

NEW PERSPECTIVES: PART II

How Do We Meet the Unique Medical Needs of Justice-involved Women in our Communities?

Diane S. Morse, MD, and John L. Wilson

Diane Morse is assistant professor of psychiatry and medicine and director of the Women's Initiative Supporting Health (WISH) at the University of Rochester School of Medicine in Rochester, NY. John Wilson is a research intern with the WISH project.

Women face steadily increasing involvement in the justice system and have myriad unmet needs.¹ They are now the fastest growing segment of the US incarcerated population, increasing 646% from 1980 to 2010 or 1.5 times the rate of men.^{2,3} Related to this rapid increase, services are primarily designed for men with justice involvement and have not yet caught up to the needs of women.⁴ It is important for medical providers to understand these trends and the basic steps in arrest and incarceration in order to best treat justice-involved women.

The increasing rate of arrests for women is attributed to many causes, including the mandatory minimum sentencing for drug convictions.⁵ Many of these women will recidivate in and out of large county jails for short stays of days to months. Smaller numbers of women commit violent crimes; thus, women are less likely than men to be incarcerated long term in federal settings. These numbers are growing, however.⁶ When a woman commits a violent crime, it is not unusual for it to be in the context of intimate partner violence (IPV) or self-defense. The man often is not arrested because women's safety concerns prevent them from pressing charges and testifying.⁷ Women reentering the community from incarceration are plagued by comorbid health conditions and face barriers to care on both intrapsychic and systemic levels.⁸ Short-term incarceration in jail with frequent recidivism results in more interruption of medical care than longer-term incarceration in prison.⁹ Short stays create multiple problems: inadequate time to establish needed care due in part to records not being received, appoint-

ments being missed, social instability engendered by recidivism, release without medication, interruption of Medicaid (which then must be reactivated), and breaks in substance abuse and mental health treatment.^{9,10} Upon enacting recent legislation aimed at increasing health care utilization in the United States, Cuelar and Cheema¹⁰ found that 10% of potential Medicaid expansion beneficiaries under the 2010 Patient Protection and Affordable Care Act (ACA) were recently incarcerated individuals. While thousands reenter the community every day and are at risk of recidivism, most efforts to date have focused on prison practices rather than those related to reentry. Prison health care is more likely to include treatment for chronic conditions including HIV,¹¹ hepatitis C,¹² and substance abuse;¹³ unfortunately, it has important limitations. In both jail and prison, there are a lack of gender-specific treatments to address women's unique needs.¹⁴ Individuals from prison face a mortality rate in the first two weeks after release that is 12 times higher than that of the general population.¹⁵ This increased risk is due to suicide, homicide, cardiovascular disease, drug overdose, and health behaviors such as cigarette smoking and unprotected sex.¹⁵ Additionally, recently released women are more likely than their male counterparts to experience mental health, substance abuse, and physical health co-morbidities; to have unstable housing related to IPV; and to engage in high-risk behavior including sex work.¹⁶⁻¹⁸ These are all undertreated conditions that medical providers can and should address.

Stigma and a lack of understanding of the needs of individuals reentering the community from incarceration in-

terfere with subsequent linkage to care.¹⁹ It is typical to label these patients according to their history of incarceration with terms such as "former inmate" and "parolee." These terms tie them to that experience for a lifetime and invite judgment. While it is important for medical providers to routinely inquire about a history of justice involvement in order to address associated risks, documentation and speech should instead utilize phrasing such as "justice involvement." Similarly, it is generally inappropriate to inquire about specifics of any crime or conviction. Doing so will cause shame and not impact health or inform the medical care needs of the individual. In the medical setting, justice-involved women report that feeling judged by providers is a barrier to seeking and obtaining treatment, including prenatal care.¹ Women striving to overcome drug and alcohol addiction are in a particular bind: They are judged for temporarily giving up their children in order to focus on treatment, unlike men who are encouraged to put their recovery first. Childcare is difficult but necessary for women to obtain in order to participate in court appointments, community supervision, and needed social services.¹ One study²⁰ found that the provision of gender-specific wrap-around services for women relating to childcare and work obligations improved recovery and drug court completion outcomes. Since 75% of justice-involved women are mothers,²¹ providers must be cognizant of these challenges. Helping justice-involved women find childcare and other needed social services can prevent stigma by normalizing their difficulties. If a dedicated staff member is not available, it is reasonable to include

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childcare resources among patient handouts in the office. Stigmatizing language should also be avoided in the medical encounter. Medical providers can appropriately inquire about “sex work” and “sexually transmitted infections,” which are less stigmatizing terms than “prostitution” and “STDs.”

Justice-involved and substance-abusing women have an increased likelihood of prior trauma that can negatively impact their health outcomes.²² It has been shown that women in drug court who experience victimization are more likely to have experienced trauma such as child abuse by a personal contact or family member as compared to men, who are more likely to experience random community violence.²³ Such traumagenic factors are likely to be associated with affective disorders.²³ To address such disparities, a variety of gender-specific programs have been developed addressing HIV prevention,²⁴ hepatitis B and C testing,²⁵ and trauma-informed interventions.^{26,27} There is some evidence that these programs can improve outcomes, but more research is needed. Lack of funding for such programs has limited their accessibility and prevented their widespread implementation.²⁸ Access to programs such as gender- and trauma-informed addiction treatment interventions varies by treatment organization.^{14,29} Medical providers should assume that justice-involved women are likely to have a history of trauma. The medical encounter should include questions about past and ongoing experiences, safety planning, and referral to appropriate mental health and IPV agencies. Trauma-informed provider strategies avoid retraumatization by giving patients more control, being supportive, and avoiding judgment.³⁰ Emotional

dysregulation, missed appointments, relapses, and recidivism can lead to such judgment. Motivational interviewing has been shown to be an effective tool in reinforcing healthy behaviors such as cessation of cigarette smoking³¹ in stigmatized populations and can be a helpful way of structuring nonjudgmental interactions. Educating office staff to better manage the behavioral needs of traumatized patients can systemically increase physical and emotional safety for patients in clinical settings. Restructuring of the office to provide physical comfort can be as simple as arranging the waiting room with enough distance between seats³² to ensure adequate personal space.

While medical providers do not control justice system factors impacting patients, they should be aware of them in order to understand the context of care, potentially mitigate patient and public health impact, and express empathy. Racial bias in the system has a large impact. Women of color are disproportionately imprisoned at two to three times the rates of white women.³³ For every 100,000 women in the United States, 47 white women, 77 Hispanic women, and 133 black women will be incarcerated.³ (Rates are even higher for men of color, contributing to racial disparities in opportunities and multi-generational risks.³⁴)

Reentry into the community after incarceration can be especially challenging for women. Jobs, job training, housing, and education can be virtually impossible to obtain in many states where laws limit access for those with felony convictions.³⁵ Many states ban food stamps for people who have committed felonies; as such, 95% of those returning to society after incarceration meet criteria

for food insecurity—a condition associated with increased HIV risk behaviors.³⁶ For women, these challenges can lead to abusive partners and/or sex work, thereby increasing their mental and physical health risks. Innovative projects designed to address these issues include reentry clinics, incorporation of legal assistance in medical settings, and inclusion of on-site social workers in large medical clinics.^{37,38} For practices without these options, providers should offer lists of local community resources to patients.

In summary, justice-involved women are steadily increasing in number and face complex multi-dimensional challenges. Medical providers can facilitate care by addressing medical, psychiatric, substance abuse, and social risks. These risks should be addressed using non-stigmatizing and trauma-informed strategies.

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