences, behaviors, and health. The MSS is administered every 3 years to all fifth-, eighth-, ninth-, and 11th-grade public school students in Minnesota, although students in fifth-grade were not asked a number of items that were deemed particularly sensitive (including items about their history of PI). As such, fifth graders were removed from the analytic sample. The survey was conducted in English in online and paper formats; the invitation was extended via letters to parents of all students, inclusive of those receiving special education, in

English, Spanish, Somali, and Hmong. Students needing accommodations in order to participate (e.g., screen readers) received them in accordance with federal and state laws. Student participation was voluntary and completely anonymous, with both students and parents given the opportunity to opt out. School districts that participated in the survey were required to follow federal laws regarding parental notification as required by the Family Educational Rights and Privacy Act and the Protection of Pupil Rights Amendment. Students may have chosen not to participate or could skip any individual question on the survey. In 2019, 83.3% of eighth graders, 75.3% of ninth graders, and 62.9% of 11th graders participated (Minnesota Department of Education, 2021). The analytic sample for this study was composed of 110,904 youth in eighth ($n = 40,654$), ninth ($n = 39,321$), and 11th ($n = 30,929$) grades.

Survey Measures

PI

PI was assessed with one item: "Have any of your parents or guardians ever been in jail or prison? (Mark ALL that apply)." Response options included: "None of my parents or guardians has ever been in jail or prison," "Yes, I have a parent or guardian in jail or prison right now," and "Yes, I have had a parent or guardian in jail or prison in the past." PI was recoded into a binary variable: 0 = "no experience of PI" and 1 = "any experience of PI."

Homelessness

Homelessness was assessed with one item: "During the past 12 months, have you stayed in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay?" Three response options included: "No"; "Yes, I was with my parents or adult family member"; and "Yes, I was on my own without any adult family members." Homelessness was recoded into a binary variable: 0 = "no experience of homelessness" and 1 = "any experience of homelessness in the last year."

Health Status and Utilization

Dependent variables included health status (overall health, physical disability or long-term health problem, mental or emotional problem, diabetes/prediabetes, asthma, allergy, any dental

problems) and health care utilization (treated for a mental or emotional problem, treated for an alcohol or drug problem, seen a dentist in the past year). The distribution of responses for general health was skewed and therefore dichotomized into “very good or excellent” versus “poor, fair, or good,” consistent with previous research using the MSS (e.g., Hiolski et al., 2019; Rider et al., 2018).

Demographic Characteristics

Five variables (age, sex, race, poverty, and region) were used as covariates in logistic regression analyses. Race and ethnicity were measured with six items. Youth were asked to endorse whether they identified with any of the following racial or ethnic groups: Hispanic or Latino/a; American Indian or Alaskan Native; Asian; Black, African, or African American; Native Hawaiian or Other Pacific Islander; and White. Youth could endorse multiple races and ethnicities. Ideally, the racial and ethnic groups would be compared, given known racialized differences in PI, homelessness, and health outcomes (Wildeman, 2014). However, because sample sizes for the other non-White races and non-Hispanic ethnicities were too small for reliable inferential statistics to be computed, race and ethnicity were treated dichotomously; based on responses to the individual items, responses were coded 0 if youth endorsed only “White,” otherwise they were coded 1. Consistent with prior work (Davis et al., 2019), poverty status was assessed with two items: “Do you currently get free or reduced-price lunch at school?” and “During the last 30 days, have you had to skip meals because your family did not have enough money to buy food?” Respondents who endorsed either of these items were coded 1, otherwise, they were coded 0. Region was coded as whether or not the school was within or outside the 7-county Minneapolis and Saint Paul metropolitan areas. Additional details about how survey measures were coded are provided in the Appendix.

Data Analysis

Participant demographic and health status characteristics were summarized with *M* (*SD*) for continuous and count (%) for categorical variables overall and grouped by PI and homelessness status. To assess for different effects by the combination of PI and homelessness status, separate logistic

regression models with outcomes for health status and utilization indicator variables were constructed where the predictor of interest for each was the interaction term between PI and homelessness. These models used complete cases and were adjusted for the potential confounding and precision variables of age, biological sex, race/ethnicity, poverty status, and region. The expected odds of each outcome with 95% confidence intervals for possible combinations of PI and homelessness were calculated and also visualized. Finally, we carried out a supplemental analysis to assess whether findings for the binary general health outcome were robust when considering the item’s range of responses. Specifically, we constructed a proportional odds logistic regression model estimating odds for each response level compared to all lower levels of the health.

All analyses were conducted in R (Version 4.0.2), and *p*-values were considered at the .05 level for statistical significance. The University of Minnesota Institutional Review Board determined this study exempt from human subjects review.

Results

Sample Characteristics

In total, 16.6% ($n = 18,415$) of the analytic sample had a parent currently or formerly incarcerated and 4.9% ($n = 5,427$) experienced homelessness in the last year. Among youth with no history of PI, 3.4% experienced homelessness in the last year. In comparison, 12.6% of youth with a history of PI experienced homelessness in the last year. As shown in Table 1, among youth with a history of PI, those who also experienced homelessness were slightly younger, and more often male, youth of color, foster care involved, and living in the 7-county metro area or in poverty than youth with a history of PI but no experience of homelessness. The dual experience group also evidenced a history of more ACEs on average. The frequency of missing responses was typically less than 5% for health characteristics, but as high as 12% for poverty.

Health Statuses and Care Utilization by Experience of PI and Homelessness

Health status and health care utilization varied by group. As shown in Table 1, youth who

Table 1

Demographic Characteristics and Health and Care Utilization of a Statewide Sample of Youth in Grades 8, 9, and 11, Overall and by Parental Incarceration and Homelessness Status—Minnesota, 2019

Characteristic	Overall (<i>N</i> = 110,904)	No parental incarceration (<i>n</i> = 92,489)		Parental incarceration (<i>n</i> = 18,415)	
		No homelessness (<i>n</i> = 89,374)	Homelessness (<i>n</i> = 3,115)	No homelessness (<i>n</i> = 16,103)	Homelessness (<i>n</i> = 2,312)
Demographic characteristics					
Grade, <i>n</i> (%)					
8 th	40,654 (36.7)	32,305 (36.1)	1,360 (43.7)	6,043 (37.5)	946 (40.9)
9 th	39,321 (35.5)	31,455 (35.2)	1,164 (37.4)	5,853 (36.3)	849 (36.7)
11 th	30,929 (27.9)	25,614 (28.7)	591 (19.0)	4,207 (26.1)	517 (22.4)
Age (years), <i>M</i> (<i>SD</i>)	14.8 (1.31)	14.8 (1.3)	14.6 (1.2)	14.8 (1.3)	14.7 (1.3)
Biological sex: Female, <i>n</i> (%)	57,178 (51.6)	46,067 (51.6)	1,371 (44.1)	8,575 (53.3)	1,165 (50.6)
Race/ethnicity, <i>n</i> (%)					
All other races/ethnicities	31,536 (28.6)	22,500 (25.3)	1,348 (43.6)	6,469 (40.4)	1,219 (53.4)
White	78,697 (71.4)	66,348 (74.7)	1,746 (56.4)	9,540 (59.6)	1,063 (46.6)
Region, <i>n</i> (%)					
7-county twin cities metro area	57,793 (52.1)	48,365 (54.1)	1,658 (53.2)	6,738 (41.8)	1,032 (44.6)
Greater Minnesota	53,111 (47.9)	41,009 (45.9)	1,457 (46.8)	9,365 (58.2)	1,280 (55.4)
ACEs, <i>M</i> (<i>SD</i>)	0.8 (1.29)	0.6 (1.0)	1.2 (1.6)	1.7 (1.7)	2.7 (2.2)
Poverty, <i>n</i> (%)	26,342 (27.1)	15,928 (20.0)	1,243 (48.1)	7,658 (55.4)	1,513 (75.6)
Foster care, <i>n</i> (%)					
No	107,113 (97.3)	87,926 (99.0)	2,840 (92.4)	14,767 (92.4)	1,580 (70.1)
Yes—during last year	911 (0.8)	158 (0.2)	100 (3.3)	290 (1.8)	363 (16.1)
Yes—more than a year ago	2,101 (1.9)	734 (0.8)	135 (4.4)	921 (5.8)	311 (13.8)
Health status and utilization					
Overall health: excellent/very good, <i>n</i> (%)	70,248 (63.3)	59,838 (67.0)	1,799 (57.8)	7,638 (47.4)	973 (42.1)
Any dental problems, <i>n</i> (%)	35,125 (32.0)	26,449 (29.9)	1,074 (35.0)	6,502 (40.8)	1,100 (48.8)
Seen a dentist for that problem, <i>n</i> (%)	25,664 (71.3)	20,161 (74.4)	732 (65.9)	4,205 (63.4)	566 (49.3)
Seen a dentist in the past year, <i>n</i> (%)	92,999 (84.4)	77,515 (87.3)	2,314 (75.2)	11,776 (73.6)	1,394 (61.1)
Physical disability/long-term health problem, <i>n</i> (%)	16,578 (15.0)	12,527 (14.1)	484 (15.7)	2,976 (18.6)	591 (25.9)
Mental/emotional problems, <i>n</i> (%)	25,525 (23.2)	17,728 (20.0)	860 (27.9)	5,827 (36.4)	1,110 (48.6)
Treated for mental/emotional problems, <i>n</i> (%)	24,742 (22.7)	17,703 (20.1)	782 (25.9)	5,238 (33.2)	1,019 (45.6)
Treated for alcohol/drug problem, <i>n</i> (%)	1,413 (1.7)	590 (0.8)	117 (5.0)	451 (4.1)	255 (17.3)
Diabetes/prediabetes, <i>n</i> (%)	2,300 (2.1)	1,515 (1.7)	140 (4.6)	436 (2.8)	209 (9.4)
Asthma, <i>n</i> (%)	17,472 (15.9)	13,267 (15.0)	487 (15.9)	3,150 (19.8)	568 (25.3)
Allergy, <i>n</i> (%)	4,742 (4.4)	3,759 (4.3)	166 (5.5)	614 (3.9)	203 (9.2)

Note. ACEs = adverse childhood experience.

reported experiencing PI and homelessness were the least likely to rate their health as excellent or very good (results from the supplemental analysis using the categorical variable revealed the same pattern; Figure S1 in the online supplemental materials), and most likely to have any dental problems, a physical disability/long-term health problem, a mental or emotional problem, diabetes, asthma, and allergies. Additionally, youth who experienced both PI and homelessness were least likely to report seeing a dentist for a problem or for preventive care, but were most likely to report being treated for a mental or emotional problem or treated for a drug/alcohol problem.

In the adjusted models controlling for sex, age, race/ethnicity, poverty status, and region, there were statistically significant differences between groups in general health, physical disability/long-term health problems, diabetes, asthma, and allergies (Table 2). There were also statistically significant differences in receipt of dental care in the past year and treatment for an alcohol/drug problem. Figure 1 shows the adjusted odds for each health and care utilization outcome examined across levels of interaction between homelessness and PI (variable-specific effects for each model are available in Table S1 in the online supplemental materials). Generally, across each of these

Table 2

Adjusted Expected Odds Ratios for Health and Care Utilization Outcomes in a Statewide Sample of Youth in Grades 8, 9, and 11, Overall and by Parental Incarceration and Homelessness Status—Minnesota, 2019

Outcome	No parental incarceration		Parental incarceration	
	No homelessness	Homelessness	No homelessness	Homelessness
Health status				
General health excellent or very good health**	1.80 (1.76, 1.83)	1.29 (1.19, 1.4)	0.94 (0.91, 0.98)	0.83 (0.76, 0.91)
Any dental problems	0.44 (0.43, 0.45)	0.55 (0.51, 0.60)	0.68 (0.66, 0.70)	0.90 (0.82, 0.99)
Physical disability/long-term health problem***	0.16 (0.16, 0.17)	0.19 (0.17, 0.21)	0.23 (0.22, 0.24)	0.35 (0.31, 0.38)
Mental/emotional problems				
Diabetes/prediabetes**	0.22 (0.22, 0.23)	0.40 (0.37, 0.44)	0.52 (0.50, 0.54)	0.90 (0.82, 0.99)
Asthma**	0.02 (0.02, 0.02)	0.04 (0.04, 0.05)	0.03 (0.02, 0.03)	0.08 (0.07, 0.10)
Allergy***	0.18 (0.18, 0.19)	0.19 (0.17, 0.22)	0.25 (0.24, 0.26)	0.34 (0.30, 0.37)
	0.04 (0.04, 0.05)	0.06 (0.05, 0.07)	0.04 (0.04, 0.05)	0.10 (0.09, 0.12)
Health care utilization				
Seen a dentist for that dental problem	2.55 (2.47, 2.64)	1.83 (1.60, 2.10)	1.81 (1.71, 1.91)	1.09 (0.96, 1.24)
Seen a dentist in the past year*	5.37 (5.25, 5.50)	3.20 (2.92, 3.52)	3.07 (2.95, 3.20)	2.13 (1.94, 2.34)
Treated for the mental/emotional problem	0.22 (0.22, 0.23)	0.36 (0.33, 0.40)	0.46 (0.44, 0.48)	0.83 (0.75, 0.90)
Treated for alcohol/drug problem*	0.01 (0.01, 0.01)	0.06 (0.05, 0.07)	0.04 (0.04, 0.04)	0.19 (0.16, 0.22)

Note. Models adjusted for sex, centered age, race, poverty status, and region. Expected odds in adjusted models calculated for the reference group: white female, average age, not in poverty, and in urban region.

Statistical significance of the parental incarceration by homelessness interaction term: * <.05. ** <.01. *** <.001.

indicators, interaction terms showed that youth with a history of PI and homelessness fared worse than their peers who experienced PI but not homelessness, and worse than those who experienced homelessness but not PI. For example, youth with the dual history of PI and homelessness had a 9% greater odds for seeing a dentist in the past year relative to the reference group; youth with the singular experience of homelessness but no PI had an 83% greater odds; and youth who had experienced PI but no homelessness had a 81% greater odds.

Discussion

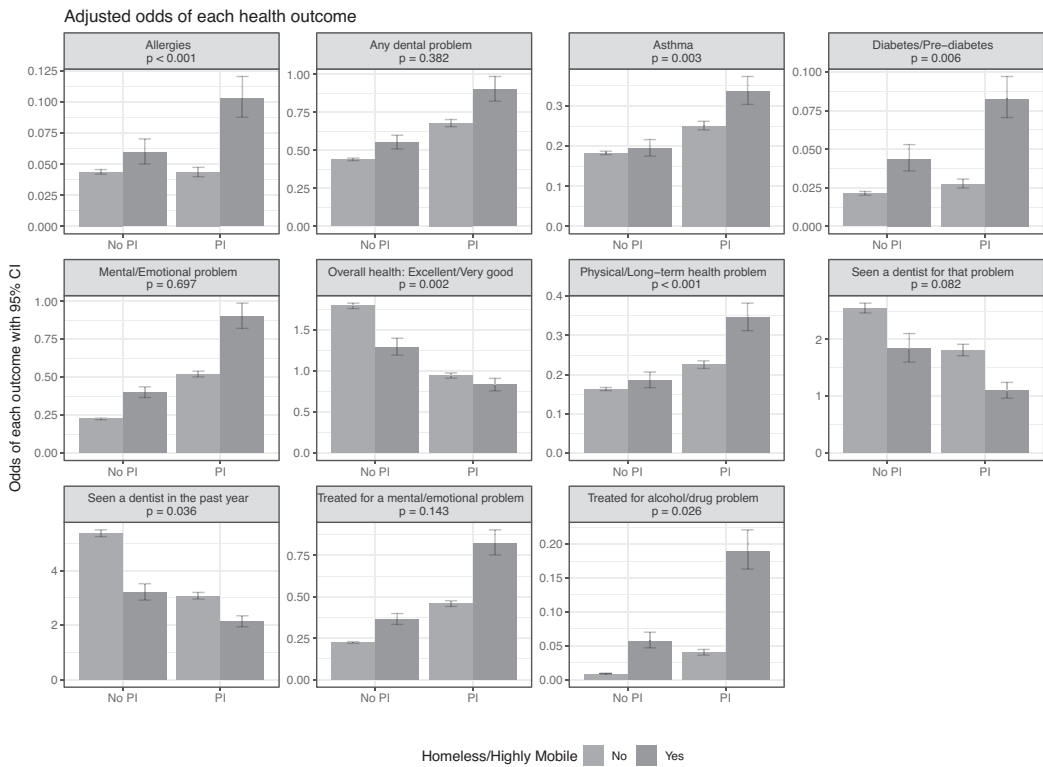
This study sought to examine mental and physical health characteristics and care utilization between youth with and without the experiences of PI and/or homelessness. Results from this study demonstrate the compounding effects of PI and homelessness for youths' mental and physical health and uptake of health care services. Specifically, youth who were homeless in the past year had differential outcomes depending on their history of PI—dually experienced youth less often perceived their own health to be excellent/very good and more often reported physical health conditions. Further, their patterns of health care utilization connoted greater oral and chemical health needs. These findings are

consistent with previous research that has examined health and health care among children with incarcerated parents (Heard-Garris et al., 2018; Lee et al., 2013) and homeless and highly mobile youth (Barnes et al., 2021; Edidin et al., 2012; Gewirtz O'Brien, Edinburg, et al., 2020), and add to a small literature examining PI and homelessness together (Casey et al., 2015; Muentert et al., 2019; Wildeman, 2014). The results extend prior work, illustrating that PI and homelessness not only affect youth health independently but also interactively. By detailing the profile of youth at varied levels of this intersection, our findings imply the potential public health benefits if more resources and political capital were dedicated to preventing these ACEs, rather than trying to ameliorate them after they occur. As Wildeman's (2014) work documented, rises in mass incarceration likely contributed to subsequent increases in child homelessness in the United States. Thus, strategies that disrupt pathways to criminal legal system involvement, such as decarceration (see Hawks et al., 2022), hold potential to prevent cascading ill health effects among children, both directly and as mediated by homelessness.

Although our study design limits our ability to mechanistically understand how these forms of adversity impact health, other literature highlights pathways that could be relevant. For example,

Figure 1

Adjusted Expected Odds Ratios for Health and Care Utilization in a Statewide Sample of Youth in Grades 8, 9, and 11, by Levels of Parental Incarceration and Homelessness Interaction—Minnesota, 2019



homelessness and PI can reflect and/or exacerbate financial instability, in turn resulting in food insecurity, reliance on nutrient-poor foods, and ultimate emergence of diabetes pathophysiology (Tarasuk et al., 2009). Similarly, youth affected by PI and homelessness are more likely to inhabit lower-quality, older housing with heightened exposure to psychosocial and physiologic stressors, such as neighborhood violence or mold (Schapiro et al., 2022). Future studies employing qualitative and causal-oriented methodologies (e.g., path analysis) can help better discern these pathways and offer insights for both primary and secondary prevention.

Limitations

Although the use of large surveillance datasets provides an excellent opportunity to examine the relationships between PI and homelessness, there are a number of limitations to the current study

that must be acknowledged. First, there are several points of ambiguity in the measures of PI and homelessness that could be important and likely have implications for healthcare utilization. For example, for those youth with a history of PI, we cannot know which parent was incarcerated or the frequency or recency of the incarceration. In this study, we combined youth with current and past experiences of PI for this first exploratory analysis, but this may have resulted in an underestimation of the relationship between homelessness and current PI. There are similar concerns with the measure of homelessness, which lacked information about length of homelessness or parental accompaniment status. Conversely, we note the strength of the MSS homelessness item which captures both sheltered and unsheltered homelessness (i.e., doubled-up), overcoming a common limitation in previous studies on homelessness in young people (da Costa Nunez & Adams, 2014).

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However, as the majority of youth under age 18 experiencing homelessness were people in families rather than individuals on their own (Henry et al., 2021), exploring these subgroups is a valuable area for future inquiry. Another limitation is the racial/ethnic diversity of the sample; although the sample largely reflects the state's demographics (U.S. Census Bureau, 2021), it was nonetheless majority non-Hispanic White. Future studies can leverage broader samples to characterize the extent to which our findings differ across race/ethnicity—above and beyond known racial disproportionality in both PI and homelessness. Because this study utilized cross-sectional data, we must refrain from making causal inferences about the effect of PI and homelessness on youths' outcomes. These results should be replicated with longitudinal data that allow for a more nuanced examination of the timing of incarceration and housing instability. Finally, we used data from the 2019 survey, which preceded the COVID-19 pandemic. The pandemic continues to have major consequences for housing stability and the criminal legal system, in ways that are yet to be fully realized. Future research should consider how rates of homelessness and PI varied during and after the pandemic, and the implications of these experiences for children's health and well-being.

Implications for Practice and Policy

Despite patterns of co-occurring risks and adverse outcomes, PI and homelessness are rarely considered together, leading to siloed—and likely ineffective—approaches to addressing the complex needs of these marginalized youth and their families. Nonetheless, longitudinal research suggests that interventions focused on disadvantaged youth may be capable of recalibrating physiologic dysfunction garnered from early life stress (Gunnar et al., 2019) pointing to the value of supporting youth and their families during this developmental window. For example, families could be screened for social determinants of health, including housing and/or incarceration to help identify those in need of additional support during outpatient, urgent, and emergency care visits. Such supports—such as legal aid and social workers—can facilitate acquisition or maintenance of affordable housing following the incarceration of a parent, which could provide crucial stability during the reentry process (Wang & Moore, 2020). Previous research has shown that despite the barriers they

face, youth experiencing family or unaccompanied homelessness have comparable rates of primary care uptake as housed youth (Gewirtz O'Brien, Barnes, et al., 2020), highlighting a key entry point for comprehensive care. Such an approach may help protect youth from the stress associated with residential and educational mobility, possibly circumventing downstream health consequences. Models that integrate and coordinate data across clinical care, education, social service, and housing systems continue to emerge, and may help ensure youth and their families receive timely support in response to developing health and social needs (Heard-Garris et al., 2018; Wang & Moore, 2020).

There is growing recognition from local and state leaders that involvement in the criminal legal system and housing insecurity are interconnected issues. At a structural level, policy approaches that enhance family economic security (e.g., rental assistance) demonstrate promise to reduce penal contact and housing instability (Pilkaskas & Michelmore 2019; Schapiro et al. 2022). Given the health experiences we profile in this study, expansion of strategies to prevent incarceration and improve access to housing should yield collateral population health benefits.

Conclusions

Youth with the dual experience of PI and homelessness are a uniquely marginalized group with heightened risk for physical, mental, and oral health conditions. We recommend that healthcare providers screen for PI and homelessness, along with other ACEs, known to compromise child health and well-being. This could help identify health risks associated with these experiences (e.g., asthma triggers in congregate shelters) to provide appropriate treatment, anticipatory guidance, or referrals. Further, we recommend that policymakers revise existing laws and policies that promulgate mass incarceration, housing barriers for those with criminal legal histories, and economic deprivation. Ultimately, achieving health equity for this group of youth will require effective policy solutions that consider the intersecting determinants, risks, and consequences of both PI and homelessness.

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(Appendix follows)

Appendix

Table A1
Measures and Operationalization of Items Used From 2019 Minnesota Student Survey

Measure	Survey item	Dichotomized response
Health status		
General health	How would you describe your health in general?	1 = <i>excellent, very good, or good</i> 0 = <i>fair or poor</i>
Any dental problem	Have you had any of the following dental problems during the past 12 months? (Mark ALL that apply) ... (a) toothaches or pain, (b) decayed teeth or cavities, (c) swollen, painful, or bleeding gums, (d) could not eat certain foods because of a dental problem, (e) missed one or more school days because of a dental problem	1 = <i>yes (one or more the problems listed)</i> 0 = <i>no (none of the problems listed)</i>
Physical disability or long-term health problem	Do you have any physical disabilities or long-term health problems (such as asthma, cancer, diabetes, epilepsy, or something else)? Long-term means lasting 6 months or more.	1 = <i>yes</i> 0 = <i>no</i>
Mental or emotional problems	Do you have any long-term mental health, behavioral, or emotional problems? Long-term means lasting for 6 months or more.	1 = <i>yes</i> 0 = <i>no</i>
Diabetes/prediabetes	Has a doctor or nurse ever told you that you have ... diabetes? ... prediabetes?	1 = <i>yes (diabetes or prediabetes)</i> 0 = <i>no</i>
Asthma	Has a doctor or nurse ever told you that you have asthma?	1 = <i>yes</i> 0 = <i>no</i>
Allergy	Has a doctor or nurse ever told you that you have an allergy that requires you to carry an epi-pen?	1 = <i>yes</i> 0 = <i>no</i>
Health care utilization		
Seen a dentist for a dental problem	Have you had (the dental problem endorsed above) treated by a dentist?	1 = <i>yes</i> 0 = <i>no, but I will see a dentist or no, I am not able to get dental treatment</i>
Seen a dentist in the past year	When was the last time you saw a dentist for a check-up, exam or teeth cleaning, or other dental work?	1 = <i>during the last year</i> 0 = <i>between 1 and 2 years ago, more than 2 years ago, or never</i>
Treated for mental/emotional problem, N (%)	Have you ever been treated for a mental health, emotional, or behavioral problem?	1 = <i>yes, during the last year or yes, more than a year ago</i> 0 = <i>no</i>
Treated for alcohol/drug problem, N (%)	Have you ever been treated for an alcohol or drug problem?	1 = <i>yes, during the last year or yes, more than a year ago</i> 0 = <i>no</i>

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