HEALTH INEQUITIES AND OUR SOCIAL RESPONSIBILITY FOR CHILDREN WITH INCARCERATED PARENTS

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ABSTRACT

There are about 2 million adults incarcerated. Of those, approximately 62% of women and 51% of men have a child less than 18 years old—that is about 4% of the US population (Ghandnoosh et al., 2024; Glaze & Maruschak, 2010; Turney & Goodsell, 2018). In fact, if parental incarceration was considered a chronic health condition, it would be the second most prevalent childhood chronic condition in the U.S. (Axelson & Boch, 2019). These children often already live in impoverished areas and the parental incarceration worsens their financial, educational, physical, and mental situations, forcing them to grow up faster and work harder (Miller, 2006). They are at increased risk of facing more ACEs in childhood and by extension, at increased risk of morbidity and mortality in childhood and adulthood. I did a literature review on the various physical and mental health inequalities these children face. Using that as the foundation, I highlight the social responsibility towards these children. The literature review showed that children are more likely than their peers without incarcerated parents to have higher rates of infant mortality, increased BMI, hypercholesterolemia, asthma, migraines, hypertension, high-sensitivity-c-reactive-protein, ADHD, ODD, conduct and substance use disorder, and lower life expectancy (Austin et al., 2022; Gifford et al., 2019; Holaday et al., 2023; Lee et al., 2013a; Roettger & Boardman, 2012; Sundaresh et al., 2021; Tung et al., 2023). I believe there are many players responsible for the physical and mental well-being of these children: themselves, family, society, and government. They are responsible for seeking help, and family members should prioritize their individual well-being. Society should encourage destigmatization, and the government should decrease costs for communication, and

increase access to healthcare for the children and caregivers. These various agents need to work together to ensure the best health for the children of our future.

I dedicate this thesis to all of the children in the world with incarcerated parents, especially those children in Palestine.

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CHAPTER 1

INTRODUCTION

A critical issue in bioethics is incarceration. This is important because there were about two million people incarcerated in 2022, and 2.7 million children under 18 years old with a parent or parents that are incarcerated (*Children and Families of the Incarcerated Fact Sheet*, 2014; Ghandnoosh et al., 2024). These children are significantly affected by their parent's incarceration, exacerbating their poverty, lower education, and especially poor physical and mental well-being, with children with incarcerated parents having higher morality than their counterparts (Miller, 2006; Sundaresh et al., 2021). In this paper, I will discuss the health effects of having a parent or parents who is incarcerated, what are some potential solutions, and who is responsible for these solutions. In the introduction, I will begin with an overview of incarceration in the US, now, how it has changed over the many years and how it has led to a large, marginalized population of children. I will then delve into the variety of problems these children face, such as financial and educational, and end with a quick introduction to the health inequalities faced.

The number of people incarcerated in the US has multiplied by six over the past fifty years, with about two million people incarcerated in 2022 (Ghandnoosh et al., 2024; Sawyer & Wagner, 2023). Nearly half of this population is located in state prisons, and the other half in federal prisons, federal and local jails, youth jails, and immigration detention (Sawyer & Wagner, 2023). Of those incarcerated, almost 7 in 10 are people of color, even though the lifetime likelihood of imprisonment of Black men has decreased from one in three to one in five black men born in 1981 and 2001, respectively (Carson, 2024; Ghandnoosh et al., 2024). Through a variety of efforts, there has been a 22% decrease in the incarcerated population over the past ten years (Carson, 2024; Sawyer & Wagner, 2023). However, there has been a 2% increase in the past year—with about 565

per 100,000 residents in the US being incarcerated (Carson, 2024; Sawyer & Wagner, 2023). Individuals are spending longer sentences, with about one in seven people in prison serving a life sentence, a 66% increase in the past 20 years (Nellis, 2021). Imprisonment causes worsening economic, social, and physical well-being for those imprisoned and their loved ones, with decreased opportunities to make money, build relationships, and access mental and physical health services, and this disproportionately affects people of color and poorer individuals (Beckett & Goldberg, 2022).

As incarceration increases, so does the number of people with incarcerated family members. Over 100 million adults have an immediate family member who was incarcerated in their lifetime, with about 10 million adults with a parent who has been incarcerated (*Children and Families of the Incarcerated Fact Sheet*, 2014; Sawyer & Wagner, 2023). Almost 2.7 million children (<18 y) in the US have at least one parent currently incarcerated, and half of these children are less than ten years old (*Children and Families of the Incarcerated Fact Sheet*, 2014). In fact, if this was considered a chronic health condition, it would be the second most prevalent childhood chronic condition in the US (Axelson & Boch, 2019). With an incarcerated parent, children are forced to mature faster than their peers to ensure the family's overall well-being. In 2004, the Bureau of Justice Statistics showed that 62% of women and 51% of men in state prison have a child less than 18 years old—with additional research showing paternal incarceration having increased negative consequences for these children (Glaze & Maruschak, 2010; Turney & Goodsell, 2018). This forces these children to be more reliant on the remaining non-incarcerated parent, increasing that adult's responsibilities as well. These children are often already in impoverished areas, worsening their financial, educational, physical, and mental situation (Miller, 2006).

Financially, children have one less person to provide for them, and oftentimes, they are going without paternal contribution to home income. This burdens the remaining caretakers in managing the cost of shelter, food, and necessities. There is also an added

cost of commissaries for the individual incarcerated and the cost of transportation, phone calls, or time off to be able to visit the incarcerated family member—with about 75% of the incarcerated having some contact with their children (Glaze & Maruschak, 2010). Additionally, children with incarcerated parents are more likely to be in special education, have poorer grades/educational attainment, and have more absences relative to their peers without an incarcerated parent (Turney & Goodsell, 2018). Research has shown some association between these children and lower skills in memory, math comprehension, and reading comprehension (Turney & Goodsell, 2018). Perhaps, some of this is due to the physical loss of another adult to check up on the child, but also due to decreased support for the remaining caretaker. Children with incarcerated parents face many financial and educational inequalities as a result of the compounded effect of incarceration.

The incarceration of a parent can change the parent-child bond for life not only because of the suggested crime committed (violent or not) but also because of the physical and emotional distance from one another. This can lead to many physical and mental health inequalities across age spans for these children, including asthma, obesity, hypercholesterolemia, migraines, HIV/AIDs, and changes in behaviors (Turney & Goodsell, 2018). Long-term physical and mental health effects that could potentially be prevented if addressed call for intervention to try and decrease these life-changing effects. This paper seeks to summarize the various physical and mental health inequalities faced by children with incarcerated parents, potential solutions, and the different parties that can contribute to potential solutions for these inequalities.

CHAPTER 2

PHYSICAL AND MENTAL HEALTH INEQUITIES

Now that I have discussed a plethora of inequities faced by children with incarcerated parents, I will refocus on health inequities, discussing the various physical and mental health inequalities faced by these children. In this section, I will start with a review of the original adverse childhood experiences (ACEs) study to help contextualize how childhood events, such as parental incarceration, can lead to long-lasting health impacts.

Adverse Childhood Experiences (ACEs):

Incarceration of a parent is considered one of the many adverse childhood experiences (ACEs) that, when compounded, are associated with an increased risk of the presence of risk factors/disease itself of ischemic heart disease, cancer, chronic lung disease, fractures, or liver disease (Felitti et al., 1998). The original ACEs study from 1998 used mailed surveys in a large US-based health maintenance organization with over 10000 responses to find an association between childhood events and adulthood health outcomes (Felitti et al., 1998). The events were categorized into seven groups: psychological, physical abuse, sexual abuse, violence against the mother, living with people who are substance abusers, have mental illness or are suicidal, or ever imprisoned (Felitti et al., 1998). Interestingly, the study showed that 50% of participants reported at least one of these events. Compared to those who had no exposures, people who had more than four categories of exposures were more likely to have increased risks of substance abuse, mental illness, sexually transmitted diseases, physical inactivity, and obesity later in life (Felitti et al., 1998).

Parental incarceration is one of the recognized adverse childhood experiences (ACEs) that a child faces between ages 0-18 and can cause serious repercussions across the person's life, such as the increased risk of heart disease, depression, substance abuse,

decreased academic achievement, and early death via toxic stress (Turney, 2018; *What Are ACEs?*, n.d.). Children with incarcerated parents are likely to face five times as many additional ACEs as their peers without an incarcerated parent (Turney, 2018). Specifically, these children have increased odds of witnessing violence in the household or having a parent with substance abuse (Rhodes et al., 2023). Evidence shows that the association of having an incarcerated parent and increased exposure to other ACEs ranges across childhood age groups, with children between 0 to 6 having the larger effect (Turney, 2018). Children with incarcerated parents have a higher risk of not experiencing positive childhood experiences, which are protective of mental health illness (specifically depression, behavior, ADHD, and substance abuse) in childhood—three times as much as their peers without an incarcerated parent (Rhodes et al., 2023). This shows that children with incarcerated parents are at increased risk of facing more ACEs in childhood and thus at increased risk of morbidity and mortality in childhood and adulthood.

Healthcare Access and Use

Now that I have established how having an incarcerated parent as a child can lead to lifelong health impacts, I need to explain the differences in the way children with and without incarcerated parents access and use health care. A cross-sectional study using the 2019 National Health Interview Survey Child Sample, a US-based survey of children 2-17 years, looked at the differences in healthcare access and use between these children (Khazanchi et al., 2023). Experiencing parental incarceration was significantly associated with Medicaid/public insurance enrollment, however there was no association with being uninsured (Khazanchi et al., 2023). Children who experienced parental incarceration compared to children who never experienced parental incarceration were significantly less likely to have a consistent location of healthcare and were significantly more likely to have a yearly dental cleaning (Khazanchi et al., 2023). Children with incarcerated parents were significantly more likely to delay or forgo medical, dental, and mental healthcare (Khazanchi et al., 2023). This population was also more likely to frequent the

emergency department and be hospitalized overnight (Khazanchi et al., 2023). This study shows that experiencing parental incarceration was associated with a barrier to accessing healthcare, as they were more likely to not have a stable provider and to delay care despite being more likely to be publicly insured. The decreased access and use of health care exacerbates the existing increased risk of multiple ACEs in children with incarcerated parents. This difference may be due to a variety of factors, including limited time off for the nonincarcerated parent, access to transportation, or a lack of babysitting options for siblings. These behaviors tend to linger into adulthood and are thus a lucrative potential avenue of improvement to decrease overall morbidity and mortality for this population (Heard-Garris et al., 2018).

Physical Health

In this section, I will outline the various physical health inequalities faced by children with incarcerated parents. I will start with a summary of how infants are specifically affected and then proceed into the lifelong physical health effects that can occur. I will conclude this section with an overview of how overall mortality is affected as a result of parental incarceration.

Infants

Infants who had an incarcerated parent pre/during/post pregnancy compared to infants without a parent that was incarcerated were more likely to have a pre-term birth (birth before 37 weeks of pregnancy), low birth weight (<2500 grams), lower Apgar scores, delivery complications, and infant mortality.

Moms incarcerated during pregnancy were more likely than non-incarcerated moms to give birth to a neonate less than 2500 grams and/or prior to 37 weeks gestation, with pregnancy risk adjustments (Austin et al., 2022). In fact, a New York census study showed births in neighborhoods with high incarceration rates compared to neighborhoods with low/no incarceration rates had a 13% higher incidence rate ratio of birth prior to 37 weeks gestation and a 10% higher incidence rate ratio of infants with birth weights less

than 2500 grams even after adjusting for race (Holaday et al., 2023). This shows that being born in a neighborhood with higher incarceration despite other risk factors was associated with pre-term birth and low birth weight, both of which are associated with developmental delays, increased susceptibility to infections, and chronic diseases (i.e., high blood pressure, chronic lung disease) in adulthood. In fact, the leading cause of death in children under five is low birth weight and prematurity (*Newborn Health: Preterm and Low Birth Weight Infants*, n.d.). Parental incarceration, despite other risk factors, showed a significant association with increased rates of prematurity and low birth weight, ultimately increasing the lifetime risk of morbidity and infant mortality.

Overall, infant mortality rates in neonates whose parents were or are incarcerated were higher than in neonates whose parents were never incarcerated. An Australian study showed maternal incarceration within five years prior to birth or during the infant's first year of life correlated with 2.2 times as likely infant mortality for those infants compared to infants with no history of maternal incarceration (Austin et al., 2022). A Centers for Disease Control and Prevention study called the Pregnancy Risk Assessment Monitoring System showed infants that experienced parental incarceration within a year prior to birth had a 49 percent odds increase of infant mortality within the first four months of life compared to infants with no history of parental incarceration (Austin et al., 2022). This shows that across the world, parental incarceration can be associated with infant mortality and thus an important factor to consider intervention to meet one of the United Nations' 17 Sustainable Goals for 2030. This is particularly important for the United States as it has the poorest infant mortality rate despite having the highest healthcare expenditure relative to other high-income countries.

Lifelong Health Impacts

As the ACEs study showed, children with incarcerated parents are more likely than children without incarcerated parents to have increased morbidity into adulthood,

such as obesity, cholesterol, asthma, migraines, hypertension, and increased inflammation. Many of the studies used to make this conclusion utilized longitudinal data from the US National Longitudinal Study of Adolescent to Adult Health (Add Health). This was data collected from the 1994-1995 school year from twenty thousand children between 7th and 12 grades and has been followed every couple of years with the most recent wave, wave V, in 2016-18.

One study using Add Health waves II to IV data showed that women whose parents were incarcerated had significantly higher body mass index than women whose parents were never incarcerated (Roettger & Boardman, 2012). Interestingly, this relationship was not significant in men, and the study further showed that women internalized their stress more and concluded that obesity was the moderator between depression and parental incarceration (Roettger & Boardman, 2012). Parental incarceration is not only associated with depression but also with obesity, which can be a risk factor for a myriad of illnesses and disability.

Researchers used Add Health Wave 1 and 4 data to show in comparison with children who never experienced parental incarceration, children who experienced parental incarceration had a significantly increased prevalence of hypercholesterolemia, asthma, and migraines in addition to other mental health concerns (Lee et al., 2013b). The study conducted further analyses based on paternal versus maternal versus both parents incarceration, and this showed that dual-parent incarceration had a significantly higher adjusted prevalence of asthma (18% vs. 18% vs. 23%), migraines (19% vs. 8% vs. 20%), and PTSD (5% vs. 6 % vs. 6%) relative to the other two groups (Lee et al., 2013b). This shows a difference in impact not only based on the specific parent incarcerated but also on the number of parents incarcerated. Additionally, asthma is one of the top reasons children miss school- missing about 13 million school days each year due to it (Navas, n.d.). Asthma is already more prevalent in children from lower-income populations, and for Black children—who are also the child population that is most afflicted by parental

incarceration—their risk for asthma and eventually missing school is multipliedß as a result.

Another study using the Add Health Wave IV and V looked at the association between parental incarceration during childhood and adult health conditions in the fourth/fifth decade of life (Tung et al., 2023). This study showed parental incarceration to have a 33% increased adjusted odds of having hypertension and 60% times increased adjusted odds of having higher high sensitivity C-reaction protein in comparison to participants without childhood parental incarceration (Tung et al., 2023). Hypertension indicates that a person's arteries are facing increased pressure, causing damage and thus decreasing blood flow and oxygen to the heart and other body organs. Additionally, hypertension increases a person's risk of heart attack, heart failure, stroke, chronic kidney disease, and visual problems (Tung et al., 2023). Therefore, it ultimately increases a person's risk for mortality. High-sensitivity C-reaction protein is a protein made by the liver that indicates body inflammation and, at increased levels, predicts cardiovascular risk (Tung et al., 2023). Both outcomes ultimately indicate an increased risk of death.

Overall Mortality

People who experienced the incarceration of a family member were predicted to live 2.6 years less than those who have not faced family incarceration—black people with about 0.5 predicted years less than white people. An increase in the number of family members incarcerated resulted in increased years lost in life expectancy; however, extended family member incarceration did not have a statistically significant effect (Sundaresh et al., 2021). In fact, children with incarcerated parents were shown to have shorter telomere lengths around 9-15 years old (Toro et al., 2022). Telomeres are repeating DNA sequences at the end of chromosomes, protecting the genetic material. Each time DNA is replicated, the telomere shortens, which is often seen as an indicator of cellular aging. Shortened telomeres have been associated with heart disease, cancer, diabetes, and an increase in mortality (Toro et al., 2022). Interestingly, the majority of the

children in the study showed an increase in telomere length over time, which potentially indicated the transition from poor to better life habits, or perhaps the children were born in lower socioeconomic status and thus had smaller telomeres (Toro et al., 2022). Of note, maternal depression was a mediator in this association (Toro et al., 2022). This continues to show how having an incarcerated parent can affect adulthood outcomes.

Mental Health

Beyond the physical health inequalities, children with incarcerated parents are more likely to have mental health problems and decreased access and use of mental health care than their peers who do not have incarcerated parents. Many children who experienced a parent being incarcerated were often known to have behavioral problems and mental health diagnoses that prevented their ultimate success in school. A mental health diagnosis in childhood is especially important because this can be a predictor of adulthood social impairment and poor quality of life because of the various impacts on life choices, including family life, educational attainment, and occupation (Davis & Shlafer, 2017).

At baseline, even prior to experiencing parental incarceration, these children are more likely than their peers to experience difficult situations testing their emotional well-being. They are more likely than their peers who haven't experienced parental incarceration to have experienced parental divorce, parental substance abuse disorder, parental criminal activity, parental mental health illness, and be a victim of crime, abuse, neglect, or household dysfunction (Ryan et al., 2023). Families who have incarcerated family members compared to those who do not are also more likely to have economic difficulties with loss of income, unstable housing, and reliance on one income. Children with incarcerated parents are more often born into a lower socioeconomic status and have many paths or causes to decrease stability and resilience, increasing their likelihood of mental illness.

A study using the Adolescent Brain Cognitive Development Study data from 2016 to 2019 showed that children with incarcerated parents were significantly more likely to have been to a mental health provider compared to children without incarcerated parents (Ryan et al., 2023). Furthermore, the study found that amongst children with incarcerated parents, Black and Latinx children were less likely to have been to a mental health provider compared to white and non-Latinx children with incarcerated parents (Ryan et al., 2023). More specific to mental health, these children were more likely to be diagnosed with attention deficit hyperactive disorder, oppositional defiant disorder, and conduct disorder. They also were more likely to have received outpatient mental health treatment and mental health medications than children without incarcerated parents (Ryan et al., 2023). Another study showed the association between having a mental illness while having an incarcerated parent and having an adult mental illness. This study concluded that these children had 1.7 times increased odds of having an anxiety disorder and 6.6 times increased odds of having a substance abuse disorder as an adult (Gifford et al., 2019).

Some studies have distinguished the different effects of having a mother versus a father incarcerated. Maternal incarceration was associated with increased depression (Poehlmann-Tynan & Turney, 2021). Children whose fathers were incarcerated were more likely than children whose mothers were incarcerated and children without any parental incarceration to have issues with attention and aggression as well as more internalizing and externalizing behaviors, which resulted in being held back a grade or placement in special education (Poehlmann-Tynan & Turney, 2021) To clarify, externalizing behaviors are when one is being physically aggressive or impulsive and internalizing behaviors are when one has increased anxiety or becoming more withdrawn in emotional response to a trigger. Both responses are significantly associated with lifelong economic and social exclusion and thus, should be prevented (Vergunst et al., 2023).

The mental health of these children is further exacerbated by the literal experience of parental incarceration: being separated from a parent, sometimes as far as hundreds of miles, and only being able to visit under strict surveillance (Davis & Shlafer, 2017). Visiting an incarcerated individual has many security checks for both the incarcerated and the visitor. The area for visiting may not be considered inviting for children or families. This allows for further deterioration of the parent-child relationship, which itself is positively associated with strong mental health (Davis & Shlafer, 2017). Studies have shown that resilient families are able to thrive despite the many anchors caused by parental incarceration; however, that resilience has to have the opportunity to be built with very optimal life experiences that most people do not get to choose or experience (Davis & Shlafer, 2017). Additionally, there is stigma and shame that comes with having a parent who is incarcerated, and this further decays the parent-child relationship and thus, resilience to mental illness.

The incarcerated parent-child relationship is also heavily influenced by the incarcerated parent-nonincarcerated parent relationships. Parental absence can cause worsening behavioral problems, which in turn can make parenting more difficult. In fact, 45% of the association between parental incarceration and the overall stress of parenting these children is due to child health and healthcare strains (Jackson et al., 2022). It is hard for the incarcerated parent to keep up with the child's various appointments from afar and difficult for the nonincarcerated parent to make time to schedule the actual appointments (Jackson et al., 2022). A positive relationship between parents showed a significantly negative association with childhood behavior problems, specifically externalizing behaviors (Jackson et al., 2022). A positive co-parenting relationship was also shown to have a positive association with a positive child mood (Jackson et al., 2022). Parental mental health is also shown an impact on the child's mental well-being. Paternal depression was positively associated with increased internalizing behaviors (Jackson et al., 2022).

The mental health of children with incarcerated parents is often neglected and deserves to be addressed properly. This can impact their future physical and mental well-being in addition to their education and financial well-being. Parental mental health and cohesiveness can impact a child's mental health and should be intervened to ultimately decrease the mental health morbidity in this population to increase the odds of overall life success and achievement for these children.

CHAPTER 3

SOCIAL RESPONSIBILITY

After highlighting the many health concerns for children, I will now try to address what can be done about it and who should be doing it. In this section, I will outline what children with incarcerated parents think would be most beneficial and then use that to extrapolate potential solutions and who could/could not be responsible for these solutions. The big question is who is responsible for the health of these children and the ways in which can society make sure it plays its role. There are many arguments as to who truly is responsible for one's health: self, non-incarcerated and incarcerated family, society, or the government (Bülow, 2023). I will argue that in the case of children with incarcerated parents in the United States, it is the combined responsibility of the non-incarcerated family, society, and the government to protect the health of these children, with the latter two having the most responsibility.

The US government hosted a session for youth with incarcerated parents to voice the support they most desire/require (*Tip Sheet for Mentors: Supporting Children Who Have an Incarcerated Parent | Youth.Gov*, n.d.). They listed six large changes they wanted to feel more supported: be able to visit more and have friendlier visits, communicate more with decreased cost, improved communications between schools and corrections, better information exchange regarding the parent's incarceration, and improved understanding of the impact of mandatory reporting rules (*Tip Sheet for Mentors: Supporting Children Who Have an Incarcerated Parent | Youth.Gov*, n.d.). These changes would allow the incarcerated parent to be more involved in schools and, ultimately, the child's life. They would also allow for a better relationship between the parent and the child, potentially helping with the mental health of both parties involved. Improving or changing the mandatory reporting rules would allow for decreased stigmatization and would also improve, at least, the mental health of these children. With

better mental health, these children and their non-incarcerated parent/family have an increased potential to be able to care for their own health (+ education and financial situation). Making communications/visits more affordable can save families money, allowing them to utilize that for proper nutrition, transportation, education, or clothing, further enhancing mental and physical health. For context, 62% in state facilities and 84% in federal facilities were placed in facilities more than 100 miles from home, and of those federally incarcerated, 43% of parents were placed more than 500 miles from home (*Children and Families of the Incarcerated Fact Sheet*, 2014). The distance from home not only decreases the likelihood of family visitation but also exponentially increases costs for visits. Between visits and phone calls with the incarcerated, one in three families was forced to go into debt (*Who Pays? The True Cost of Incarceration on Families*, 2015). These changes requested by the youth should be feasible solutions to keep the parent-child relationship robust and to decrease additional avoidable stress/trauma caused by simply having a parent who is incarcerated. These are practical solutions, but it is important to consider how this can be applied to health for children with incarcerated parents.

Who Should Be Responsible?

Now that the youth's needs are highlighted, I will walk through the various agents (self, remaining caregivers, society, government) in fulfilling these needs, specifically for health inequalities, and what are some actual solutions they can provide.

Self

Naturally, the first person one may want to blame is the person who is facing the health inequities, but in this case, these are children, and they are affected as an adverse effect of something affecting their parents. One-third of the disease burden in higher-income countries, like the US, comes from intentional behaviors such as smoking, drinking, and unhealthy eating habits ("The Burden and Trend of Diseases and Their Risk Factors in Australia, 1990–2019," 2023). One may argue that it is one's own

responsibility to remedy these habits and prevent morbidity. However, this argument is not valid regarding the health inequities faced by children with incarcerated parents. These children are minors and thus lack the capacity and ability to make decisions for themselves. They are at an increased risk of morbidity and mortality because of the circumstances in which they were born, often poor, underserved areas, and to a parent that either was or will be incarcerated. The child could not have influenced their parent to not be any of those things and thus not be responsible for the health inequities they face. However, the older kids are responsible for voicing their opinions and making sure their non-incarcerated family members are aware of any struggles they are facing.

Family

The next group I will consider is the non-incarcerated and incarcerated family members of the child with an incarcerated parent.

Non-Incarcerated Family

The non-incarcerated family members are often overburdened with their responsibility towards children with incarcerated parents. Thus, their share of the responsibility needs to be lowered. Most of these families are of lower income and lower education status, causing the odds of life to already be against them, even prior to the family member's incarceration (Miller, 2006). The incarceration further worsens the low income as they have one less income to rely on and one less person to share responsibilities amongst. Not only is that one person now responsible for the child's livelihood alone, but also responsible for the additional costs to provide and maintain contact with the incarcerated. These additional costs include court fees, travel to and from the facility, phone calls, emails, toiletries, shoes, clothes, and all other costs incurred because of a sudden shift in having one less person providing. In fact, only 35% of the non-incarcerated family members were able to meet their family's basic needs due to these additional costs (*Who Pays? The True Cost of Incarceration on Families*, 2015). Having less income volatility could allow for better mental and physical health for the

non-incarcerated family members, including the children (West & Castro, 2023). So, a potential solution for this could be for the government to enforce lower costs to not only visit and communicate with incarcerated individuals but also to decrease the cost of commissaries, or at least have an income-based sliding fee system. Besides the financial aspect, non-incarcerated family members are also socially overburdened with caring for children with incarcerated parents. Non-incarcerated family members have a decreased life expectancy, so it is important to protect their physical and mental well-being (Sundaresh et al., 2021). Specifically, it is a very high mental burden for these family members to remain positive for the child while losing a loved one and handling the household responsibilities alone. In fact, 45% of the association between parental incarceration and the overall stress of parenting these children is due to child health and healthcare strains (Jackson et al., 2022). Thus, the non-incarcerated family members of children with incarcerated parents are responsible for at least seeking mental health resources to ultimately be able to better care for the child with the incarcerated parent.

Incarcerated Family

While speaking about family, it is important to also consider the incarcerated family member and what role they play in resolving the health inequities being faced by their children because of their incarceration. In theory, it may seem like the individual incarcerated is fully responsible for the ramifications of their actions on their children. However, it is important to consider a few things, such as prior socioeconomic status, mental illness, and rehabilitation. The majority of the incarcerated parents with children come from lower socioeconomic status, which is further exacerbated for the child after imprisonment. The incarcerated individual cannot be faulted for something they were probably born into as well (Miller, 2006). Many incarcerated individuals struggle with their own mental health and perhaps that played a role in their actions leading to the incarceration (*Mental Health*, n.d.) Additionally, it may be safer for the child for the more violent and harmful parent to be incarcerated and rehabilitated. Regardless, the

incarcerated parent is responsible for their child's well-being, even while inside the facility. First and foremost, the incarcerated individual is responsible for taking care of their own well-being to then be able to provide for their child. As such, they must seek the physical and mental health resources they require. Next, it is their responsibility to maintain communication with their child, remaining family members, and the child's health care providers to ensure a cohesive team for the child. Many prisons may not facilitate these services, but they should be required to maintain strong parent-child relationships.

The family members, incarcerated or not, are responsible for seeking the mental and physical resources they require to be in the best overall well-being to provide and maintain the best well-being for the child. However, they cannot do it without any additional support, and for that reason, they will require help from the general society and the government.

Society

Now that I have discussed the responsibility of the child and their family members, I will now shift to highlighting society's role in decreasing the health inequities faced by children with incarcerated parents.

As a society, in the US, we should be more responsible for the well-being of children with incarcerated parents. We are all made aware of the sheer number of people who are incarcerated in our society, and thus, we must consider the effects this may have on the children of those incarcerated (*Children and Families of the Incarcerated Fact Sheet*, 2014). More specifically, in garnering more interest on the topic, decreasing the stigmatization and marginalization of these children, and encouraging our governments to do what is best for these children.

Children with incarcerated parents are often stigmatized for having parents that did a wrong that led to their eventual incarceration (Phillips & Gates, 2011). Unlike outward disabilities, children can conceal this difference to the public, however they are

forced to disclose where their parents on when asked and that may lead to stigma, whether from other adults or other peers (Phillips & Gates, 2011). And sometimes the stigma may result in the child being more self-aware and hesitant to seek any help because of a fear of rejection and impartial treatment (Phillips & Gates, 2011). This is often based on what the child has been taught is acceptable versus unacceptable behaviors and traits in society. In fact, in Canada, a study showed that the fear of shame and stigma was more harmful than the way the children with incarcerated parents were treated (Phillips & Gates, 2011). This de-stigmatization is especially important for teachers and pediatricians who should also be responsible for ensuring better communication with the family and the incarcerated parent. Furthermore, this would lead to better relationships amongst teachers/pediatricians and children with incarcerated parents increasing their network for support and ultimately leading to better physical and mental wellbeing.

Society is responsible for ensuring the language and behaviors used for those incarcerated and their children are destigmatized. This could lead to better mental and physical wellbeing for the incarcerated individual and their children. Society cannot manage all the changes required for bettering a child with an incarcerated parent's health, thus the public should also rally for changes in the prison system/government that can allow for improvement of the child's health.

Government/Governing Bodies of Prisons

The last agent that may be responsible for the health of children with incarcerated parents: the government/governing bodies of prison systems. The U.S. government can take many actions to ensure the physical and mental wellbeing of children with incarcerated parents. But first, I should establish: why should they?

In 1990s, the United Nations had a convention on the rights of the child to universally provide children with rights that are nondiscriminatory, in the best interest of the child giving the child the right to life and the right to be heard, a few amongst the 54

articles (*Convention on the Rights of the Child*, n.d.). All the countries of the United Nations accepted these rights, except the U.S., where instead, we continue to have things like the death penalty and life imprisonment for children. The U.S. however is committed to the United Nation's 17 sustainable goals (*The U.S. Commitment to the Sustainable Development Goals*, 2023). This population is one where many things are compounded: poverty, food insecurity, lack of social support, and thus requires additional support to achieve good health and well-being for children with incarcerated parents (Miller, 2006; *The U.S. Commitment to the Sustainable Development Goals*, 2023).

Now that I have established why they should do more, I should address what they should do. As previously mentioned, youth with incarcerated parents wanted cheaper and increased ways to communicate with their incarcerated parents (*Tip Sheet for Mentors: Supporting Children Who Have an Incarcerated Parent | Youth.Gov*, n.d.). For this, the governing bodies of prisons can try to place parents of incarcerated parents in closer facilities and potentially provide transportation to and from the facilities for families to be able to have an affordable option for visiting their loved ones (Bülow, 2023). Facilities themselves can also have better visiting rooms that foster engaging relationships between parents and their children, with things such as many books, non-dreary paint, and décor. It is especially important to make sure that children can visit their incarcerated family members without feeling like a prisoner themselves ie. multiple security checks, disrespectful behavior from the guards, etc. The government should also provide free communication access to children with incarcerated parents, so that they do not have to spend more money just to be able to speak to their parents on the phone/video or via email (*Tip Sheet for Mentors: Supporting Children Who Have an Incarcerated Parent | Youth.Gov*, n.d.). The government should also be responsible for providing mental health resources to both the incarcerated individual and their family members to truly provide a rehabilitating service for the incarcerated and provide support for the innocent family members. This should be an opt-out system where everyone is required to have a visit

with a mental health provider but can choose to opt out whenever they choose. This would allow for better mental and even physical well-being for all parties involved, including the children.

The government/governing bodies of prisons are responsible for increasing communication between children and their incarcerated parents and providing mental health resources for the family and incarcerated parent to ensure the overall well-being of all parties involved.

CHAPTER 4

DISCUSSION

Now that we have talked about the health inequities faced by children with incarcerated parents versus those without incarcerated parents and analyzed who is responsible for helping, we should now understand this paper within the context of the research that already exists. I will start by stating the main take aways of this paper, and then I will contextualize this problem in an Urban Bioethics framework, address the limitations of this study, and conclude with future research recommendations.

Key Findings

Children with incarcerated parents are more likely than children without incarcerated parents to face multiple ACEs in childhood, and have increased morbidity and morality throughout their lifetime (Rhodes et al., 2023; Sundaresh et al., 2021). Many studies have shown that these children are more likely to have decreased health care use, increased infant morality and increased mental health diagnoses (Holaday et al., 2023; Khazanchi et al., 2023; Ryan et al., 2023). In fact the mental health diagnoses are also common in the non-incarcerated parent, as well (Jackson et al., 2022) . These children are significantly impacted by their parent's incarceration and it dramatically affects both their mental and physical health starting from infancy all the way throughout childhood and adulthood. The parental incarceration leaves traumatic effects for their lifetime. These are innocent children whose physical and mental wellbeing are being deteriorated as a result of their social environment. Thus, this warrants social change and there are 4 agents that could potentially be responsible for changing these inequities: self, family, general public, and government/governing bodies of prison (Bülow, 2023).

There are many studies that have looked at the differences in health between children with and without incarcerated parents but none that have also outlined the social

responsibility towards these children (Toro et al., 2022; Turney, 2017, 2018; Turney & Goodsell, 2018).

Urban Bioethics Framework

Here, I will contextualize the various agents within an urban bioethics framework, as this is a problem that should be viewed and understood within the social determinants of health (Blustein, 2001). The main principles of urban bioethics are: autonomy, beneficence, and justice (Blustein, 2001). Using these principles I will outline my recommendations for the various agents.

The child with an incarcerated parent is responsible for speaking up for themselves and making sure their support network is aware of what he or she needs to thrive. This is the child's autonomy. However, it is important to consider that as children, not all of them will have the capacity to have autonomy, but those that do are required to be given their autonomy.

The family members of the child also have to speak up about their needs and thus a reflection of their autonomy, but also they have a duty in doing good for the child and preventing the child from harm, beneficence and non-maleficence. In some ways, the parent that is incarcerated may potentially be seen as one that ignored this responsibility by incurring some harm on their child due to the parent's incarceration.

Using the justice, beneficence, and non-maleficence principles, the general public has the responsibility to work towards destigmatizing the language used when speaking about those that are incarcerated in addition to advocating for better conditions for these children and their parents.

The government and governing principles are responsible using the beneficence, non-maleficence, and justice principles in that they should look out for these children's wellbeing by creating communication opportunities, physical and telephone, that are cheaper and more conducive to fostering parent-child relationships.

Limitations

This review is limited by the studies used in this review. They were not all from the United States but were used to generalize to the United States population.

Future Research Recommendations

There is a need for more discussions, such as town halls, with incarcerated parents, their children, and their non-incarcerated family members to find out what needs they have and what they require to best support their health. They can also include various agents, such as people to represent the public (e.g., pediatricians and schoolteachers) and some to represent the government to allow all the main stakeholders to have conversations as to how to best support children with incarcerated parents.

Additionally, there is a need for research to understand how teachers and pediatricians could support these children such as connecting the family to resources for affordable transportation to the prison or setting aside additional time to allow the child to open up. In the future, practitioners should be able to quickly retrieve a resource list/books for the child and their family to use as a guide through the various resources. Research in small group sessions amongst children with incarcerated parents is also needed too understand their relevance and if helpful how could it be implemented, country-wide.

Ultimately, these discussions could lead to research that can analyze specific solutions to find some that lead to the least mortality and lifetime morbidity in this population.

CHAPTER 5

CONCLUSION

There are many children with incarcerated parents in the US and as an ACE that could potentially increase the risk of other ACEs by 5, it is important to address the health inequalities they face and how to manage them (Turney, 2018). These children are more likely to have higher rates of infant mortality, increased BMI, hypercholesterolemia, asthma, migraines, hypertension, high-sensitivity-c-reactive-protein, ADHD, ODD, conduct, and substance use disorder. (Austin et al., 2022; Gifford et al., 2019; Holaday et al., 2023; Lee et al., 2013a; Roettger & Boardman, 2012; Tung et al., 2023). They are also more likely to delay medical, dental, and mental healthcare (Khazanchi et al., 2023). Individuals, who had a family member that was incarcerated compared to those who did not, were predicted to live 2.6 years less (Sundaresh et al., 2021). This is a serious public health/bioethical issue.

As a marginalized population, these innocent children deserve special attention from various agents to help them receive the support they require to thrive. There are many players who are responsible for the physical and mental well-being of these children, including themselves, their non-incarcerated and incarcerated family members, general society, and the government/governing bodies of US prisons (Bülow, 2023). The children are responsible for seeking help, as needed. Family members are also responsible for the child's health and seeking help as needed in addition to caring for their own well being. The general public should discourage stigmatizing incarcerated individuals and should advocate for changes to decrease the health inequities. The government should decrease the cost of communication, physical and virtual/telephone, create environemnts that are inviting for better parent-child relationships, and increase access to healthcare for the children and caregivers. All the different parties need to

collaborate more frequently to alleviate the differences in physical and mental well-being for children with incarcerated parents compared to children without incarcerated parents.

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