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Discussion

Promoting health equity to prevent crime

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ABSTRACT

Traditionally, research activities aimed at diminishing health inequalities and preventing crime have been conducted in isolation, with relatively little cross-fertilization. We argue that moving forward, transdisciplinary collaborations that employ a life-course perspective constitute a productive approach to minimizing both health disparities and early delinquent involvement. Specifically, we propose a multidimensional framework that integrates findings on health disparities and crime across the early life-course and emphasizes the role of racial and socioeconomic disparities in health. Developing the empirical nexus between health disparities research and criminological research through this multidimensional framework could fruitfully direct and organize research that contributes to reductions in health inequalities and the prevention of crime during the early life course. We also propose that this unified approach can ultimately enhance public safety policies and attenuate the collateral consequences of incarceration.

1. Introduction and background

Due to the staggering social, economic, and public health costs of crime, the development of new conceptual approaches that can better direct prevention are sorely needed. We draw upon seminal knowledge from the health sciences and criminology to fashion an organizing framework to direct research and policy regarding health toward preventing early onset delinquency – a precursor to future contact with the criminal justice system. We propose that greater alignment between health policy and criminal justice policy could result in synergistic benefit, particularly when such policies focus on early prevention and intervention (Forrest and Riley, 2004).

Health disparities researchers have long investigated the existence of health inequalities between different subsets of the population and the processes by which such inequalities are maintained over time (Kawachi et al., 2005; Wang and Beydoun, 2007). More specifically, a large body of scholarship has revealed that race and SES structure exposure to a host of health risks (Kawachi et al., 2005; Wang and Beydoun, 2007), creating racial and socioeconomic disparities in health that are among "the most robust and well-documented findings in social science" (Currie and Stabile, 2002). In a similar fashion, health scholars have highlighted the ways in which the social and developmental *consequences* of ill health are also stratified by race/ethnicity and SES (Braveman and Barclay, 2009). Moreover, economic and occupational success, educational attainment, and life chances in general are likely to be impaired further when individuals of lower social position incur various health risks early in life (Braveman, 2014).

Scholarship on the origins and social repercussions of health disparities has been expanded in recent years by research that employs a life-course framework – a vital theoretical paradigm in the march toward health equity (Braveman, 2014). Overall this body of work suggests that health disparities are not only discernible, but significant during the early years of life and that there are important long-term consequences of these early health disparities for success and well-being during adolescence and adulthood (Palloni, 2006). Although there is an abundance of literature highlighting differential cascading developmental and social challenges that arise from early health disparities (Braveman and Barclay, 2009; Braveman, 2014; Palloni, 2006; Mollborn, 2016; Mollborn et al., 2014), one potential developmental consequence of health inequalities that has largely been overlooked is crime/delinquency. Public health scholarship to date examining the role of early health inequalities in child outcomes has focused on discrepancies in various developmental outcomes that are predictive of delinquency (e.g., low impulse control, cognition, academic performance), but often stops short of exploring early involvement in delinquency as a potential consequence of differential exposure to health risks during the early life course (Mollborn, 2016; Mollborn et al., 2014). Relatedly, transdisciplinary progress on this topic has been limited thus far due to the disciplinary divide between those who study crime (e.g., criminologists) and those who study health (e.g., medical sociologists, public health scholars, epidemiologists).

Still, work that bridges the gap between the health sciences and

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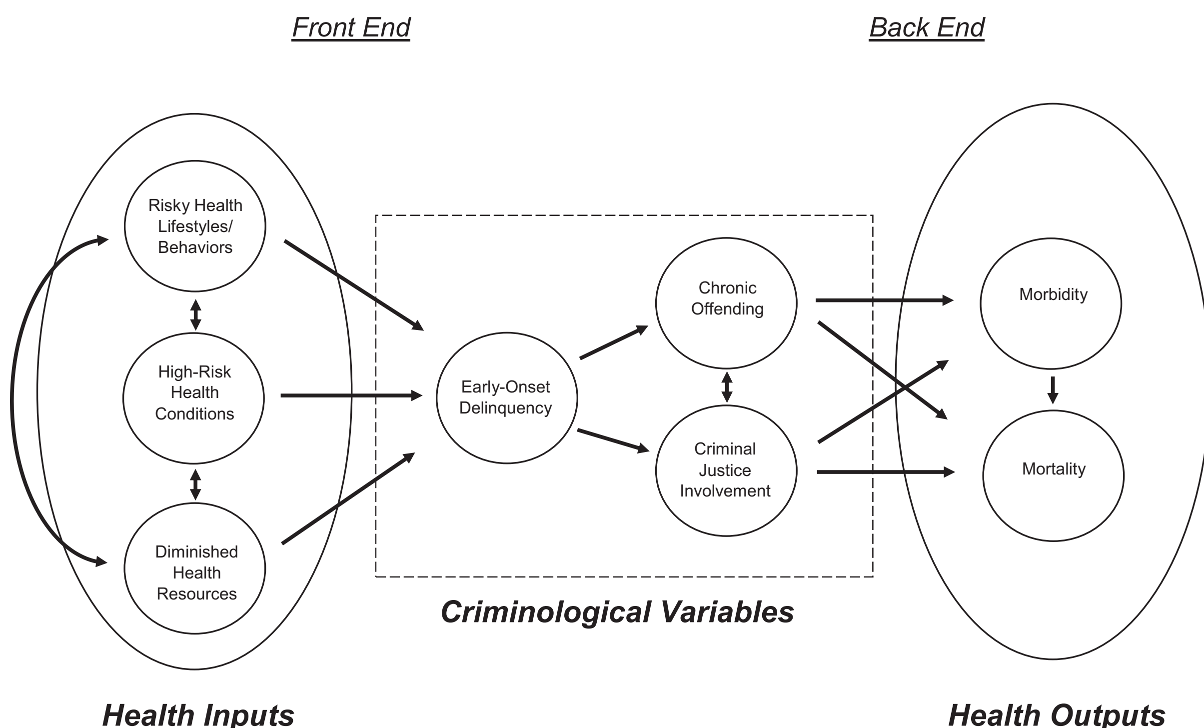

Fig. 1. The interconnections between health, crime, and criminal justice involvement across the life course[1].
[1]Double-headed arrows in this conceptual model denote correlations/covariation between constructs.

criminology is by no means non-existent, even though criminological research on the role of early health disparities in subsequent offending behaviors is lacking. The bulk of extant criminological research linking health and crime is instead typically "back-end" in its approach, exploring criminal justice involvement as a social determinant of health among adolescents and adults. For instance, criminological research indicates that incarcerated adolescents and adults experience a higher rate of morbidity and mortality, relative to non-incarcerated populations (Vaughn et al., 2014). This can include functional limitations, depression, suicidality, pancreatitis, hepatitis, STDs, and poor general health (Vaughn et al., 2014; Schnittker and John, 2007). Incarcerated populations are also more likely to have limited access to health resources and diminished quality of care (Barnert et al., 2016), while also being more likely to engage in high-risk health behaviors post-release (Porter, 2014). Despite the contribution of this literature to our understanding of the linkages between crime, criminal justice involvement, and health, it overlooks the potential role of disparities in *early* health risks for subsequent involvement in crime and delinquency. As Fig. 1 illustrates, scholarship linking health and crime must be expanded to account for interconnections between health, crime, and criminal justice involvement across the life course (i.e., both back-end and front-end processes).

Perhaps even more importantly, extant literature on the nexus between health and crime, including the limited body of "front-end" literature, is largely divorced from research examining racial and socioeconomic health disparities (Jackson, 2016; Jackson et al., 2017; Jackson and Vaughn, 2017). This oversight persists in the face of a strong rationale for overlapping disparities in health and early delinquency that is buttressed by the similar explanations of socioeconomic and racial disparities in both health and offending (Currie and Stabile, 2002; Gallo and Matthews, 2003). Ultimately, possible linkages between health disparities and offending disparities during the early life course are plausible and deserve empirical attention. We propose that disparities in multiple dimensions of health (e.g., health behaviors/lifestyles, conditions, and resources) during early developmental stages (i.e., prenatal/perinatal, infancy, and childhood) can contribute to disparities in subsequent delinquent behaviors. We also propose that these linkages should be examined as a means of preventing crime by promoting health equity during the early life course.

2. Health inequalities and early delinquency: developing a multidimensional framework

The study of the nature and underpinnings of health disparities, or diminished health in the context of social disadvantage, is integral to the intersection of the health and social sciences (Adler and Newman, 2002). This body of research, for instance, has provided evidence for socioeconomic disparities in a host of mental and physical health conditions (Schreier and Chen, 2013). The disparities process can occur in various contexts and through several mediating mechanisms, including adverse housing conditions, neighborhood disadvantage and associated deficits in social capital, and diminished access to fundamental health resources, such as housing and health care (Krieger and Higgins, 2002). Research has also provided evidence for racial/ethnic disparities in health, particularly in the United States (Williams and Jackson, 2005). These racial disparities in health may be partly explained by differential access to social capital, de facto residential segregation into unequal neighborhoods, an ongoing history of racial discrimination, discrepancies in access to medical care, and differential engagement in high-risk health behaviors by minority groups (Williams and Jackson, 2005; Elster et al., 2003). Developmental research has indicated that socioeconomic and racial disparities in health and development during the early life course are in large part due to discrepant developmental ecologies across SES and race/ethnicity (Mollborn, 2016). Broadly speaking, developmental ecologies are the interconnected features of everyday environments within fairly proximate meso-level settings (e.g., home, childcare setting, school, neighborhood, etc.) that mold children, their interactions, and every facet of their development during the early stages of life, including their health (Mollborn, 2016). To the extent that race and SES structure developmental ecologies in a systematic way, health inequalities across race and SES are also likely to emerge, even during early life stages.

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