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Maternal imprisonment, economic marginality, and unmet health needs in early adulthood

Holly Foster [a,*], John Hagan [b]

[a] Texas A&M University, Dept. of Sociology, MS 4351 TAMU, College Station, TX 77843, United States
[b] Northwestern University and the American Bar Foundation, 750 N. Lake Shore Drive, Chicago, IL 60611, United States

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ABSTRACT

There is relatively little research on access to the health care needed by children whose mothers have been incarcerated, and even fewer studies of how effects of lack of access continue and cumulate as these children transition from living with parents, parent surrogates, or foster care into adulthood. We find in a nationally representative U.S. panel study ($n = 9418$ participants from 1995 to 2007–2008 in the National Longitudinal Study of Adolescent and Adult Health) that young adult children of incarcerated mothers are less likely to receive the health care they need. These effects hold in models that take into account covariates and receipt of health care in the past, a useful control for unmeasured heterogeneity. In this analysis for 2007–2008, economic marginality mediates maternal incarceration on young adult unmet health care needs. Health insurance mediates a smaller portion of this effect. The findings of this research provide important bench marks for assessing the effects of the 2010 passage and the 2013 implementation of the Affordable Care Act [ACA], as well as prospective efforts to change or repeal the ACA.

1. Introduction

Ten percent of young adults (20–29) reported during the 2008 Great Recession that they did not receive needed medical care (Cohen and Bloom, 2010). Recent research suggests parental incarceration is a source of child health problems (Lee et al., 2013; Turney, 2014). The long term implication is that children of incarcerated parents experience heightened risks of chronic health problems that recur and intensify through the adult life course. We examine the role of economic marginality – including early adult unemployment and economic insecurity - as an intervening mechanism that links maternal incarceration to unmet health needs among young adult children. Our goal is to estimate both the association between maternal incarceration and early adult unmet health needs and the role of economic marginality in mediating this relationship.

There are reasons to expect that maternal incarceration is an important experience in the lives of children. Recent studies have found that maternal incarceration is associated with housing instability (Geller and Franklin, 2014) and poor maternal health (Turney and Wildeman, 2015b), both of which may affect child health. Earlier studies reported that maternal incarceration is associated with placement of children with relatives and in foster homes instead of with fathers (Glaze and Maruschak, 2008; Johnson and Waldfogel, 2004; Mumola, 2000). Programs providing access to health care following the placement of these children with relatives or foster parents typically terminate in adulthood (Courtney and Heuring, 2005), increasing the risk of long-term adverse economic and health consequences for children.

Although the recent National Research Council (2014: Chapter 9) report on *The Growth of Incarceration in the United States* summarizes extensive research on paternal incarceration effects on children, there are comparatively few studies of effects of maternal incarceration on children, and this impact is therefore uncertain. Wakefield and Wildeman (2014:73) point out that maternal incarceration could have "null effects" on children's health – apart from other troubled aspects of their mothers' lives. However, conclusions about maternal incarceration have primarily been based on analysis of one source of data on young children (see National Research Council, 2014:270, 275). Wakefield and Wildeman (2014) also warn that "paternal and maternal incarceration leads children into different, but parallel, forms of marginalization" (116), and in a subsequent study Turney and Wildeman (2015a) find maternal incarceration has damaging effects under some conditions.

There is growing evidence that maternal and paternal incarceration have adverse effects on *older* children, during adolescence and early adulthood (Huebner and Gustafson, 2007; Foster and Hagan, 2013; Hagan and Foster, 2012; Lee et al., 2013; Muftic et al., 2016). Hagan and Foster (2015) caution that underestimating economic marginalization effects associated with maternal incarceration, and restricting attention to fathers, may inadvertently result in the kind of selective

* Corresponding author.
E-mail addresses: hfoster@tamu.edu (H. Foster), jhagan@abfn.org (J. Hagan).

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findings that arose from exclusively male sampling in early cardiovascular studies. They also argue that to effectively observe effects of maternal incarceration, it may be necessary to track cumulative processes over time and extending into adulthood. Studies (e.g., Sampson and Laub, 1997; Sykes and Pettit, 2015) indicate that disadvantages such as parental incarceration cumulate and compound for children as they transition through life.

Yet there is little research on cumulative effects of maternal incarceration on adult children (Arditti, 2012). We consider links between both paternal and maternal incarceration and child access to health care, emphasizing the insufficient attention given to economic disadvantage as a potentially marginalizing mediating mechanism resulting from *maternal* imprisonment and leading to unmet health needs among children in early adulthood.

1.1. Maternal incarceration and economic marginalization

The National Research Council (2014:273; also Walmsley 2012, 2015) reports that >200,000 women - nearly a third of all incarcerated women worldwide - are incarcerated in the United States. U.S. incarceration of women is six times higher in 2010 than in 1980 (Kruttschnitt, 2010) and more than two thirds of incarcerated American women are mothers (Glaze and Maruschak, 2008; Mumola, 2000). Research on maternal incarceration suggests that economic and health risks cumulate in women's lives and may compound for their children as well as themselves (Johnson and Waldfogel, 2004; Seigel, 2011; Giordano, 2010; Wakefield and Wildeman, 2014). However, this process is under researched (National Research Council, 2014:275).

Women experience more economic challenges than men before imprisonment. They are more likely to report no place to live, too little to eat, and inadequate clothing (McClellan et al., 1997). Thirty percent of women receive welfare before incarceration compared to 8% of men (Greenfeld and Snell, 1999). Arditti et al. (2003); National Research Council, 2014:267) emphasize that these economic problems are compounded by parental incarceration. For example, housing instability increases following parental incarceration (Geller et al., 2009; Desmond, 2016). Yet while research examines economic marginality as a pathway to female imprisonment, the ensuing gender specific intergenerational consequences and mediating economic mechanisms of effect transmission in the early adult lives of children are under researched.

Theories of economic marginality and female criminality (Chesney-Lind, 1997; Simon and Landis, 1991; Hunnicutt and Broidy, 2004; Steffensmeier et al., 1989) imply pathways to unmet intergenerational health needs. As noted, children of incarcerated mothers may be at risk when they enter adulthood and leave the care of parent(s), parent surrogates, or foster care - all or any of which may have provided childhood access to needed health care – and none of which may be able to do so in adulthood. Youth transitioning through this period, called emergent adulthood (around the ages of 18–34 [see also Arnett, 2000; Furstenberg et al., 2003]) may be especially vulnerable as they navigate *transitions from home to employment and experience economic marginalization* (cf., Danziger and Ratner, 2010); and these vulnerabilities may have increased during the Great Recession of 2008 (Sykes and Pettit, 2015).

Past studies of children's access to medical services consider child's age, gender, race/ethnicity, and maternal education, as well as family resources, including income and insurance status (Aday et al., 1993). Sampson and Laub (1997) stress that bonds between children and parents may be more influential in successful transitions to adulthood than the intactness of nuclear families, but these maternal and paternal sources of influence are incompletely understood. Additionally, insurance status is a robust predictor of medical care among young adults (Cohen and Bloom, 2010; Cheng, 2006), and the absence of insurance identifies youth seen infrequently by physicians (Cheng, 2006; Flores et al., 1999). Maternal college attendance and higher parental education are associated with physician visits for children (Cheng, 2006; Flores et al., 1999), and prior medical care strongly predicts physician contact (Cheng, 2006). African American and Hispanic youth see physicians less often (Cheng, 2006; Flores et al., 1999; Lasser et al., 2006).

The specific measures used in this paper are detailed below. Here we lay out the logic and sequence of our analysis. We begin with a measure of past access to medical care as a lagged control for otherwise unmeasured heterogeneous influences on receiving needed health services (Allison, 1990; more specifically, see National Research Council, 2014:276–277). We simultaneously include maternal and paternal incarceration, measured as time spent in jail or prison. Jail and prison are different, but "the similarities are striking from a health perspective" (National Research Council, 2014:203).

We next introduce background controls for mothers' and fathers' education, smoking, alcoholism, and bonds to the child, which are all identified as risk factors in health outcomes for children of incarcerated parents (National Research Council, 2014: Chapter 7). We further introduce background measures of the young adult child's race and ethnicity, age, gender, and family structure in childhood.

The preceding variables are all controlled in estimating the effects of the Wave 4 measures of economic marginality we introduce next, along with two other potential contemporary mediators also measured at Wave 4: college degree and life-time arrests.

The first of the final group of mediators is a measure of young adult unemployment, followed by living with parents in young adulthood as a possible result, and we then add a measure of whether the young adult child has health insurance. Next we introduce our measure of economic insecurity, which includes problems in paying for housing, utilities, phone service, and food (see Hagan and Foster, 2015; Schwartz-Soicher et al., 2011:5; also Sykes and Pettit, 2015). We also include a measure of whether the young adult child has completed a college degree or been arrested (Brayne, 2014). Schwartz-Soicher et al. (2011:3) note that justice system contact of the child as well as the mother can lead to being ostracized at crucial points when financial and emotional resources are needed to gain access to health care. Our outcome measure is based on responses of young adult children to a survey item asking about unmet needs for medical care.

1.2. Data and methods

Pettit (2012:87–90) observes that the National Longitudinal Study of Adolescent and Adult Health [Add Health] provides unique data to assess effects of parental incarceration on children. Add Health has tracked the children of incarcerated and non-incarcerated parents of youth from adolescence to adulthood, along with measurement of health, school, work experiences and other factors (Harris, 2009).

Add Health began in 1995 by sampling grades seven to 12 in 132 U.S. schools (Chantala and Tabor (2010); Udry and Bearman, 1998). The Add Health data uniquely represents a national cohort born during the onset of mass incarceration. Parents participated in one wave and children in four waves of data collection, with a response rate in 2007/8 of 80.3% at ages 24–32 (Harris et al., 2009), when nearly three thousand (n = 2926/15,701 = 19%) of the wave 4 cohort reported a parent who had been incarcerated (Harris et al., 2009). This number includes special Add Health sub-samples for which there are no sampling weights (see Chen and Chantala, 2014). Our analysis is based on the weighted longitudinal sample, in which 1789 of the youth reported having had an incarcerated parent (n = 1789/out of the longitudinal analytic sample of 9418 = 19%).

Retrospective survey items can recreate cohorts' experiences of fertility, social mobility, and other salient events, including parental incarceration (Brewin et al., 1993; Hagan and Palloni, 1988). Add Health respondents reported parental incarceration reliably: if new onset cases are excluded, the correlation between Wave 3 and Wave 4 reports of parental incarceration is 0.82 ($p < 0.001$). Descriptive statistics are presented in Table 1.