Women and the Incarceration Epidemic: What Every Healthcare Provider Needs to Know

The Case of Nicole Anderson
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Case Goal:
Increase student awareness of the incarceration epidemic among women and implications for health care providers

By the end of the case, students will know:

- Prevalence of women offenders
- Demographic characteristics of women offenders
- Health risks & problems commonly experienced by women offenders
- Potential barriers to care
- Pertinent screening protocols

Key Concepts:

- Definitions:
  - Incarceration
  - Recidivism
  - Reentry
  - Jail/ Prison
- Health problems & consequences associated with incarceration
- Implications for healthcare providers
- Cultural competency/ cross cultural efficacy
- Health literacy

Learning Objectives:

After working through this case, the student will be able to:

- Define the prevalence of women offenders and the associated risk factors
- Describe the demographic characteristics of women offenders and how this compares to male offenders
- Describe common health problems experienced by women offenders
- Identify possible barriers to care and possible solutions related to:
  - Access to care
  - Treatment plans/ adherence and compliance
  - Previous experiences
- Identify pertinent screening protocols
- Describe the role of the health care provider in screening and treating women with a history of incarceration.
Facilitator Guide

_Not for Distribution to Students_

The Case of Nicole Anderson

As described above, the goal of this case is to increase student awareness of the incarceration epidemic among women and implications for health care providers. This case will introduce students to key concepts related to social determinants of health specific to incarceration. Students will discuss the prevalence rates and reasons for incarceration among women offenders, demographic characteristics, health risks and issues commonly experienced, barriers to care, screening protocols, reasons for non compliance in patients and how to effectively include questions about incarceration status into the social history.

Learners: This case is for both beginners (pre-clinical) and advanced students (senior medical students and residents). This module is intended for small groups (15 students or less) for an optimal learner experience and discussion of the topic and case.

Instructional Format: With pre-clinical students (beginners), the case should be implemented in two sessions using a traditional problem based learning format. The first session should include an introduction to and review of the case and identification of key learning issues as students progress through Ms. Anderson’s story. The second session should include a robust discussion of some of the key points of Ms. Anderson’s story as they relate to all of the learning issues presented and resources provided in the case. Students should leave the second session and complete the case review understanding incarceration among women and how a history of incarceration can influence patients’ health and health care behaviors as well as the role of the healthcare provider in screening and assessing women who may have a history of incarceration. For more advanced students and residents, the case can be completed in one session that will include both a review of the case, discussion points and provided resources.

Case Organization: The case is organized into 5 sections which include 1) case 2) a narrative section (definitions, characteristics of women offenders and health problems, barriers and challenges to care, health literacy, key points for a focused medical history for women with a history of incarceration and 10 things every health care provider should know about women with a history of incarceration), 3) required resources for review, 4) recommended resources and 5) references.

Additional Considerations: This case may challenge and reveal student stereotypes and biases related to incarceration and treating patients with a history of incarceration. Discussions and learning issues should challenge stereotypes and biases and encourage empathy and understanding of the complicated and multifaceted lives of women with a history of incarceration.
Abbreviated List of Suggested Learning Issue topics

- List major risk factors for heart disease
- Calculate 10 year risk for heart disease
- Medication adherence rates/ reasons for non compliance
- Lifestyle changes recommended to reduce risk of heart disease
- Demographic characteristics of women offenders
- Common health issues associated with women offenders
- The association between abuse and incarceration status
- Health literacy (definition, common concerns and need for plain language, methods to enhance patient provider communication such as the teach back technique)
- Trauma informed approaches to care
- Screening protocols for sexual abuse, domestic violence (intimate partner violence), substance abuse

Additional suggested learning issues are provided as part of the facilitator prompts, questions and discussion points outlined below.
The Case of Nicole Anderson

You are completing part of your internal medicine rotation at the outpatient clinic of your university’s hospital. Your attending asks you to initiate the interview with her first patient, a young African American woman who is new to the clinic.

Clinical Vignette – Part 1

Nicole Anderson is a 29 year old African-American woman. She has come to the clinic for a check up and drug screening needed to fulfill the requirements for a work program she is participating in.

Medical History:

Ms. Anderson states that her last check up was about a year and a half ago and that she was prescribed a medication by the doctor at that time but is unsure of what it was for. “Yes, the last time I did see a doctor, he did give me some medication but I don’t know what the name of it was or really what exactly it was for.” She states that after it was prescribed she took the medication “fairly regularly” but that she stopped taking it completely about 4 months ago. She says that she doesn’t think that she really needed it and also that she didn’t like having to take medication daily so she stopped. Since she has stopped taking the medication though she says she has been fine. She could not recall the last time she had a check up before that time. She admits that she hasn’t been to the doctor very often. She states that she has smoked about a half of pack to a pack of cigarettes a day for about 12 years. She has been pregnant 5 times with only 3 live births. She tells you that she needs for you to complete paperwork for a new job she plans to start soon.

Family History:

Ms. Anderson’s mother suffered a heart attack 8 months ago at the age of 47 and her grandmother died from a heart attack about 6 years ago.

Social History:

Smoking?
Alcohol?
Substance Abuse?
Incarceration?
Living situation?
Sexual hx?
Daily activities?
Facilitator or Independent Study Questions & Prompts

1. What are your initial thoughts about Ms. Anderson?

2. What information do you present to your attending at this point?

3. What else do you want to know about Ms. Anderson at this point?

4. What questions might you include as part of your social history?

What are your initial thoughts about Ms. Anderson?

There are several components of the first section that should be highlighted by students.

Students should comment on Ms. Anderson’s remarks about being prescribed a medication by the doctor but not knowing what the medication is for.

What medication might this be? What condition or disease might this be?

There are several reasons Ms. Anderson may not have understood what the purpose of the medication was. These may include the following:

a. Although she was informed by the doctor that she needed medicine, she doesn’t remember what the medication was.

b. She never fully understood what the condition was that required prescription medication.

Underlying causes for her lack of understanding and compliance could be due to:

i. visits to the clinic which result in seeing several health providers,

ii. poor health literacy,

iii. lack of effective communication

iv. language barriers

v. lack of buy-in of significance of health issue or need for treatment

Students may also want to discuss patient beliefs about medication use and hypothesize some of the reasons Ms. Anderson may have decided to stop taking the medicine. Ms. Anderson states that she doesn’t think she needs the medication. Students should discuss patient perception and the role of asymptomatic illness in patients medication use. Patients who don’t feel sick may be less likely to comply with medication use.

You may also want to inquire about Ms. Anderson’s statement that she doesn’t want to take medication daily. Common reasons for patient non compliance are listed below. Students should discuss this briefly and include it as a learning issue.

- Poor patient-provider communication
- Lack of understanding due to poor education, literacy and language skills
- Lack of consensus about significance of disease and risks of untreated illness
- Cultural beliefs and perspectives
- Patient factors such as denial or depression

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• Psychosocial stressors
• Substance abuse
• Economic hardship / cost of medication
• Side effects
• Lack of trust
• Previous negative experiences

What information do you present to your attending at this point?

Pt is a 29 year old African-American woman here for a check up and drug screening test as part of a work program requirement. Her last check up was 18 months ago when she was given a medication she didn’t take. She has a 6 pack year smoking history. She has had 5 pregnancies and 3 live births. She has a premature CAD history (mother with MI at age 47). No other social history was obtained.

What else do you want to know about Ms. Anderson at this point?
A more thorough history and evaluation of risk factors. A more indepth family history. A social history and sexual health history.

What questions might you include as part of your social history?

Additional Student Considerations

• Students may begin to discuss Ms. Anderson’s heart attack risk due to the information provided about her mother as well as her additional risk factor of smoking, as well as history of Hyperlipidemia, Diabetes (or gestational Diabetes), for example.
• Students should also inquire about the 5 pregnancies with 3 live births and raise questions about were the other 2 pregnancies voluntarily terminated or a result of a miscarriage. What is the relevance of either to this case and Ms. Anderson’s presentation thus far? Do students consider asking about birth control given her 5 pregnancies at the age of 29 and smoking? Advanced learner students might consider the role of unwanted pregnancy as a presentation of reproductive coercion in intimate partner violence settings.
• Lastly, students may also comment on various other components of the social history including asking questions about Ms. Anderson’s current living situation (e.g. Does she live with her children? Does she have family or friends to help with the children?) as well as other questions they may raise regarding substance abuse or incarceration history (however, students may address this later in the case). Students should discuss what questions they typically include as part of the social history and how each is relevant to Ms. Anderson’s presentation and patient care in general (social determinants of health).
You present Ms. Anderson to your attending:

“Ms. Anderson is a 29 year old African American woman who comes to the clinic for a requisite drug screening and check-up before starting a new job. She has no significant past medical history, is not taking any medications, and smokes cigarettes (12 pack years). We completed paperwork, including information on her health and drug screening so that she can begin working.”

**Physical Examination:**

General: Moderately overweight African-American female, sitting in a chair comfortably conversing.

Vital Signs:

- BP: Standing: 165/95 mmHG   Lying: 158/88
- Pulse: 88 BPM   Respiratory Rate: 16/min
- Ht: 5’8”   Wt: 245lbs
- Waist Cir: 44”

HEENT: Optic fundi are normal, without exudates or hemorrhages. She has no papilledema

- Neck: No carotid bruits; normal thyroid
- Lungs: Clear to auscultation and percussion
- Breasts: No masses or nipple discharge, no axillary lymphadenopathy
- Heart: Regular rate and rhythm, normal S1, S2, no murmurs, rubs, or gallops, PMI-5th ICS, midclavicular line

- Abdomen: Soft, non-tender, no masses palpable, no abdominal bruits
- Neurologic: Intact
- Extremities: No edema bilaterally
- Pulses: 2+ and symmetrical
Facilitator or Independent Study Questions & Prompts

What are the key positive and negative findings on examination? What is her BMI? (37.8)

BMI Calculator available at http://www.nhlbisupport.com/bmi/

What is your problem list for this patient?
- Hypertension
- Obesity
- Smoking
- Premature FHx CAD
- Job Placement
- Reproductive care options counseling / safe sex counseling
Clinical Vignette – Part 2

You and your attending discuss the physical examination and next steps to take with Ms. Anderson. You reenter the room to resume your conversation.

Due to Ms. Anderson’s BMI you mention that she is overweight and recommend that she try to lose weight. However, she responds immediately by saying that she just recently gained the weight over the past few months. “I know about my weight but I have gained a lot of weight over the past few months. I have not always been this size.” Then, you ask if there were changes in her diet or activity level to prompt the change in weight. She states that she has not been physically active at all really and she says that her diet did change over the last few months but recently (the last couple of weeks) she has eaten a little differently.

You also ask her if she has ever been told that she has high blood pressure. She says no. It is probably just all of the stress she has had recently. You briefly ask about the stress she mentioned but she responds that things will be better once she begins her new job and again asks if you will complete the paperwork favorably. You then ask if the medication that she was prescribed previously could have been for high blood pressure. She says she doesn’t know and doesn’t really remember what the doctor told her. She also states that she really doesn’t want to take any medications. You tell her that you are concerned about her risk for heart disease because of her family history, weight and hypertension. You recommend prescribing her medication to help control her blood pressure and discuss a weight plan regimen. You complete her paperwork and schedule another appointment with her in 2 months. She states that it may be hard for her to make appointments due to her new job as well as childcare responsibilities but she will try.

Facilitator or Independent Study Questions & Prompts

1. What is Ms. Anderson’s cardiovascular risk?
2. What additional questions would you like to ask Ms. Anderson?
3. What concerns do you have based on your conversation with Ms. Anderson?

What is Ms. Anderson’s cardiovascular risk?

Determining Ms. Anderson’s cardiovascular risk – Students should consider Ms. Anderson’s sex, age, smoking status, blood pressure, and cholesterol level and may consult the NHLBI – 10 Yr. Cardiovascular Disease Risk Calculator (http://hp2010.nhlbi.nih.gov/atpiii/calculator.asp)

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What additional questions would you like to ask Ms. Anderson?

Students should comment on Ms. Anderson’s remarks about her weight gain. “I know about my weight but I have gained a lot of weight over the past few months. I have not always been this size.”

- Do students believe that Ms. Anderson just gained the weight over the past few months as she states?
- If so, what are some possible reasons she could have gained so much weight so fast? Do students list incarceration as a reason for quick weight gain?
- If students do not believe her statement about her recent weight gain, what are their thoughts about why she makes this statement so emphatically?
- What are some weight management strategies recommended by students? Do students consider cost as well as potential barriers discussed by Ms. Anderson including a new job and childcare responsibilities? Do students address any other possible barriers? Students should develop learning issues on evidence based weight management strategies that are contextually relevant for Ms. Anderson.

Ms. Anderson again states that she doesn’t want to take any medications. Students should comment on this remark. What are some possible reasons Ms. Anderson may not want to take medications? Reasons may include personal beliefs about medication use, costs associated with taking medications routinely or she may not feel sick and believe that she needs to take a medicine, among others.

You should discuss these reasons with students focusing on the role of patient beliefs and perceptions on health decisions, economic burden of medications and the possible availability of resources and programs to provide financial assistance to women in similar situations as well as other barriers that students may address.
Clinical Vignette – Part 3

Ms. Anderson misses her appointment in two months. After missing her appointment you check with the clinic pharmacy and learn that she never filled her prescription.

Facilitator or Independent Study Questions & Prompts

Facilitators should guide students through the three major questions presented below. Students can reflect on the previous discussion with Ms. Anderson and some of the points in the conversations that indicated that she may not return to her follow up visit or fill her prescriptions. Again, students should reflect on what some of the possible reasons are for missing her appointment and not filling her prescription. They may also discuss again basic reasons for non compliance.

1. What were some of the red flags in your conversation with Ms. Anderson?
   • Evidence of not being connected with ongoing care
   • Lack of belief that hypertension is a discrete medical condition that warrants treatment versus “all due to stress”
   • History of being lost to care
   • Priority identified as weight not hypertension
   • Preoccupation with new job and childcare (over health issues)

2. What are some of the reasons Ms. Anderson may have missed her appointment? Some examples include:
   • New job may not release her for doctor’s visits (or she may lose the job if she is absent for a doctor’s visit)
   • She does not feel sick
   • She does not want to address issue of why she didn’t take her medicine
   • She is still overweight and doesn’t want to return until she’s lost weight

3. What are some of the reasons Ms. Anderson may have not filled her prescription?
   • Didn’t believe she needed it / doesn’t feel sick
   • Couldn’t afford it
   • Didn’t have time to go to the pharmacy and get it
   • Didn’t want to take a medicine on a continuous basis
   • Feels doctors and drug companies just want to make money by giving out medications for people to take
Clinical Vignette – Part 4

Almost a year has passed and you are now completing a rotation in emergency medicine. The chief resident asks you to initiate an interview with one of the patients. While you don’t recognize the name, as soon as you walk in to the room you realize that this is the patient you had seen awhile ago.

It has been 10 months since you last saw Ms. Anderson. She has come to the Emergency Department with “very bad headaches.” She complains of frequent headaches for the past 2 months which have worsened in the past week, preventing her from working. She states that the frequent headaches are making it hard for her to work and that she cannot afford to lose this job. This past week her headache was accompanied with blurry vision. She remembers you from the last time she saw you in the clinic and she asks if you can please help her because she needs to be able to return to work.

You go out to present Ms. Anderson to the resident. You state that you vaguely remember that you saw her previously and that she was a hypertensive patient. You state that when you last saw her you attempted to discuss her cardiovascular risk with her, counseled her on a weight management plan, and prescribed an anti-hypertensive medication. You recall that she missed her follow-up appointment and never filled her prescription.

You then state how frustrated you are with non-compliant patients. The resident asks you to accompany her while she asks Ms. Anderson some additional questions.

“Hello Ms. Anderson, I’d like to ask you a few more questions about what has brought you here today. I understand you’ve been experiencing bad headaches for the past 2 months and that they have been affecting your work. In the past, have you ever been told that you had hypertension, meaning high blood pressure?”

She states that she remembers hearing the word “hypertension” the last time she visited a doctor and was given a medication, but she felt fine and didn’t see the need to take the medication. The resident explains that hypertension or high blood pressure puts her at risk for other health problems, including things like heart problems and headaches like she’s experiencing now. The resident explains that while high blood pressure can’t be sensed and she may feel fine, the medication lowers blood pressure and reduces her chances of future health complications. The resident asks Ms. Anderson if she understands why the medication was prescribed and if she has ever taken a medication for this condition in the past? Ms. Anderson reports taking some pills a few years ago, but stopped because she didn’t think she needed it and didn’t like taking a pill everyday.

The resident asks her if there have been any recent changes or stressful events in her life that may be related to her headaches. Ms. Anderson says that she’s been trying to get her life together and has been working long hours so that she can support her children. She is afraid of losing her job and custody of her children.
The resident asks her if she uses any drugs or alcohol. Ms. Anderson states “I’ve been clean for 3 years… I can’t risk losing my kids again.” The resident asks her what caused her to lose her children in the past. She states that she was incarcerated for using cocaine and didn’t see her children for 2 years. She is concerned about making her headaches go away because if she loses her job she might lose custody of her children. The resident commends Ms. Anderson for being clean for 3 years and sympathizes with her concerns about her children. Due to her history of incarceration, the resident screens her for a history of sexual abuse and domestic violence. Ms. Anderson screens positive for sexual abuse.

The resident then returns to the discussion of her headache symptoms, high blood pressure and willingness to try a medication. Ms. Anderson states that she’s apprehensive about taking a medication again because “it might make me start using again.” The resident validates her concerns and assures that she will work with her and check in to see how she is doing. She also tells her that she can refer her to a therapist to help her further process her fears of using again and the trauma from the abuse she experienced. She uses the SMART model to develop a plan with her to help her stick to her medication.

1) **Specific task:** This medication is for your high blood pressure. Your high blood pressure may be the cause of your headaches. You take this to help lower your blood pressure and relieve your headaches.

2) **Measurable:** You take this medication once every day for 8 weeks and then you will come back to the clinic and they will measure your blood pressure again to see if it is lower.

3) **Achievable:** You have to take the medication even if you feel fine because it only works if you take it every day. Over time it will gradually lower your blood pressure.

4) **Realistic:** It is helpful to take the medication at the same time everyday with an activity you normally do. This will help you remember to take the medication. For example, you can take the medication each morning with breakfast.

5) **Time frame:** High blood pressure is something that is managed long-term. You may have to take this medication for many months or even years, but it is necessary to lower your blood pressure and prevent you from having future health problems.

Ms. Anderson agrees to try the medication and you set up a follow-up appointment in two months with her in the clinic.
Facilitator or Independent Study Questions, Discussion Points & Prompts

How do students feel regarding the remark about being frustrated with non-compliant patients? How might checking in on how communication is received decrease the frustration?

Discuss the inclusion of screening for a history of incarceration as part of the social history. What were some of the red flags throughout the case that were linked to a history of incarceration? Red flags include specific mention of unexplained gaps in time, (I stopped taking my medication 4 months ago), sudden weight gain, fears that you will sign her paperwork favorably, fear of taking medication routinely (aka, getting ‘addicted to a medicine’) and substance abuse. What opportunities existed for students to have first asked Ms. Anderson about a history of incarceration?

Students should discuss their thoughts about individuals who are incarcerated and biases they may have. Students may also discuss what they know about characteristics of women offenders and identify relevant learning issues. What screening protocols should be used after Ms. Anderson discusses her history of incarceration? What is the association between experiences of sexual or physical abuse, substance abuse, and incarceration in women?

As described below in the narrative, women with a history of incarceration are at increased risk for substance abuse, relationship violence and sexual abuse and should be screened for drug and alcohol abuse, intimate partner violence and sexual abuse.

Students should consider the role of substance abuse in Ms. Anderson’s reasons for not wanting to take medications. In Ms. Anderson’s case, although cost, perception of illness and need to take medications when she didn’t feel sick played a role, her major concern was that taking a medication everyday would somehow “trigger her substance abuse.” Because of her history of substance abuse she doesn’t want to take any medications because she feared it would somehow lead her to start using again. How do students address this concern? While some drugs are habit forming and not recommended for patients with a history of substance abuse, such concerns may not be as applicable for medications prescribed for high blood pressure. How do students recommend addressing this concern with Ms. Anderson? What are other ways the resident could have addressed this concern?

Compounding some of the previously discussed issues is health literacy. The narrative below discusses the role of effective communication in medication adherence using the SMART model. Employment of the SMART model entails: “Specific tasks” that are “Measurable”, “Achievable”, “Realistic”, and have an established “Time frame.”

With a history of incarceration, substance abuse and sexual abuse students should discuss the role of and importance of trauma informed care in caring for patients who have experiences of trauma. Students should discuss what else the resident could have done to address Ms. Anderson’s description of her “stress”, medication use fears, weight management techniques and heart disease risk overall.

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The narrative also describes common terminology associated with incarceration, characteristics of women offenders, and related health issues, health literacy, screening protocols and trauma informed approaches to care. Lastly, as a result of discussing the case, resources provided in the narrative and learning issues students should discuss the health issues of incarcerated women as well as the role of the health care provider.
THE CASE OF NICOLE ANDERSON

Student Materials

You are completing part of your internal medicine rotation at the outpatient clinic of your university’s hospital. Your attending asks you to initiate the interview with her first patient, a young African American woman who is new to the clinic.

Clinical Vignette – Part 1

Nicole Anderson is a 29 year old African-American woman. She has come to the clinic for a check up and drug screening needed to fulfill the requirements for a work program she is participating in.

Medical History:

Ms. Anderson states that her last check up was about a year and a half ago and that she was prescribed a medication by the doctor at that time but is unsure of what it was for. “Yes, the last time I did see a doctor, he did give me some medication but I don’t know what the name of it was or really what exactly it was for.” She states that after it was prescribed she took the medication “fairly regularly” but that she stopped taking it completely about 4 months ago. She says that she doesn’t think that she really needed it and also that she didn’t like having to take medication daily so she stopped. Since she has stopped taking the medication though she says she has been fine. She could not recall the last time she had a check up before that time. She admits that she hasn’t been to the doctor very often. She states that she has smoked about a half of pack to a pack of cigarettes a day for about 12 years. She has been pregnant 5 times with only 3 live births. She tells you that she needs for you to complete paperwork for a new job she plans to start soon.

Family History:

Ms. Anderson’s mother suffered a heart attack 8 months ago at the age of 47 and her grandmother died from a heart attack about 6 years ago.

Social History:

Smoking?
Alcohol?
Substance Abuse?
Incarceration?
Living situation?
Sexual hx?
Daily activities?

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You present Ms. Anderson to your attending:

"Ms. Anderson is a 29 year old African American woman who comes to the clinic for a requisite drug screening and check-up before starting a new job. She has no significant past medical history, is not taking any medications, and smokes cigarettes (12 pack years). Her paperwork was completed favorably, including information on her health and drug screening so that she can begin working."
Physical Examination:

General: Moderately overweight African-American female, sitting in a chair comfortably conversing.

Vital Signs:

BP: Standing: 165/95 mmHG   Lying: 158/88
Pulse: 88 BPM   Respiratory Rate: 16/min
Ht: 5'8"   Wt:  245lbs
Waist Cir: 44"

HEENT: Optic fundi are normal, without exudates or hemorrhages. She has no papilledema

Neck: No carotid bruits; normal thyroid

Lungs: Clear to auscultation and percussion

Breasts: No masses or nipple discharge, no axillary lymphadenopathy

Heart: Regular rate and rhythm, no murmurs, rubs, or gallops, PMI-5th ICS, midclavicular line

Abdomen: Soft, non-tender, no masses palpable, no abdominal bruits

Neurologic: Normal

Extremities: No edema

Pulses: 2+ and symmetrical
Clinical Vignette – Part 2

You and your attending discuss the physical examination and next steps to take with Ms. Anderson. You reenter the room to resume your conversation.

Due to Ms. Anderson's BMI you mention that she is overweight and recommend that she try to lose weight. However, she responds immediately by saying that she just recently gained the weight over the past few months. “I know about my weight but I have gained a lot of weight over the past few months. I have not always been this size.” Then, you ask if there were changes in her diet or activity level to prompt the change in weight. She states that she has not been physically active at all really and she says that her diet did change over the last few months but recently (the last couple of weeks) she has eaten a little differently.

You also ask her if she has ever been told that she has high blood pressure. She says no. It is probably just all of the stress she has had recently. You briefly ask about the stress she mentioned but she responds that things will be better once she begins her new job and again asks if you will complete the paperwork favorably. You then ask if the medication that she was prescribed previously could have been for high blood pressure. She says she doesn’t know and doesn’t really remember what the doctor told her. She also states that she really doesn’t want to take any medications. You tell her that you are concerned about her risk for heart disease because of her family history, weight and hypertension. You recommend prescribing her medication to help control her blood pressure and discuss a weight plan regimen. You complete her paperwork and schedule another appointment with her in 2 months. She states that it may be hard for her to make appointments due to her new job as well as childcare responsibilities but she will try.
Clinical Vignette – Part 3

Ms. Anderson misses her appointment in two months. After missing her appointment you check with the clinic pharmacy and learn that she never filled her prescription.
Clinical Vignette – Part 4

Almost a year has passed and you are now completing a rotation in emergency medicine. The chief resident asks you to initiate an interview with one of the patients. While you don’t recognize the name, as soon as you walk in to the room you realize that this is the patient you had seen awhile ago.

It has been 10 months since you last saw Ms. Anderson. She has come to the Emergency Department with “very bad headaches.” She complains of frequent headaches for the past 2 months which have worsened in the past week, preventing her from working. She states that the frequent headaches are making it hard for her to work and that she cannot afford to lose this job. This past week her headache was accompanied with blurry vision. She remembers you from the last time she saw you in the clinic and she asks if you can please help her because she needs to be able to return to work.

You go out to present Ms. Anderson to the resident. You state that you vaguely remember that you saw her previously and that she was a hypertensive patient. You state that when you last saw her you attempted to discuss her cardiovascular risk with her, counseled her on a weight management plan, and prescribed an anti-hypertensive medication. You recall that she missed her follow-up appointment and never filled her prescription.

You then state how frustrated you are with non-compliant patients. The resident asks you to accompany her while she asks Ms. Anderson some additional questions.

Hello Ms. Anderson, I’d like to ask you a few more questions about what has brought you here today. I understand you’ve been experiencing bad headaches for the past 2 months and that they have been affecting your work. In the past, have you ever been told that you had hypertension, meaning high blood pressure?

She states that she remembers hearing the word “hypertension” the last time she visited a doctor and was given a medication, but she felt fine and didn’t see the need to take the medication. The resident explains that hypertension or high blood pressure puts her at risk for other health problems, including things like heart problems and headaches like she’s experiencing now. The resident explains that while high blood pressure can’t be sensed and she may feel fine, the medication lowers blood pressure and reduces her chances of future health complications. The resident asks Ms. Anderson if she understands why the medication was prescribed and if she has ever taken a medication for this condition in the past? Ms. Anderson reports taking some pills a few years ago, but stopped because she didn’t think she needed it and didn’t like taking a pill everyday.

The resident asks her if there have been any recent changes or stressful events in her life that may be related to her headaches. Ms. Anderson says that she’s been
trying to get her life together and has been working long hours so that she can support her children. She is afraid of losing her job and custody of her children.

The resident asks her if she uses any drugs or alcohol. Ms. Anderson states “I've been clean for 3 years… I can't risk losing my kids again.” The resident asks her what caused her to lose her children in the past. She states that she was incarcerated for using cocaine and didn't see her children for 2 years. She is concerned about making her headaches go away because if she loses her job she might lose custody of her children. The resident commends Ms. Anderson for being clean for 3 years and sympathizes with her concerns about her children. Due to her history of incarceration, the resident screens her for a history of sexual abuse and domestic violence. Ms. Anderson screens positive for sexual abuse.

The resident then returns to the discussion of her headache symptoms, high blood pressure and willingness to try a medication. Ms. Anderson states that she’s apprehensive about taking a medication again because “it might make me start using again.” The resident validates her concerns and assures that she will work with her and check in to see how she is doing. She also tells her that she can refer her to a therapist to help her further process her fears of using again and the trauma from the abuse she experienced. She uses the SMART model to develop a plan with her to help her stick to her medication.

6) **Specific task**: This medication is for your high blood pressure. Your high blood pressure may be the cause of your headaches. You take this to help lower your blood pressure and relieve your headaches.

7) **Measurable**: You take this medication once every day for 8 weeks and then you will come back to the clinic and they will measure your blood pressure again to see if it is lower.

8) **Achievable**: You have to take the medication even if you feel fine because it only works if you take it every day. Over time it will gradually lower your blood pressure.

9) **Realistic**: It is helpful to take the medication at the same time everyday with an activity you normally do. This will help you remember to take the medication. For example, you can take the medication each morning with breakfast.

10) **Time frame**: High blood pressure is something that is managed long-term. You may have to take this medication for many months or even years, but it is necessary to lower your blood pressure and prevent you from having future health problems.

Ms. Anderson agrees to try the medication and you set up a follow-up appointment in two months with her in the clinic.
**Narrative:**

**Definitions**

There are several terms commonly used related to incarceration. Please review the following resources to become familiar with these terms.

The following definitions were retrieved from the Bureau of Justice Statistics:
http://bjs.ojp.usdoj.gov/content/reentry/definition.cfm

*Parole* - a period of conditional community supervision following a prison term. If the conditions of supervision are violated, the parolee can be returned to prison to serve any of the remaining portion of the sentence.

*Parole violators* are offenders who are returned to prison for violating the conditions of their release or for a new offense committed while under parole supervision.

*Recidivism* – refers to a previously incarcerated individual who commits any criminal acts that result in the rearrest, reconviction, or return to prison of previously incarcerated individuals with or without a new sentence during a three-year period following the prisoner’s release.

*Reentry* is a broad term used to refer to the transitioning of offenders from prison back to the community.

Additional definitions can be found on the Bureau of Justice Statistics website at:
http://bjs.ojp.usdoj.gov/index.cfm?ty=tda
Incarceration & Women's Health

**Women Offenders:**
Female offenders represent a vulnerable population of women with many needs who have survived very troubled communities (Richie et al., 2001). While males are incarcerated at much greater rates than females overall, incarcerated women represent the fastest growing incarcerated population and minorities are disproportionately represented (Hatton et al., 2006; Braithwaite et al., 2005; Mullen et al., 2003; Clarke, 2000; Young 1998). The number of female inmates has increased over four fold since the 1990s with about 60% of women being sentenced for drug convictions (Richie et al., 2001; Bell et al., 2004). However, only up to 10% of women with substance abuse problems receive drug treatment while incarcerated (Richie et al., 2001).

Women offenders are often economically disadvantaged, have lower levels of education, have experiences of abuse and may report homelessness prior to incarceration (Bell et al., 2004). Most female offenders are reproductive age and approximately 10% are pregnant when arrested (Maeve, 2003; Bell et al., 2004). Between 70-80% of women offenders are mothers to dependent children and unlike male offenders are often the primary caregiver at the time of incarceration (Braithwaite et al., 2005; Wolf, 2006). As a result children of women offenders are more likely to be placed in foster care (Wolf, 2006). Moreover, children of incarcerated parents are at increased risk for later incarceration (Richie et al., 2001).

**Health Problems:**
Prior to incarceration, women offenders often have complex life situations, are uninsured or underinsured, have not received routine primary care and in general have poor health (Hatton et al., 2006; Alemagno et al., 2004; Braithwaite et al., 2005; Clarke, 2000). Many women may have exchanged sex for drugs or attempted suicide (Hatton et al., 2006). Consequently, many of these women have multiple health needs and suffer from chronic and infectious health conditions. Several women report medical problems at the time of imprisonment (Hatton et al., 2006; Young, 1998).

Many incarcerated women, (between 60 -70%) report histories of physical or sexual abuse or both (both childhood and adult) and may be at increased risk for substance abuse, high risk pregnancies as well as sexually transmitted diseases (Hatton et al., 2006; Braithwaite et al., 2005; Freudenberg et al, 2005; Alemagno, 2004; Richie et al., 2001; Clarke, 2000; young, 1998). The trauma from such abusive experiences is often a contributor to both physical and mental health problems (Wolf, 2006).

<table>
<thead>
<tr>
<th></th>
<th>Probation</th>
<th>Local Jails</th>
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<tr>
<td>Ever physically or sexually abused</td>
<td>41%</td>
<td>48%</td>
<td>57%</td>
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<tr>
<td>Both</td>
<td>18%</td>
<td>27%</td>
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**Women and the Incarceration Epidemic: What Every Healthcare Provider Needs to Know**
The Case of Nicole Anderson
Curriculum Development, Piloting and Evaluation Supported by the Valentine Foundation
Health problems commonly reported include the following (Wolf, 2006; Hatton et al., 2006; Alemango, 2004; Maeve, 2003; Richie et al., 2001; Young, 1998):

- Alcohol and drug abuse
- Infectious diseases including STDs and HIV
- Chronic diseases (asthma, hypertension, diabetes, epilepsy, etc.)
- Pregnancy and gynecological problems
- Obesity
- Dental disease
- Depression and other mental health problems
- Domestic Violence

Related symptoms commonly reported include the following (Young, 1998):

- Pain/ cramps/ irregular menstrual flow
- Headache
- Sleeping difficulty
- Depression/ suicidal thoughts

Such medical conditions are found at much higher rates among incarcerated women as compared to women in the general population (Alemagno, 2004; Young, 1998). Women offenders often report limited and inconsistent health care prior to their incarceration however; connection to health care upon release is an important contributor to health and well being (Maeve, 2003). In a study conducted by Freudenberg and colleagues (2005) unmet health needs or having a STD since release predicted recidivism for a drug related offense. In addition, having health insurance reduced the risk of dealing drugs after release from prison (Freudenberg et al., 2005). Another study reported that women who connected with health services after they were released were less likely to be rearrested (Bell et al., 2004).

Women have shorter sentences (Wolf, 2006) than men and most women return to their communities after incarceration. Returning with the same or additional health issues is a significant public health concern especially concerning infectious diseases (Hatton et al., 2006; Restum, 2005; Young, 1998).

**Barriers & Challenges to Care:**
The complicated lives and histories of female offenders along with the multiplicity of psychosocial and substance abuse problems and overall health needs can present unique challenges for health care providers (Alemagno, 2004). Economic challenges, addiction and high prevalence of depression may contribute to additional barriers to care in community venues (Bell et al., 2004). Additional challenges may include documenting an accurate history due to fear and distrust of authority figures including health care providers, previous negative health care experiences and lack of awareness of history (Alemagno, 2004). Some of the tools provided below can be used to address some of these barriers.
Health Literacy

Limited health literacy may also pose a significant challenge (Adams & Leath, 2002). Seventy percent of prisoners demonstrated limited literacy according to the National Adult Literacy Survey (NALS). Moreover, health literacy is defined as the “degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” (US DHHS, 2000) The literacy demands of health materials frequently exceed the reading abilities of the average American adult. Language frequently used in the medical encounter is filled with medical terminology and scientific jargon. Because there is social stigma attached to acknowledging reading difficulties or vocabulary limitations, patients may mask these difficulties to preserve their dignity. Therefore a health-care provider’s ability to use common words and perceive whether a patient understands risks and tasks to be completed is an important determinant of the quality of the interaction and ultimately the patient’s health.

Patients with lower health literacy and chronic disease are less knowledgeable about their conditions. They may have difficulty understanding their diseases, risk factors, key prevention or promotion practices and medication regimens. This underscores the importance of bridging the health literacy gap to promote better patient health outcomes. One method to enhance the understanding among patients with low health literacy is the “teach back” or “show me” technique. In this approach clinicians ask patients to explain key concepts and instructions discussed in order to demonstrate understanding (Williams, 2002). Other recommendations include giving information slowly and using “living room” language, drawing pictures, writing down key instructions or tasks, limiting the amount of information given at each interaction and repeating instructions.

Another tool that may facilitate effective communication and medication adherence is the SMART model*. Employment of the SMART model entails: “Specific tasks” that are “Measurable”, “Achievable”, “Realistic”, and have an established “Time frame.” As an example, the SMART model can be applied to medication regimens.

1) **Specific task:** describe the medication and what condition the medication is being prescribed for

2) **Measurable:** describe how the medication should be taken. How much should be taken and how often? Also, describe the desired health outcome of taking the medication

3) **Achievable:** the medication should be appropriate for the desired health outcome

4) **Realistic:** the medication regimen should be easy to integrate into a daily routine. Perhaps provide quick suggestions like taking the medication at the same time daily to help patients with this.

5) **Time frame:** describe how long the medication should be taken to achieve the desired health outcome (Is it for short term or long term use?)

Women and the Incarceration Epidemic: What Every Healthcare Provider Needs to Know
The Case of Nicole Anderson

Curriculum Development, Piloting and Evaluation Supported by the Valentine Foundation
Trauma Informed Approaches to Care:

The relationship between past experiences of trauma and the incidence of negative health outcomes warrants special attention. For example, a history of being abused dramatically increases the chances that a woman will abuse alcohol or drugs (Covington, 2007). One study found that 74% of addicted women report a history of sexual abuse, 52% reported physical abuse, and 72% reported emotional abuse. Because there is such a strong association between trauma and other issues such as substance abuse, it is important to integrate trauma theory into services for women.

Trauma theory posits that the impact of trauma on human functioning needs to be fully recognized in order to appropriately treat affected individuals. This theory stresses the importance of physicians taking a trauma-informed approach to care. This is an approach that acknowledges the importance of the biological, psychological and emotional effects of trauma and violence. This approach is informed by knowledge and understanding of these experiences in patients and how these can influence health as well as the medical encounter. It also involves creating a trauma-sensitive culture within institutions.

Trauma is not limited to suffering violence; it includes witnessing violence as well as stigmatization because of gender, race, poverty, incarceration, or sexual orientation (Covington, 2007). The term trauma encompasses both the event itself and the response to the event or negative experience. Symptoms of trauma include: depression, substance abuse, anxiety, eating disorders, risk behaviors, chronic hyper arousal, flashbacks, and withdrawal/avoidance. Post-traumatic stress disorder (PTSD) is one consequence of trauma. PTSD is an anxiety disorder that can develop after exposure to one or more terrifying events that threatened or caused grave physical harm. It is a severe and ongoing emotional reaction to an extreme psychological trauma. Some of the symptoms associated with PTSD include re-experiencing the event through nightmares and flashbacks, avoidance of stimuli associated with the event, estrangement from other people, and hyper vigilance. Somatic manifestations of PTSD can include pain, disability, gastrointestinal, cardiopulmonary, neurologic, or reproductive dysfunction.

For these reasons, it is necessary for healthcare providers to understand trauma theory as a conceptual framework for clinical practice and to provide trauma-informed care for their patients (Covington, 2007). Trauma-informed services should do the following:

- Consider the trauma patients have experienced
- Avoid triggering trauma reactions or retraumatizing the woman
- Adjust behaviors to support the woman’s coping capacity

Dr. Judith Herman describes a three-stage model for trauma recovery: 1) safety 2) remembrance and mourning and 3) reconnection. The “safety” stage focuses on caring for oneself in the present. Experiences in the criminal justice system can trigger memories of earlier abuse. It can be traumatizing when a survivor of sexual abuse has a body search or must shower with male correctional officers nearby. Furthermore, incarceration itself can be traumatizing and the racism and class discrimination that are
characteristics of the criminal justice system can be further traumatizing (Covington, 2007). “Remembrance and mourning” focuses on trauma that occurred in the past. Women in this phase often begin to acknowledge the incredible amount of loss in their lives. In the third stage, “reconnection”, the focus is on developing a new self and creating a new future (Covington, 2007).

Dr. Sandy Bloom has also created the Sanctuary Model (http://www.sanctuaryweb.com/sanctuary-model.php) which represents a trauma-informed method for creating or changing an organizational culture in order to more effectively provide a cohesive context within which healing from psychological and social traumatic experience can be addressed. It aims to provide care grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans. The Sanctuary Model includes training in trauma theory, attachment theory, and dissociation for all administrators, staff, and support staff. It encourages a shift from perceiving clients or patients as “sick” or “bad” to injured people who have already survived significant adversity. Furthermore, it fosters a comprehensive understanding of the individual and social legacy of trauma.

Additional information about intimate partner violence can be found at the Women’s Health Information Blog at http://whepducom.blogspot.com/2010/08/intimate-partner-violence-more-and.html
Focused Medical History for Incarcerated Populations

What NOT to ask:
- About the nature of or reason for incarceration
- About past criminal history
- Any information that would not directly inform the quality or appropriateness of their medical care

What to ask:
✓ Screening questions for substance abuse including drugs (prescription and illicit) and alcohol prior to, during, and since incarceration
✓ Screening questions regarding physical or sexual abuse or violence prior to, during, and since incarceration
✓ Past medical history prior to, during, and since the time of incarceration
✓ Mental health history and treatment prior to, during, and since the time of incarceration
✓ What medical care or attention (if any) they received during incarceration, including substance abuse programs
✓ Sexual history prior to, during, and since the time of incarceration including information about the number of partners, the nature of the sexual encounters (Has she ever exchanged sex for money or drugs or other compensation?)
✓ Last screening for any STIs or infections such as HIV, Hepatitis B and C, etc.
✓ Assess patient’s readiness and willingness to remain abstinent from substances
✓ Discuss the importance of the concurrent treatment of both mental health issues and substance abuse or addiction disorders
✓ Medical insurance status so as to work within patients’ means in developing treatment strategies
1. Women represent the fastest growing incarcerated population.

2. While a majority of women are sentenced for drug convictions only a small portion receives drug treatment while incarcerated.

3. Most incarcerated women are of reproductive age and approximately 10% are pregnant when arrested.

4. 60-70% of incarcerated women report histories of physical or sexual abuse or both.

5. Incarcerated women are at increased risk for substance abuse, high risk pregnancies as well as sexually transmitted diseases.

6. 3-4% of incarcerated women have HIV/AIDS, but less than 50% are tested.

7. Unmet health needs or having a STD since release predicts recidivism for a drug related offense.

8. Those who connect with health services after they were released are less likely to be rearrested.

9. Limited health literacy poses a significant challenge to obtaining care.

10. Great need for qualified physicians to serve this population of women!
Required Resources for Review:

Justice/Prison

- Bureau of Justice Statistics: http://www.ojp.usdoj.gov/bjs/

Heart Disease & Women


Obesity

- Weight Control Information Network WIN http://win.niddk.nih.gov/publications/medical.htm#challenge

Health Literacy:

- Plain Language.Gov: http://www.plainlanguage.gov/

Trauma Informed Approaches to Care

- Stephanie S Covington, PhD, LCSW - http://www.stephaniecovington.com/books.php
- Sandra L Bloom, MD - http://www.sanctuaryweb.com/sanctuary-model.php
Additional Recommended Resources

Domestic Violence:
- National Coalition Against Domestic Violence: http://www.ncadv.org/
- Futures without Violence: http://www.futureswithoutviolence.org/

Domestic Violence Screening Protocol: RADAR
(http://www.instituteforsafefamilies.org/pdf/healthcare/AdultRADARcard.pdf)

Additional Intimate Partner Violence & Sexual Violence Assessments
The following is a link to a number of Intimate Partner Violence & Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings


Sexual Abuse
The following is a link to the sexual assault screening tool of the American Congress of Obstetricians and Gynecologists
http://www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=1477

Alcohol Abuse: “CAGE”

Drug Abuse: “CRAFFT”
http://www.mayoclinicproceedings.com/content/85/4/380.full

Health Literacy
- Health Communication Activities:
  http://www.health.gov/communication/literacy/quickguide/

- National Center for Education Statistics:
References:


Young, D. Health status and service use among incarcerated women. Family and Community Health. 1998; 21(3):16