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The Puzzle of a Silent American Epidemic

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My kiwi medical training instilled a kōrero mai (“speak to me”) philosophy into patient care. A few years before I began medical school, New Zealand opened the celestial doors of its first dedicated children’s hospital, Starship. By the time I graduated, the state-of-the-art Starship still reserved CT and MRI scans for New Zealand’s highest acuity patients. This scarcity of resources pushed me to rely on a hands-on approach to problem-solving.

At the turn of the millennium, I moved to the United States, where my first work experiences transported me to a new galaxy of healthcare. In the organized chaos of San Francisco General Hospital’s emergency room, we routinely ordered CTs and MRIs on trauma patients. In the zen NICU at Stanford Children’s Hospital, we titrated every bodily function with cutting-edge technology.

A few years before my move to the US, the landmark Adverse Childhood Experience (ACE) study identified ten childhood traumas—including the incarceration of a family member—that were associated with long-term negative health and well-being outcomes. Since then, many studies have enhanced our understanding of how the conditions where people live, learn, work, and play (or their social determinants of health) can impact their health and well-being. Trauma-informed care acknowledges the impact of life experiences on patient and provider health outcomes.

While healthcare in the US has transitioned to a more holistic approach, American incarceration rates have eclipsed those of other countries for 20 years, fueling a mass incarceration crisis. Nearly 1 in 2 adults experiences an immediate family member’s incarceration. 1 in 14 American children experiences parental incarceration, making it a more frequent childhood experience than asthma. Many families do not disclose forced separation from a parent because labeling a child by their association with an incarcerated parent can perpetuate trauma. The stigma associated with incarceration can lead to social exclusion and discrimination, including teacher and healthcare provider bias.

My personal interest in children of incarcerated parents turned to advocacy when I discovered that childhood parental incarceration is a silent American epidemic associated with long-term risks to physical, mental, and social health. Parental incarceration also disproportionately affects people living in poverty, as well as racial and ethnic minority groups. Almost 25 years after the ACE study, there is little evidence-based research to inform improved outcomes for children of incarcerated parents, and few pediatric providers are comfortable

caring for this community. However, we know that parents, educators, and healthcare providers play a critical role in helping children develop resilience in the face of adversity.

The *Pediatrics in Review* article “Caring for Children of Incarcerated Parents” is a practical guide packed with tips and resources for healthcare providers to support children of incarcerated parents (10.1542/pir.2021-005466). While there are no validated tools to identify or address parental incarceration, a kōrero or chat with patients whose needs have been historically neglected by the healthcare community is a positive step towards healing.