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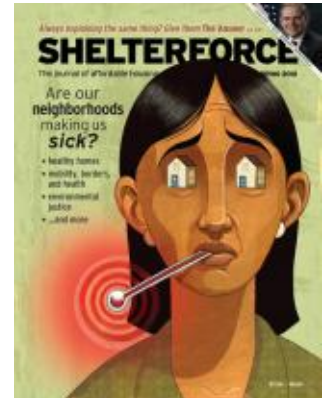
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Prescription for a New Neighborhood

Housing mobility can complement community revitalization for children with serious health challenges. By [PHILIP](#)

[TEGELER AND SALIMAH HANKINS](#)



Kaswana Cook and her daughter Patience relocated through Baltimore's Housing Mobility Program. (Courtesy of Poverty and Race Research Action Council)

Elementary school kids run home after exiting the school bus on the corner of a suburban tree-lined street. Parents and dogs stroll behind. Among the crowd is Nyla, a 9-year-old, brown-eyed, smart, energetic fourth-grader with long braids. She happily passes her classmates laughing as she sprints and bounces up the stairs to her home that she shares with her mom and 16-year-old brother in Orchard Beach, Md.

Nyla is a typical fourth-grader who just a few years ago suffered from a severe form of asthma that prevented her from doing most types of physical activity. Before her mother, Sabrina Oliver, moved to this middle-class neighborhood, she lived in Edmondson Village, a high-poverty neighborhood in West Baltimore known for its crime and soaring asthma rates. At Nyla's old

school, the nurse had a breathing pump ready for her in case they heard that all-too-familiar wheezing that generally accompanies an asthma attack. According to Oliver, Nyla's asthma was so severe that she went to the hospital every two months for treatment. She was even hospitalized for three days while the doctors tried to get her asthma under control.

In addition to her daughter's health, Oliver has had her own struggles with debilitating depression and received disability benefits because of it. Oliver

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The community development and health sectors can and should work together to reduce health disparities and improve everyone's health.

says, “I wanted to get out because of the killings. I wanted a better life for me and my children.” Desperate for change, she signed up for the [Baltimore Housing Mobility Program](#), which helps low-income families move from high-poverty neighborhoods to low-poverty areas of opportunity with jobs, grocery stores, and good schools. “I needed to see past poverty.”

Run by Metropolitan Baltimore, with the support of HUD and the Housing Authority of Baltimore City, the mobility program has moved over 1500 very low-income families to desegregated “areas of opportunity” under a court-ordered settlement from *Thompson v. HUD*, a 1995 public housing desegregation case.

Oliver first moved to Parkville, a suburb north of the city, then to Orchard Beach in Anne Arundel County. Over the three years that she lived in Parkville, her daughter saw a steady improvement in her health, and she’s experienced no symptoms in the six months since the family moved to Orchard Beach.

In addition to her daughter’s health improvements, Oliver says that her depression has lifted. She no longer worries about her kids’ basic safety and was able to get off of anti-depressants and disability. She is now working part-time and has started attending community college.

Different Environment = Better Health?

Was the dramatic improvement in Nyla’s asthma and her mother’s overall mental health the result of her family’s move out of a segregated neighborhood with a severe concentration of poverty? People who work at the Baltimore Housing Mobility Program see stories like this all the time, but are they more than anecdotes?

Yes. The association between residential segregation and minority health disparities is widely documented. David Williams, a professor at the Harvard School of Public Health, calls segregation “a fundamental cause of racial disparities in health in the United States.” These effects are of particular concern for vulnerable children. As professor Dolores Acevedo-Garcia of Brandeis University has observed, “although neighborhood conditions may influence health outcomes in all age groups, exposure to neighborhood disadvantage during childhood may be particularly harmful, as the effects of this exposure may continue into adolescence and adulthood.”

Recent research also points to the potential value of housing mobility in improving some of these negative health effects. In a [2009 article in *Pediatrics*](#), Williams documented the strong links between neighborhood disadvantage and childhood asthma rates, and in a [widely publicized recent report](#) in the *New England Journal of Medicine*, researchers showed that the final data from HUD’s 10-year “Moving to Opportunity for Fair Housing Demonstration,” or MTO, showed significant reductions in obesity and diabetes for women who are given the opportunity to move from high-poverty to low-poverty neighborhoods. Subsequent MTO research showed significant mental health improvements for women and girls who had the opportunity to move to lower poverty neighborhoods. The results from the MTO demonstration are especially remarkable, because MTO is widely acknowledged to be a relatively “weak” mobility demonstration, often moving

families to neighborhoods within the same city and school district, and into neighborhoods that, while low poverty, were not “high opportunity” in relation to communities throughout their metropolitan regions.

The cumulative effect of this public health research and our own experience with families like Oliver and her daughter have led us to ask why HUD can’t move more aggressively to support strong housing mobility programs like the one in Baltimore—especially for the most vulnerable children like Nyla. The savings to the public health system alone could pay for these moves many times over. The moral and legal imperative to improve the health conditions of neighborhoods where so many low-income families live is indisputable, but for the most vulnerable children like Nyla, these improvements will not come fast enough.

Kaswana Cook and Her Children

If Kaswana Cook heard her pager go off, more often than not she would have to drop what she was doing at her job as a housekeeper at a Towson, Md., hospital to rush to the daycare center where her eight-month-old baby, Patience, was cared for, and was probably having an asthma attack. The various medications that had been prescribed for her didn’t work and Cook would race her daughter to the emergency room at Johns Hopkins Hospital to be poked and prodded and—hopefully—saved.

This was a scary, but familiar routine for Cook. These calls came at least twice a month and forced her to miss about 60 days of work a year. “If I didn’t have my FMLA [Family Medical Leave Act] papers, then I would have lost my job,” she says. Frustrated and scared, Cook intuitively knew that her house and her environment in a low-income neighborhood in Baltimore were part of the problem—the air quality, lack of trees and parks, the old, decrepit housing, the roaches and bedbugs, and a toxic gas leak were all factors that had confined her to this torturous routine.

She knew that she needed a way out, so with a housing voucher and the help of the [Baltimore Housing Mobility Program](#), Cook and her family found a new home in Columbia, Md., about 20 miles south of Baltimore.

Today, Patience is a toddler who loves to run in the backyard of her new home—a modest three-bedroom house in a quiet cul-de-sac. In the two years since Patience moved here, she has not had a single asthma attack, not one seizure, not one complication, not one occasion to go to the ER. Was it the new environment? “The change was immediate,” Cook says. “As soon as we moved, her asthma went away.”

Like Patience, her 13-year-old brother Tyrell has seen his own health improve since the move, albeit in a different way. In their old neighborhood, Tyrell literally feared for his safety. He would get regularly bullied by kids who were bigger and tougher than him. “They always picked on him. He didn’t really play sports, he loves school, and he likes reading, spelling, and math,” says Cook.

One day, the bullying took a violent turn when Tyrell was hit in the head with a rock. Tyrell staggered home and when his mother saw him, she was terrified. She rushed him to the hospital where he received ten stitches to his

head.

Since Tyrell moved to Columbia, he has had no problem with bullying. He loves school, is on the honor roll, and is looking forward to studying Chinese and playing the violin next year. He says he has many friends at school and loves his new neighborhood.

“Now that they feel safer, the kids will walk around the trails in the neighborhood,” Cook says, recalling how before her children were afraid to walk outside.

Cook has a new job in Columbia working as a customer service representative at a major retailer and hopes to start nursing school. What’s more, when she hears that familiar beeping sound at work, her heart no longer jumps into her throat. Instead, she knows it is the sound of the truck bringing new stock, and she smiles.

What HUD Should Do

Working with these families motivates us to press HUD to move faster on its housing mobility agenda. We need more programs like Baltimore’s Housing Mobility Program in more cities.

These programs should prioritize children and adults with chronic conditions that are likely to be improved by a move to a lower poverty neighborhood—conditions like depression, obesity, diabetes, hypertension, PTSD, and asthma. But they also need to be available for all the families who want to move to safer neighborhoods with better schools.

Section 8 also needs to be reformed to improve health outcomes through mobility. HUD knows what needs to be done, and Sec. Shaun Donovan has spoken eloquently on the subject: we need a better rent-setting system for the housing voucher program to give families access to rental housing in higher opportunity communities. We need to fix the Section 8 administrative fee system to incentivize mobility, and we need to repair the broken voucher portability system that complicates family moves across PHA “jurisdictional lines.” HUD is working on these issues, but money is tight and the bureaucracy does not always move as quickly as it should.

Although HUD has repeatedly expressed interest in these health-targeted ideas, they are not yet on the policy table—and they will likely stay off the table as long as their only advocates are among civil rights groups. We need our colleagues in the community development field to support mobility programs as a necessary complement to building stronger, healthier low- and mixed-income communities. We need to enlist pediatricians and local public health officials to step up and be heard on these issues as well. As part of this effort, PRRAC has reached out to the [National Medical-Legal Partnership Network](#), and the Joint Center for Political and Economic Studies has included housing mobility as a strategy in its [Place Matters](#) network of county public health officials across the country.

Of course, most families in poor communities will not choose to move, and we in the housing and community development field have a responsibility to continue to work with residents to radically improve their neighborhoods and

schools. But even those families committed to staying have the right to move, especially if they are receiving federal housing assistance. When we are able to make that right a reality, we will have finally created true “neighborhoods of choice.” Our cities and metropolitan areas will be stronger as a result—and our most vulnerable children will be healthier.

Philip Tegeler is executive director of the Poverty & Race Research Action Council, and a member of the Baltimore Regional Housing Campaign.

Salimah Hankins is an attorney and the fair housing associate for the American Civil Liberties Union of Maryland.

[More information about Philip Tegeler and Salimah Hankins](#)

RELATED RESOURCES

- [Resources Prescription for a New Neighborhood? Housing Vouchers as a Public Health Intervention.](#) PRRAC, July 2010.
- [Two Simple Changes to Improve Health Outcomes in the Section 8 Voucher Program.](#) PRRAC, April 2011.
- [New Homes, New Neighborhoods, New Schools: A Progress Report on the Baltimore Housing Mobility Program,](#) by Lora Engdahl. October 2009.
- [“Neighborhoods, Obesity, and Diabetes—A Randomized Social Experiment,”](#) by Jens Ludwig, et al. The New England Journal of Medicine, 2011.

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