Social Science & Medicine 167 (2016) 128–139

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Crime victimization and the implications for individual health and wellbeing: A Sheffield case study

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ARTICLE INFO

Article history:
Received 26 October 2015
Received in revised form
28 June 2016
Accepted 9 August 2016
Available online 15 August 2016

Keywords:
Crime
Victimization
Public health
Wellbeing
Violence
Social model of health
Deprivation
UK

ABSTRACT

Public health and criminology have developed largely independently of one another at the research and policy levels so that the links between crime victimization and health status are not well understood. Although it is not difficult to support the idea of crime as a threat to the health of individuals and the wider community, the difficulty lies in quantifying the impact of crime on public health, while controlling other variables, including gender and ethnicity. We report the results of a study, the goals of which were to: develop an understanding conceptually of the relationships between different types of crime (violent and non-violent) and health; explore the impact of victimization on quality of life and physical and psychological wellbeing; investigate the role of social and demographic factors in shaping any relationships.

The study is based on 840 responses from a postal survey administered to 4,100 households in Sheffield, England, located primarily in deprived areas where overall crime rates were high. Non-violent crimes were more frequently reported than violent crimes and in general, inner city neighbourhoods were associated with higher violent crime rates. Out of 392 victims of crime, 27% of individuals detailed physical injuries resulting directly from a crime event and 31% had taken some medical steps to treat a crime-related injury. 86% experienced at least one psychological or behavioural change, including stress, sleeping difficulties, loss of confidence, and depression. Logistic regression models estimated victimization risk based on various social and demographic variables. Violent crimes were consistently linked with higher odds of seeking medical treatment and a higher likelihood of experiencing psychological ill health effects or behavioural changes. In comparison, victims of non-violent or property crimes were not significantly associated with mental health or behavioural/lifestyle effects.

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1. Introduction

What society deems to be a criminal act has traditionally been the exclusive burden of the criminal justice system, dealt with primarily through the police, courts, and penal system. Although the criminal justice system has served us well in terms of prosecuting criminal acts and enforcing public safety, its resources become significantly overburdened when asked to concentrate more on crime prevention and the provision of additional services for treating and supporting the victims of crime (McManus and Mullett, 2001).

The health sector is unavoidably drawn into dealing with many of the consequences of crime, especially violent crime. Violence is one of the leading causes of death worldwide for people aged 15–34 years (McManus and Mullett, 2001). By definition, violent crime impacts directly on health, while the health effects of non-violent crime may be more indirect or psychological (Khalifeh et al., 2015). The economic cost of dealing with the consequences of crime translates into billions of US dollars in annual healthcare expenditures worldwide, and billions more in terms of work absenteeism, law enforcement, and lost productivity (Blau and Blau, 1982). However, identifying crime as a public health issue remains a relatively new idea, despite the close proximity of both sectors.

Research and policy making in the area of public health adopt a broad, interdisciplinary perspective focusing on population health as the outcome of many factors affecting the lives of individuals, families, and communities in different ways and via many

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http://dx.doi.org/10.1016/j.socscimed.2016.08.018
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pathways (Amick et al., 1995). The *social model of health* articulates these factors within a multidimensional definition of health that includes human well-being, human development, and quality of life, whilst emphasizing a community approach to promoting public health where the goal is to provide the maximum benefit for the largest number of people (Fineberg et al., 1994; Hanson et al., 2010).

The primary goal of this study is to explore and to better understand the impacts of crime on individual health and wellbeing drawing on the social model of health. Specific objectives are to develop an understanding of the conceptual foundation underlying the links between crime (violent and non-violent) and health status, to explore the effect of the victimization experience on quality of life and physical and psychological wellbeing, and to investigate the role of social and demographic factors in the health-crime relationship. The study is interdisciplinary in nature, integrating concepts and methodology from the fields of criminology, public health, and geography.

2. Research background

The research challenge here is to analyze and quantify the impact of crime on public health within a framework that draws on the social model of health. Fig. 1 illustrates our conceptual model linking crime and health. Crime levels are one element of the social environment within which people live their lives. High crime levels combined with material deprivation seriously damage that environment especially if associated with low levels of social cohesion. Social cohesion is, in fact, reflective of the sense of injustice, discontent, and distrust in a community – the greater the level of distrust among individual members, the less cohesive a society becomes (Kawachi and Berkman, 2000). According to social disorganization theory (Sampson and Groves, 1989), a breakdown in social cohesion can lead to crime, which contributes further to conditions that may lead to poor health.

Deprivation has long been associated with poor health, including increased risk of early death and higher rates of illness from certain diseases (Merton, 1957). For example, socioeconomic deprivation has been associated with higher rates of admission to hospital (Struthers et al., 2000) and higher case fatality from heart failure (MacIntyre et al., 2000). Feelings of deprivation originate from comparisons to perceived social norms, which tend to change over time and place. *Absolute deprivation* entails deprivation characteristics that apply to all people with fewest opportunities (the lowest income, the least education, the lowest social status). In contrast, *relative deprivation* refers to feelings or measures of economic, political, or social inequality (Merton, 1957). It is the discrepancy that exists between what a group expects to obtain and what it actually has, or the discontent people feel when compared to others who are more advantaged (Bayertz, 1999).

Relative deprivation is not only associated with public health inequalities, but may also generate high levels of crime, originating from dissatisfaction and unhappiness that can lead to protest behaviour and rebellion (Runciman, 1966). The greater the scale of status inconsistency, the more pressure exists to close the gap and more strenuous efforts made to succeed by fair means or foul (Elbagen and Johnson, 2009). Such “social ingredients” can lead to scenarios that cultivate higher crime rates in neighbourhoods. One reason why greater income inequality or relative deprivation is related to higher crime rates is its tendency to increase social divisions, thereby decreasing social cohesion (Kennedy et al., 1998; Baily, 1984; Messner, 1989).

High crime levels affect how people live and work, and at a group level may affect behaviour and attitudes within communities (see for example, Jeffery, 1971). Some high crime areas have high rates of temporary or permanent disability or even death. Others have high rates of various psychological disorders and self-limited mobility (Alpert et al., 1997; Andrews et al., 2003). In general, victims of crime have a poorer perception of their physical health, more chronic limitations on physical functioning, and more chronic medical conditions (Kirkland and Mason, 1992; Miller et al., 1993; Ullman and Siegel, 1996). The difficulty lies in quantifying the impact of crime on health and disentangling its effects from other confounding variables, such as gender, ethnicity, and employment status (Amick et al., 1995; Cornaglia et al., 2014).

Only a few studies have documented the long-term physical and psychological deterioration of those who suffer stress, fear of crime, repeat victimization, and poverty (Benzeval et al., 1995; Fischbach and Herbert, 1997, Freeman and Smith, 2014; Gowman, 1999; Kilpatrick et al., 1997). McManus (2000) suggested that people living in disadvantaged circumstances and high crime neighbourhoods are more at risk to disability and illness. Some studies have suggested that reducing income inequality would enhance social cohesiveness, which could lead to lower crime rates and better population health (Kaplan et al., 1996; Lynch et al., 1998; Wilkinson, 1996). This further highlights the knowledge gap that exists and the challenges of pinpointing the contribution that crime victimization makes to people's health status.

This study is based on the hypothesis that high crime rate areas are associated with poor health in the resident population.

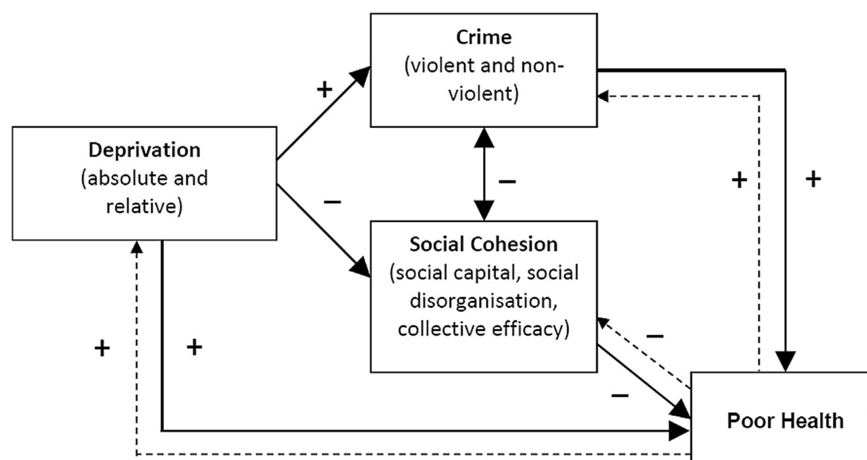

Fig. 1. Conceptual framework of the links between crime, deprivation, and health.

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