TRAUMA ON A SPECTRUM: IDENTIFYING AND MANAGING TRAUMA SYMPTOMS AND DYSREGULATION IN CORRECTIONAL HEALTHCARE SETTINGS

By Elizabeth Martin, Ph.D., Consulting Psychologist, Centurion; Seairah Reedy, Psy.D., CCHP-MH, Vice President of Psychological Services, Centurion; Setarreh Khan-Mohammadi, Psy.D., Clinical Operations Behavioral Specialist, Centurion

Trauma comes back as a reaction, not a memory.” - Bessel van der Kolk, MD

Currently, trauma-informed care is being regarded as the most humane approach to healthcare and is especially necessary in correctional settings based on the high lifetime prevalence of traumatic experiences in incarcerated individuals. Researchers have posited new diagnoses of trauma and their findings suggest that trauma should be viewed on a spectrum. With regards to viewing trauma on a spectrum, research has indicated that there is a gamut of trauma-related problems that occur which are specific to the traumatized individual and are dependent on many factors including the age at which the trauma occurred, the individual’s relationship to the agent responsible for the trauma, social support received, and the duration of the traumatic experience(s) (van der Kolk, 2000). Therefore, we know that each individual has distinctive and varying reactions to traumatic experiences based on the aforementioned factors. Despite individuals’ processing trauma differently and subsequently presenting with a wide range of symptoms, we do know that regardless of how individuals react to trauma, the lingering effects of trauma live in our bodies and dysregulate our nervous systems (van der Kolk, 2014). Therefore, there are concrete somatic strategies that can be used to treat a wide range of trauma symptoms. There are many different types and definitions of trauma. For many, trauma is perceived as a single, terrifying event, such as a sexual assault. Yet, as practitioners it is important that we are aware of often overlooked types of trauma such as childhood maltreatment (e.g., abuse and neglect in childhood), collective (e.g., the COVID-19 pandemic), transgenerational (e.g., trauma passed on throughout generations such as in descendants of Holocaust survivors), and vicarious (e.g., responding to a patient’s suicide).

Speaking to rates of Posttraumatic Stress Disorder (PTSD) and exposure to trauma, research has found that incarcerated individuals have significantly higher rates of both exposure to trauma and PTSD than the general population. In fact, research indicates that 99 to 100% of incarcerated individuals report exposure to at least one traumatic event in their lifetimes (Gosein et al., 2016; Wolff et al., 2014). Likewise, rates of PTSD range from two to ten times higher in incarcerated individuals than in community samples (Facer-Irwin et al., 2019; Wolff et al., 2014).

In assessing the impact of trauma on our patients, and keeping in mind that trauma should be viewed on a spectrum, it is crucial to remember that not all individuals exposed to a potentially traumatic event develop trauma symptoms or PTSD and others develop symptoms that do not fit the PTSD diagnosis. Trauma psychiatrist and researcher Bessel van der Kolk, MD (2002), noted, “It has become clear that in clinical settings the majority of traumatized patients seeking patients suffer from a variety of psychological problems that are not included in the diagnosis of PTSD.” As such, it is important that providers are familiar with an increasingly-researched diagnosis, although one that remains excluded from the DSM: Complex PTSD (van der Kolk, 2002).
CALL TO ACTION - 
VOICE YOUR SUPPORT OF CORRECTIONAL MEDICINE TO ACGME

By Dr. Charles Lee, MD, JD, CCHP-P, President, ACCP

The Accreditation Council for Graduate Medical Education (ACGME) is considering formal recognition of fellowship programs in “carceral medicine” (an emotion-free term suggested as a replacement for “correctional medicine”). Recognition would encourage major clinical institutions to plan and support educational and practical programs of one to two years in length, increasing both the level of professional respect for carceral physicians (not to mention nurses, physician assistants, advanced practice nurses, and so on) and likely the number of professionals who consider jails and prisons for their professional work settings. Many examples of the importance of this type of recognition exist, perhaps nowhere so impactful as in emergency medicine, which after recognition moved from being a clinical backwater to being a respectable career choice.

There is currently an active comment period during which the ACGME will receive comment from interested parties. Nowhere will we find parties more interested than in the current crop of correctional medicine practitioners; excuse me, the carceral medicine practitioners. There is an insert here in CorrDocs that also outlines the call for comments.

I, Dr. Charles Lee, current ACCP president, am in place to encourage your thoughtful comments and share them with the approval committee. The proposal itself is short; twenty-one pages including the Executive Summary, not including appendices and bibliography. It is too long to publish here in CorrDocs but not too long for you to download and review it, either briefly or in detail.

I believe that this type of formal recognition will create a generally accepted quality bar which itself will help our patients and our peers. Healthcare is currently grappling with the Quadruple Aim, a group of four goals which are sometimes in conflict. These are improvement in patient outcomes, improvement in patient satisfaction, improvement in provider satisfaction, and increase in healthcare efficiency (lowering of costs). The Quadruple Aim is a concern that the ACGME will consider as it reviews the fellowship proposal.

My attitude on this is clear. Formal recognition by the ACGME would be a major step in the journey from “why would you work in a prison?” to “you have a special range of experience and expertise which contributes to healthcare inside and outside of the carceral community.”

Please use this URL to view the proposal: https://www.acgme.org/what-we-do/accreditation/new-specialty-or-subspecialty-proposals. Comments (whether general or line-by-line) are due to the ACGME by July 8, 2022. The comment form can be found at corrmedrandc.docx (live.com).

“IRONY IS…”
PRACTICING MEDICINE FROM THE BENCH

By Rebecca Ballard, MD, FACCP, CCHP-P

April 18, 2022 - “Irony is me going the entire pandemic without getting COVID and then two days after they lift the mask mandate on planes…Get COVID-19”

Ironic? That’s cute. Many of us call it science.

That was a Facebook (aka Meta) post by a pilot acquaintance who contracted COVID shortly after April 18, 2022, when little-known Florida federal judge Kathryn Kimball Mizelle struck down the Biden administration’s public transportation mask mandate.

The mandate was not removed because the risk of COVID was eliminated, not even minimized to the point of safe congregation. It was centered on the ancient debate of personal rights vs public good that has resounded since the beginning of COVID.

As the virus became embedded in our communities in early 2020, the arguments for and against “sheltering in place,” closure of non-essential businesses, mask mandates, etc. rolled across the country, often in the wake of COVID’s steady progression. Very few jurisdictions preemptively took action before the virus’s grip took hold. The arguments focused on personal freedom’s importance over the public’s health. As we saw, those that put priority on the public’s health were able to “flatten the curves” of infection, hospitalization, and death.

Once vaccines were available, the debate arose anew with mandates for specific occupations. It seemed every time a new step was taken in combatting the epidemic, there were many who thought it was a step backwards for individual rights.

I was genuinely surprised with the fervor the public health measures were met with. It seemed to me that individual rights are moot if there are no individuals left to enjoy them. Public health, in effect, protects personal rights by keeping the community healthier. We’ve been living with these, complying with them without argument for decades.

Where I live, we must wear shoes to enter any public establishment. It’s a law designed to protect the health of our feet so we don’t contract or spread plantar warts, tinea pedis, and the like. Many are also disgusted at the thought of stepping on floors where other’s bare feet had been. I’d be interested to find out how many of those resisting wearing a mask on a plane would feel about stepping on the body scanner barefoot after hundreds of people had stood barefoot on it before them.

Where I live, we must wear a shirt to enter any public establishment. I cannot think of a health reason for that one to be honest with you. I think it was more for the comfort of the patrons, not wanting to see exposed torsos while shopping or eating.

Where I live, I can’t bring my dog into stores or restaurants by decree of the public health department.

Somehow the consequences of all these public health regulations seem to pale in comparison to those of a deadly epidemic that can also lead to “long hauler” effects, yet there is deafening noise demanding the right to do what we want with our bodies and to keep the government off them (I’m not even going to down the abortion angle right now).
INTRODUCTION INTO POINT-OF-CARE ULTRASOUND (POCUS)

By Jena J. Lee, MD, Medical Director, Topeka Correctional Facility, Kansas

Point-of-care ultrasonography (POCUS) refers to the use of bedside ultrasonography imaging to provide immediate clinical information for diagnosis and management of a variety of conditions. Its use is well established in the emergency department and many hospital-based specialties. Since smaller, portable, and less expensive ultrasound devices arrived on the market, there has been increasing interest in POCUS as an aid to the traditional physical examination. POCUS may be used in assessing not just acutely ill patients, but also in resource-limited outpatient settings where it has the potential to decrease delays in obtaining consultative ultrasounds or replace them altogether. 1

In a study to determine whether POCUS performed by physicians changed the diagnosis or treatment of patients in mobile clinics in rural Uganda, researchers found that it facilitated confirmation of the suspected clinical diagnosis in up to 50% of cases and supported a change in the initial diagnosis in 23% of cases. 1

Multiple studies have demonstrated how task-shifting from traditional physical examination to POCUS can overcome care challenges sometimes observed in countries with lower socioeconomic status. Locations with limited diagnostic infrastructure and limited specialized healthcare personnel saw improved health outcomes and reduced costs. POCUS provided definitive diagnostic information that reduced hospital stays, referrals, and resource expenditure.

One might wonder why correctional medicine has not followed in the growing utilization of POCUS seen in the general outpatient setting. True, many of the same POCUS barriers in the outpatient setting affect the correctional medicine community, including learning new psychomotor skills, developing training and quality assurance programs, and incorporating its use in practice as novices require more time to learn while managing competing clinical responsibilities. 6, 11 Despite these concerns, as an addition to our diagnostic armamentarium, POCUS would likely provide correctional healthcare settings with improved diagnostic capabilities, expedite workups, and augment resources in our underserved populations.

Personal POCUS Experience

I would like to share a few brief experiences in my nascent foray in utilizing POCUS in the correctional setting and describe how it provided clear, cost-saving, diagnostic benefits, improving my care management.

Working at a women’s correctional facility, we tend to have waves of patients complaining of post-prandial right upper quadrant pain. Often we would add them to a list for an abdominal ultrasound. However, since our ultrasound service comes to our site about once a month, there can be significant delays in obtaining diagnostic information.

After receiving two POCUS units to trial at our site, we have been able to avoid that delay and even have directed several patients directly to surgery due to obvious abnormalities found by POCUS. Most recently, a patient was found to have a large, distended gallbladder with thickened and fibrotic walls upon surgical excision after our POCUS exam identified the possible need for a cholecystectomy.

Prior to our new POCUS units available in the examination room, we would have had to wait for an outpatient scheduled ultrasound appointment, a period of weeks during which complications could have developed. POCUS permitted us to provide diagnosis and treatment more rapidly and avoid a delay during which an elective cholecystectomy could have turned into an urgent one.

We are still learning on our POCUS units and find many opportunities to practice using these machines during daily clinic hours. Due to patient numbers and hours in a day, it is not feasible to POCUS every day, but when you find yourself in a situation where there is diagnostic uncertainty, it helps in the evaluation and possibly the diagnosis.

In one case, a woman came to the nursing sick call clinic with spontaneous urticaria and angioedema (not involving the airway) with blood pressures in the 90s/60s (not her normal). The patient was admitted to the infirmary and treated for a possible allergic reaction, with consideration for other causes of edematous states such as heart failure. One of the handheld POCUS machines we were testing was equipped with Artificial Intelligence (AI) cardiac echo analysis software, which provided a quick assessment of the patient’s cardiac function, essentially ruling out heart failure with an EF of 57%.

POCUS is also a great tool to document and support a provider’s rationale for a referral. When making a case for referring a patient to a specialist, POCUS can provide supporting images to be uploaded into an EHR if available.

In another example, consider a patient with four weeks of knee swelling and pain who, while hospitalized for an unrelated issue, had a dry tap by orthopedic surgery. Upon return to the correctional site, while waiting for an MRI to be performed, two more attempts to access the effusion were made, but each time the tap was dry. Then we performed an ultrasound-guided arthrocentesis, which verified needle placement in the suprapatellar pouch.

POCUS is also a great tool to document and support a provider’s rationale for a referral. When making a case for referring a patient to a specialist, POCUS can provide supporting images to be uploaded into an EHR if available.

In another example, consider a patient with four weeks of knee swelling and pain who, while hospitalized for an unrelated issue, had a dry tap by orthopedic surgery. Upon return to the correctional site, while waiting for an MRI to be performed, two more attempts to access the effusion were made, but each time the tap was dry. Then we performed an ultrasound-guided arthrocentesis, which verified needle placement in the suprapatellar pouch.

Photo 1: POCUS AI driven auto ejection fraction

Photo 2: Needle visible on the left of the picture entering the suprapatellar pouch with reverberation artifact just below the needle.

Continued on Page 9...
IRONIES AND IRON CAGES: A LOOK INSIDE A STATE CORRECTIONAL FACILITY

By Christine Lu, MD, PGY-1 Psychiatry Resident Leader, The Wright Center for Graduate Medical Education

M y co-resident and I, psychiatric residents at The Wright Center for Graduate Medical Education, recently had the opportunity to visit the mental health unit (MHU) at SCI-Waymart, a correctional facility in a neighboring town. This MHU’s psychiatric service is headed by Dr. Sohrab Zahedi, a forensic and correctional psychiatrist, who invited us to shadow him and peek into a small piece of his world to learn, and possibly imagine, if we could envision correctional psychiatry becoming a part of our future careers.

The setting of the facility was unassuming, housed just a few hundred feet behind a small neighborhood in Waymart, Pennsylvania. Our escort met us at the sally port and walked us to the building where the MHU was housed. The grounds seemed so serene, nothing like I’d imagined, with Victorian style buildings and a cool, green, scenery and vast sky that was only mildly interrupted by the barbed wire fences. And as I walked onto the MHU, it felt like walking back into the hospital unit I just left.

MHU’s structure includes a central nursing station with monitoring capabilities; art and other positive messages cover the walls; and a basketball hoop and other activities are provided in the group room. As a first-year psychiatry resident, I spend most of my time working on an inpatient psychiatry unit that looks much the same. Then I saw the first sign that something was different: a room where mini-cells, fit to house a single individual, were stacked next to each other. These cells, called “therapeutic pods,” are used to run groups with patients who pose significant safety concerns. It was a stark reminder that we were in fact, not in a hospital, but at a correctional facility, visiting those who have been convicted of serious crimes. And yet, this was still a mental health treatment unit, so the juxtaposition of needling cages to create a therapeutic environment felt ironic to us.

Dr. Zahedi arranged for us to interview one of the patients, declining to give us any background so we could formulate our own clinical impressions. Normally, I’d open with a simple, “how can I help?” but that sentiment felt trite and inappropriate for the situation. The patient was cooperative, seemingly charming, articulate, but the circumstances clearly indicated that there was more to the story than they let on. The patient evaded answering most of our questions, and I’m sure we did not even scratch the surface of what was going on underneath. However, the interaction was enough to make me wonder if the patient had experienced significant past trauma, as is commonplace in the incarcerated population. I also wondered if perhaps the patient’s mental illness had manifested as a different set of behaviors, could I have seen this very patient in a civil setting. While the circumstances under which I was meeting this patient were unusual, the psychiatric symptoms I detected were all too familiar to me. I suppose a lot of people have a similar sentiment, wondering how a person can commit certain crimes. I suppose I wondered what makes one person with a disease process do one thing, and what made this patient we saw do another. And is that something that would have been preventable?

After the interview, we visited other patients, some of whom were completely out of touch with reality. Those patients were so clearly unable to care for themselves that I questioned if they even knew where they were or what they had done. It felt like we were seeing the forgotten subset of the incarcerated population, those deemed guilty in the eyes of the law, yet too mentally ill to be housed in “gen pop,” but by our observation, still needing a lot of care. ▶

Continued on Page 9...
A
ccessing care in jails and correctional facilities is modeled after the fee-for-service model in which facilities tend to schedule patients for appointments when they have an acute problem (sick call) or when they are due for their specific chronic disease monitoring. The National Commission on Correctional Health Care (NCCHC) Standards for Jails and Prisons state that a responsible physician should determine the medical necessity and/or timing of screening and other preventive services. (J-B-03 and P-B-03). Similarly, for patients with chronic disease, the standards require that a responsible physician determine the frequency and content of periodic health assessments for those with chronic conditions (J-F-01 and P-F-01).

Unfortunately, there is limited evidence to support the optimal healthcare provider encounter intervals for best patient outcomes. A handful of studies have retrospectively analyzed this relationship among patients with hypertension and diabetes and found that shorter encounter intervals are associated with improved achievement of blood pressure control and a composite endpoint of cardiovascular event or death (Guthmann 2005, Xu 2015). Another study evaluated changes in blood pressure among patients with hypertension and diabetes by encounter frequency (Turchin 2010). This study found that the blood pressure of patients with average intervals between encounters of ≤1 month normalized after a median of 1.5 compared with 12.2 months for encounter intervals >1 month (P<0.0001). Finally, in a study of patients with diabetes, the median time to hemoglobin A1c <7.0%, LDL-C <100mg/dL, and blood pressure <130/85mmHg was significantly shorter in patients who saw their physicians at intervals between 1 to 2 weeks vs. 3 to 6 months (Morrison 2011).

These findings suggest that more frequent visits for patients with uncontrolled hypertension and for patients with uncontrolled diabetes may be optimal. In our correctional healthcare environments, a vast majority of our patients have multiple comorbidities beyond hypertension and diabetes. According to the Center for Addiction and Mental Health (CAMH), substance abuse disorders and psychiatric conditions are four to seven times more common in correctional settings than in the community. Given the complexity of the population, the volume of patients, and the state our patients are in when we receive them, getting the right care to the right patient is pivotal.

Distributing healthcare resources is currently akin to spreading peanut butter on bread; the same level of resources is offered to every patient. This is clinically ineffective and expensive. To maximize our scarce resources, increase efficiency, and improve outcomes, jails and prisons should analyze their patient populations and customize care and interventions based on the individual patient’s risk.

Healthy patients, for example, should not require a high level of intensive support. On the other hand, high intensity resources should be reserved for high-risk patients. Clinical pathways based on risk with flexible care plans can then match the patient needs with the appropriate resources.

The responsibility to effectively risk stratify an incarcerated patient population should not be solely shouldered by physicians. The effective deployment and execution of this model requires a heavy investment in infrastructure, training, and, most importantly, a commitment from the top down. Risk stratifying patients enables healthcare providers to identify the right level of care and services for patients and populations. This is accomplished by assigning a risk status to patients and then using this information better to direct care and improve overall health outcomes.

We recommend more studies to evaluate the effectiveness of risk stratification in correctional healthcare settings. Furthermore, more research in corrections is required to recommend a cadence of visit frequency based on risk stratification.

References:


Editor’s Comment: This is an interesting piece, one that stimulates some thought. It effectively questions some of the conventional wisdom of medicine as practiced both in and out of corrections, identifying some clinical behaviors which, once considered, seem ripe for change. I was reminded of what my graduating medical school class was told oh, so many years ago: “Half of what we have taught you is wrong. The problem is, we don’t know which half.”

Dean

Were you unable to attend the ACCP 2021 Educational Fall Conference OR 2021 Mini-Series

We’ve got you covered!

Announcing the ACCP Online Education Program!

Easy to earn CME credits!
Self-paced study options!
Attend just one or as many sessions as you like!
Or - you can purchase the complete 2021 Fall Conference OR 2021 Mini-Series!

To register please visit us at:
https://accpmed.org/education/php
The American College of Correctional Physicians (ACCP) recognizes the validity of the following:

1. Multiple studies have documented racial and ethnic disparities in healthcare in the United States. Racial and ethnic minorities are less likely to be prescribed a wide range of medical and surgical treatments than others. Racial and ethnic minorities as a group tend to have less confidence in the medical system and in their health care providers. They are less likely to seek out medical care when sick. The result of all of these disparities has led to overall worse medical outcomes for many racial and ethnic groups in the US healthcare system.

2. Multiple studies have documented racial and ethnic disparities in the US Criminal Justice system. Historically, racial and ethnic minorities have been more likely to be arrested, more likely to be found guilty in trial and more likely to be sentenced to long prison terms than others. These disparities have resulted in many racial and ethnic groups being over-represented in US jails and prisons.

3. Multiple studies have documented racial and ethnic disparities in training programs for medical professionals in the United States. In particular, racial and ethnic minorities are less likely than their counterparts to be selected for admission to medical schools, less likely to be selected for residency programs and less likely to be hired after finishing their medical training. These disparities have resulted in many racial and ethnic groups being under-represented in many healthcare professions, including as physicians.

4. Multiple studies have shown that all people have biases and prejudices that influence their decision making. Some of these biases and prejudices result from ignorance of other cultures and peoples. Many of these individual prejudices operate on a subconscious level. Human bias, prejudice and stereotyping, both conscious and subliminal, contribute to each of the racial and ethnic disparities listed above.

The American College of Correctional Physicians (ACCP) supports efforts to increase awareness of racial and ethnic disparities in Correctional Medicine and efforts to eliminate these disparities. These efforts should take place on several levels:

1. Increasing awareness among Correctional Healthcare workers of the historical problem of racial and ethnic disparities.

2. Promoting uniformity and equity of Correctional Healthcare. This can be accomplished by using Evidence-Based guidelines for the delivery of healthcare in jails and prisons.

3. Promoting increased representation of previously disadvantaged racial and ethnic groups in Correctional Healthcare.

4. Promoting Civil Rights legislation and litigation aimed at reducing racial and ethnic disparities in the criminal justice system.

5. Promoting efforts to collect data on access to healthcare and healthcare outcomes in Correctional Facilities.

ACCP strongly encourages each individual to acknowledge their own intrinsic biases and prejudices and actively work to eliminate any healthcare disparities that might arise from these. Examples of actions individuals can take include:

1. Seek to understand and validate each patient’s individual ethnicity, background and culture.

2. Understand and acknowledge that individual patients will have varying levels of education, mastery of English, and trust of the “System” that will affect their ability to understand and accept healthcare.

3. Understanding that, based on culture, education and background, individual patients will vary in the following:
   a. Their response and description of pain.
   b. Their understanding of medications and medical procedures.
   c. Their willingness and ability to be candid with medical staff.

4. Acknowledge our own intrinsic biases and prejudices and seek to overcome them.
   a. Do not prejudge patients based on their past history, culture, race, religion or mastery of English.
   b. Do not prejudge patients based on their chief complaint, description of pain or other symptoms.
   c. Do not prejudge patients based on their distrust of the medical system in general or in you in particular.
   d. Actively work to provide uniform and fair medical care to all patients. This can be accomplished by using Evidence-Based guidelines for the delivery of healthcare in jails and prisons.
Complex PTSD is characterized as a traumatic response to chronic, prolonged, and severe interpersonal abuse, and symptom presentation includes emotion dysregulation, destructive behavior (e.g., drugs, self-harm), dissociation, poor sense of self (e.g., excessive guilt, shame), interpersonal difficulties, somatization, and loss of sustaining beliefs (van der Kolk, 2002).

Why is it important to understand Complex PTSD? As noted, often individuals with extremely severe trauma histories do not meet criteria for PTSD. Their symptoms may be subthreshold for a diagnosis of PTSD, or their symptoms may not align with the PTSD symptom constellation. Consequently, individuals with distressing trauma responses may not receive sufficient or necessary treatment. In correctional settings, trauma-based behavioral dysregulation, such as hypervigilance, aggression, acting out, and high-risk behaviors may be chalked up to antisocial patterns. Further, such individuals are often misdiagnosed with PTSD, Borderline Personality Disorder, or other disorders (van der Kolk, 2002). In addition, individuals with Complex PTSD frequently do not respond to traditional trauma treatment (e.g., prolonged exposure, cognitive restructuring; van der Kolk, 2002). With regard to Complex PTSD in incarcerated populations, thus far there has been limited, albeit interesting, research. A 2021 UK study found that Complex PTSD is over two times more likely than PTSD in incarcerated than community males (Facer-Irwin et al., 2021). Therefore, it is recommended that providers be cognizant of the various types and presentations of trauma, as a one-size-fits-all approach to both assessment and treatment does not apply to traumatized, incarcerated individuals.

Keeping in mind the aforementioned rates of trauma, PTSD, and Complex PTSD, in incarcerated individuals, coupled with the literature overwhelmingly concluding nearly all male and female incarcerated individuals have been exposed to at least one traumatic event in their lifetimes (Gosein et al., 2016; Warren et al., 2009; Wolff et al., 2014), it is necessary that as providers we recognize trauma symptoms and that we utilize universal precautions. Universal precautions in trauma-informed care speaks to treating all legal-involved individuals we meet as though they have trauma backgrounds. Additionally, it is important to remain cognizant of our incarcerated individuals’ behaviors which may be maladaptive in nature but which are the skills these individuals have developed to cope with trauma, despite the fact that they may not always be healthily adaptive (e.g., self-harming behavior, aggressive behavior, and substance use). As such, it remains vital that when we are treating patients with difficult behaviors, we remain sensitive to the trauma framework—that these patients may be doing the best they can to survive in a world that has been unsafe for them. Therefore, not only should we as practitioners remain conscious of the various presentations of those who have experienced trauma, but we should also strive to prevent re-traumatization of an already vulnerable patient population. We do this by applying universal precautions to every patient we treat, offering our patients choices, respect, and dignity. For example, prior to taking a patient’s blood pressure, we can tell the patient where we will be touching them and why. We can walk them through the steps of the procedures we complete. A brief explanation can help to prevent possible re-traumatization as we may not know if our patient has a history of trauma and may quickly be re-traumatized by a stranger’s touch.

If we come into contact with a patient whom we believe may be having a trauma response or appears to be experiencing symptoms associated with their trauma, it is important to keep a few things in mind. First, the activation of trauma symptoms is a nervous system response designed to protect the individual. Therefore, during nervous system dysregulation, it is wise to use concrete strategies to re-regulate the nervous system and bring it back to a state of homeostasis.

This can be done quickly in a medical office using concrete techniques:

1. The provider can lead the patient in a grounding exercise in which the provider asks the patient to list five things they can see, four things they can touch, three things they can hear, two things they can smell, and one thing they can taste.
2. The provider can ask dysregulated patients to take ten, slow, deep breaths.
3. The provider can lead the patient through a short guided somatic mindfulness meditation such as a body scan (somatic meditation focuses on internal sensations allowing individuals to become aware of their bodies). Scripts as short as five minutes are available on the internet.
4. Lastly, practitioners may help calm the patient by allowing them to run water over their hands. The patient should start by running cold water over their hands while focusing on how the temperature feels on each part of their hand from their nails to their wrists. The patient should then switch to warm water and focus on how the sensation on their hands changes. Allow the patient to do this exercise for a few minutes until their nervous system calms down and to returns to a state of homeostasis.

References


Substance Abuse and Mental Health Services Administration (SAMSHA). 2019. Trauma and Violence: https://www.samhsa.gov/trauma-violence


In times of conflicting opinions and interests, sometimes the courts have to step in…and sometimes they have to play doctor. We’ve all dealt with court-orders for medical care. If you review the history of correctional medicine you’ll find that most of the tenets of health care delivery to the incarcerated population are derived from lawsuits.

However, the decision to remove the mask mandate for public transportation was not based on what is healthy, for the public nor for an individual. It was based on maintaining an individual’s sovereignty. Basically, you can choose to wear a mask or not to wear a mask – you don’t have to, but if you don’t you should be willing to accept the consequences. Like my dad used to say about helmet laws; “if you aren’t smart enough to wear a helmet, then your squash ain’t worth saving”. He was against laws mandating personal behavior but also expected everyone to accept responsibility for their choices.

An ID nurse said something similar when it came to the COVID vaccine mandates. “Stupid’s gotta hurt.” If she chose to not get vaccinated and then got COVID, then she should expect some pain. If she chose to not wear her helmet while riding her motorcycle, her hair would be a tangled mess – stupid’s gotta hurt.

But what happens when someone’s stupid hurts more than just them? What about the mask-wearer’s right to try to avoid getting a communicable disease? COVID protections work best when everyone is following the mask mandates. And what’s worse is that the Judge Mizelle’s removal of the mandate may have given the false impression that the risk is lower, which is completely false. Masks were actually working, actually protecting people from catching/spreading COVID. Physicians at the CDC and other public health institutions have been saying this for two years, we’ve seen it work firsthand for two years, but it only took one judge (rated “not qualified” by the American Bar Association, based on her limited amount of experience post-law school) to unmask the risk to everyone.

Now that’s ironic.

An ID nurse said something similar when it came to the COVID vaccine mandates. “Stupid’s gotta hurt.” If she chose to not get vaccinated and then got COVID, then she should expect some pain. If she chose to not wear her helmet while riding her motorcycle, her hair would be a tangled mess – stupid’s gotta hurt.

But what happens when someone’s stupid hurts more than just them? What about the mask-wearer’s right to try to avoid getting a communicable disease? COVID protections work best when everyone is following the mask mandates. And what’s worse is that the Judge Mizelle’s removal of the mandate may have given the false impression that the risk is lower, which is completely false. Masks were actually working, actually protecting people from catching/spreading COVID. Physicians at the CDC and other public health institutions have been saying this for two years, we’ve seen it work firsthand for two years, but it only took one judge (rated “not qualified” by the American Bar Association, based on her limited amount of experience post-law school) to unmask the risk to everyone.

Now that’s ironic.
And what do we do with that knowledge? Dr. Zahedi had also discussed with us the reality of the constraints of the correctional system, which included a review of the prison healthcare budget, the laws, and the social aspects that influence the treatment that the incarcerated population receives. This contrasted with my experience in the civil setting because financial costs of treatment and overall public safety took a much more prominent consideration in a patient’s treatment plan.

Overall, I was grateful for this vastly different experience of psychiatry than what I had otherwise seen in my first year in training. I was disappointed when our visit was over, but I was thankful for the opportunity to see the conditions under which the treatment of this severely mentally ill population takes place. I originally chose the field of psychiatry because I deeply believe that humanity is inherently good, mental illness can be treated, and everyone is deserving of healthcare. The irony is not lost on me that I have empathy for people that some would say are incapable of the same. Yet, I left Waymart with a renewed dedication to help those with mental illness and deep appreciation for the opportunity to take a look inside a population that is often forgotten, dismissed, and yes, also in need of treatment.

Despite confirmation of needle placement, this was also a failed arthrocentesis due to joint fluid viscosity. This photo was entered into the patient’s chart and added to the orthopedic referral, which was approved.

POCUS is also valuable when utilized to solve more common issues that occur in correctional facilities, such as obtaining a successful phlebotomy or obtaining IV access in a longtime IV drug user. Other potentially valuable uses for POCUS include assessing blunt trauma patients. A quick FAST (focused assessment with sonography in trauma) could be performed while awaiting AMR service. POCUS could provide more information to assist and direct critical care on- and off-site, understanding that this use of POCUS is less than definitive and would not rule out intra-abdominal injury.

It is important to remember that this device should never be the primary determining factor for directing care. The history and physical examination remain the most important tools, with POCUS being a diagnostic tool which can provide immediate information to better steer our patient care. Finally, many administrative questions need to be addressed before POCUS can be incorporated into our settings. Issues which require consideration include patterns of documentation, ability to archive images (hopefully in an electronic medical record), protocols for standardization of use, and processes for oversight, just to name a few. It is already clear that POCUS has a part to play in delivering high quality outpatient care, even with its basic IV access indication. POCUS is a tool which we can all welcome.

References:
IN THIS ISSUE

Trauma On A Spectrum: Identifying And Managing Trauma Symptoms And Dysregulation In Correctional Healthcare Settings

• Call To Action - Voice Your Support Of Correctional Medicine To ACGME

• “Irony Is…” Practicing Medicine From The Bench

• Introduction Into Point-Of-Care Ultrasound (POCUS)

• Ironies And Iron Cages: A Look Inside A State Correctional Facility

• The Need For A Different Approach To Access Care In Corrections

• ACCP Position Statement On Health Disparities In Jails And Prisons