



Neurosupport Centre, Norton Street, Liverpool L3 8LR

Tel: 0151 298 2666 Fax: 0151 298 2333 Email: epilepsy@mrea.demon.co.uk Website: www.epilepsymersey.org.uk

epilepsy in prison - a guide for prison staff

About this guide

Epilepsy is the most common of all neurological disorders and all prison staff are certain to encounter it within the course of their work. This guide sets out to give a basic understanding of epilepsy and the issues it raises in caring for inmates who are subject to seizures. It is not intended to be a substitute for in depth training programmes.

About the authors

Alice Hanscomb is a member of the Executive Committee of the Joint Epilepsy Council for the UK and Ireland . She has a national reputation in the field of epilepsy education and is much in demand as a speaker and trainer in health education.

Peter Rogan is Chair of Mersey Region Epilepsy Association and an Honorary Life Member of the Joint Epilepsy Council for the UK and Ireland. For five years he served as a member of the Board of Visitors of Liverpool Prison. He was awarded the MBE for services to people with epilepsy.

Bill Walker worked a Principal Officer in Health Care at Liverpool Prison. His experience in dealing with inmates who have epilepsy is extensive and he has been responsible for the organisation of many courses about the condition with the prison.

INTRODUCTION

Epilepsy in the prison population tends to have a higher prevalence than in the general population for a number of reasons. Because of this it is important that those working in the prison environment have an understanding of this common neurological disorder in order to be able to handle it more effectively. Also, not only do inmates have a higher prevalence, there are increased factors which may trigger seizures such as high levels of stress, restricted activity and possible drug abuse. In addition, being in close confinement with others makes it vital that epilepsy is understood and handled sympathetically.

SOME BASIC FACTS AND FIGURES

Epilepsy is not a disease but a symptom of a neurological disorder which presents as seizures. There are many different types of seizure, some of which are instantly recognisable, whilst others are not.

It can affect anybody at any time, regardless of colour, creed, age or level of intelligence. It can appear quite suddenly and sometimes without obvious cause, although in many cases a cause can be found.

Epilepsy is the most common of all neurological disorders, affecting at least 1 in 131 of population. Applied to the UK this means that there are up to 456,000 people with the condition and worldwide the figure extends to over 50 million.

According to the World Health Organisation approximately 1 person in every 20 may have an epileptic seizure at some time in their lives. Every day, approximately 81 people in the UK are diagnosed as having epilepsy.

DIAGNOSIS

Epilepsy is very commonly misdiagnosed, being mistaken for, amongst other things, faints, migraines or non-epileptic episodes closely resembling true seizures. The latter episodes come under the title of Non Epileptic Attack Disorder (NEAD), which is discussed in a separate section.

In order to make the correct diagnosis, doctors rely heavily on clear descriptions, from reliable witnesses, of what actually happened during episodes which could be epileptic. Prison officers and others working alongside prisoners can be of great assistance here by noting down what actually happened. The questions which will need answering are:

- Was there any warning immediately before the episode?
- What exactly happened during the episode?
- How long did it last?
- Did the person describe any different feelings before the episode?
- Was there only one kind of episode or was there more than one?
- What was the person doing before the episode and how were they afterwards?

Because of the 24 hour care given, it is highly likely that more than one person employed in the prison will witness an inmate having seizures and it would be helpful if they could confer with each other in describing what actually happened. The observations of fellow inmates are also important.

TYPES OF SEIZURE

Seizure types have been classified into two main divisions - generalised seizures and partial seizures. There are also some seizures which cannot be so easily classified as they may show elements of more than one type during the seizure.

GENERALISED SEIZURES

In these types of seizure the whole brain is affected by abnormal electrical disturbance and the person becomes unconscious of surroundings. The following are some examples of generalised seizures:

tonic-clonic seizures

These used to be known as “grand mal” seizures. The seizure usually starts with a cry and a loss of consciousness with the person falling to the ground. The ‘tonic’ phase where the muscles tighten is followed by a ‘clonic’ or twitching phase. Finally there may be confusion, often followed by sleep. In addition to the very obvious convulsive movements an observer may see the lips turn blue and if the tongue has been bitten blood may trickle from the mouth with frothy saliva. It is possible, but by no means always the case, that the person could be incontinent or, in rare cases, doubly incontinent.

tonic seizures

These seizures are quite dramatic. The muscles stiffen and, if standing up, the person will fall heavily to the floor, often receiving injury to the head. There is no jerking. Recovery is usually very quick.

atonic seizures

The muscle tone is lost, causing the person to flop and fall to the ground. They are sometimes referred to as “Drop Attacks.” The person falls heavily to the ground and although recovery is swift the result is often head or facial injury.

clonic seizures

In these seizures the muscles contract and relax continuously causing the person having the seizure to twitch and jerk repeatedly.

myoclonic seizures

“Myo” means muscle and clonic” means jerk. When myoclonic seizures occur the muscles jerk rather as if the person has had some sort of electric shock. Seizures usually occur shortly after waking or before retiring to bed when the person is tired. There is a loss of consciousness but it is hardly noticeable because the period is so brief.

absence seizures

These seizures, more common in children, are sometimes referred to as “petit mal.” They occur suddenly, provoking a brief trance-like state. The person stares blankly into space and their failure to respond when they are spoken to often results in them being thought as not paying attention.

PARTIAL SEIZURES

Only one part of the body is affected by these seizures since the abnormal electrical activity of the brain is localised to a specific area. They are subdivided into two types - simple partial seizures and complex partial seizures.

simple partial seizures

These seizures are sometimes called auras or warnings as the person experiencing them is totally aware that the seizure is happening. They can take many forms including taste, twitch, etc.

complex partial seizures

These seizures usually originate in the temporal lobes of the brain and are non convulsive in nature. They differ from simple partial seizures because they produce impaired or altered consciousness. Epilepsy with this type of seizure is sometimes called Temporal Lobe Epilepsy (TLE) or Psychomotor Epilepsy. The seizures often commence with a simple partial seizure (or aura). They may then go on to unknowingly pluck at clothing or smack lips and perhaps wander aimlessly about the room. Their behaviour is seen to be out of character and they come across as being confused and often unresponsive to people around them.

STATUS EPILEPTICUS

This phrase is used to describe a situation when a seizure is prolonged or when there is a series of seizures during which the person does not regain consciousness. It is a medical emergency which needs medical treatment by a doctor. As a guide, medical help should be sought if a seizure lasts longer than 5 minutes or if one seizure follows another without the person regaining consciousness.

TRIGGERS

Certain situations can increase seizure frequency. These are outlined below.

lack of compliance

Neglecting to take medication as and when directed is a recipe for disaster. It is vitally important that the inmates do not attempt to vary dosage or withdraw medication of their own accord. The prescribing of antiepileptic medicine is an exact science and should be left to experts.

emotional stress

Stressful situations encountered in everyday living can provoke seizures. As well as acknowledging that being in prison is in itself stressful for some, particularly for ‘first timers,’ areas of concern for inmates can include such things as a breakdown in personal relationships with people both within and outside of the prison. A poor relationship with a supervising officer can be so stressful as to provoke seizures and so regard has to be given to any breakdown of such a relationship.

illness

Some people have seizures at times of ill health.

tiredness

It is a well known fact that sleep deprivation can provoke seizures.

alcohol

Excessive drinking leads to an increase in seizure pattern because the effectiveness of antiepileptic drugs can be impaired.

restricted activity and boredom

The regularity of seizures is inclined to increase when the mind is unoccupied. This is a particularly relevant factor because one thing that prison inmates can be sure of is that they will have plenty of time on their hands with not a lot to do.

photosensitivity

Seizures can be provoked in a small number of people by flickering light. If seizures are provoked by watching a TV screen, the following simple precautions can be taken.

The TV should always be viewed in a well lit room, from a distance of at least 2 metres, with a small lamp placed on the top.

For inmates who use a visual display unit (VDU) and are photosensitive, there are some simple steps to take in order to reduce the effects of light stimulus.

- after working at the VDU for 15 minutes they should take a 5 minute break
- they should sit at a slight angle to the screen
- covering one eye temporarily or permanently does cut down the effect of flicker but can weaken eyesight
(the advice of an eye specialist should be taken before embarking on this type of action)
- use a special clip-on screen cover to reduce the flicker.

FIRST AID

For inmates susceptible to convulsive seizures it is essential that those responsible for their care, namely prison staff, should have a knowledge of first aid procedures in the event of seizures occurring. There is also a strong case to be argued that the cell mates of those who have seizures should be familiar with basic first aid procedures.

In the event of a convulsive seizure, the following basic steps should be taken:

- **Keep calm**
- **Only move the person if in danger**
- **Protect the head and body from injury by moving hard objects away and placing something soft under the head**
- **Do not try to stop the seizure**
- **DO NOT FORCE ANYTHING INTO THE MOUTH**
- **As soon as the seizure has stopped put the person on their side, ideally in the recovery position**
- **Summon medical help**
- **Stay with the person and allow a period of rest after the seizure**

NON EPILEPTIC ATTACK DISORDER

Some people are diagnosed as having epilepsy because they have attacks which bear all the features of epileptic seizures but, in fact, the episodes are non-epileptic. To the untrained eye it is very difficult to distinguish a true epileptic seizure from a non-epileptic attack. These non-epileptic attacks are often called “pseudoseizures.” Medically, the condition is called Non Epileptic Attack Disorder (NEAD).

To complicate the issue, some people with epilepsy also experience non-epileptic attacks.

Non-epileptic attacks can occur across the whole age range but are more frequent in adolescence and early adult life. The disorder tends to be more prevalent in women.

It would appear that some people seem to be susceptible to non-epileptic attacks when they find that they are unable to cope with certain situations which they find to be unbearable. One such situation could be that of being taken into custody. On the other hand some have attacks which are unrelated to any specific situation and they occur ‘out of the blue.’

Whatever the cause of or reasons behind non-epileptic attacks, the taking of antiepileptic drugs is of no practical use and can, in fact, make matters worse. Once the episodes are recognised for what they are the most likely route for treatment is that of psychotherapy.

ANTIEPILEPTIC DRUGS

All people with active epilepsy receive medication to control their seizures and it is vital that they receive the prescribed drug in the prescribed dose, as and when required. Abrupt withdrawal, a distinct possibility when a person is taken into custody, should be avoided at all costs as it may precipitate severe rebound seizures.

The following is a list of the most commonly used antiepileptic drugs:

CHEMICAL NAME	TRADE NAME
acetazolamide	Diamox®
carbamazepine	Tegretol®
	Tegretol Retard®
clobazam	Frisium®
clonazepam	Rivotril®
ethosuximide	Emeside®
	Zarontin®
gabapentin	Neurontin®
lamotrigine	Lamictal®
phenobarbitone	Luminal®
	Prominal®
phenytoin	Epanutin®
primidone	Mysoline®
sodium valproate	Epilim®
	Epilim Chrono®
	Convulex®
topiramate	Topamax®
tiagabine	Gabitril®
vigabatrin	Sabril®
zonisamide	Zonogran®

diazepam is the most common drug used to treat status epilepticus (see seizure types). It is manufactured under three names, viz. Valium®, Stesolid® and Diasemuls®.

All drugs have possible side effects and antiepileptic drugs are no exception. Information on these side effects is best obtained from the prison pharmacy or the prison doctor.

Since barbiturates can be recreational and are habit forming it is possible that some inmates might claim to be taking them for the control of seizures when they do not have epilepsy at all. The implications of such a scenario are obvious.

Generally speaking, people with epilepsy do not carry significant amounts of their medication around with them and so the claims of those taken into custody that they have epilepsy should be taken at face value and investigated.

EPILEPSY AND WORK

Epilepsy is not a reason for someone not to work. Boredom and mental laziness can be a precipitant factor for seizures and so it is far better for a prisoner with epilepsy to be active in a workshop or assigned to other working duties than to be confined to a cell for long periods.

This of course begs the questions of whether it is safe for people with epilepsy to work in some situations and whether the diversion of a seizure occurring is a risk to security.

The answer to the first question is that the vast majority of jobs assigned to prisoners are entirely safe and suitable. An individual risk assessment should give a clear indication of whether a certain activity could cause injury should a type of seizure occur. Situations where elements of climbing are necessary are to be avoided whereas activities confined to floor level should not present a problem.

The question of whether people with epilepsy should be employed using machinery is often raised and sometimes used as a “get out” to avoid taking them on in a workshop situation. In most cases this is unreasonable, since properly guarded machinery should be safe for all.

Any prisoner who has epilepsy and who, having complied with the regulations laid down by the DVLA, and holds a valid driving licence which allows for private cars to be driven on the public highway, should be considered available for a driving job within the prison.

Security factors to be considered are more tricky. There can be no doubt that the onset of a convulsive seizure or a complex partial seizure which might involve some bizarre behaviour could cause a major diversion of which some prisoners could take advantage and create a serious risk to security. It is vital therefore that arrangements are made so that this cannot happen, whilst making every effort to maintain the employment activity.

CELL LOCATION

It is preferable for prisoners with epilepsy, especially those who have seizures that cause them to fall, to be located at ground floor level.

When placed in a double unit cell where bunk beds are used, for obvious reasons it is wise to arrange for the prisoner with epilepsy to sleep on the bottom bunk.

As previously mentioned, there is a strong case to be argued for the cell mate of a prisoner with epilepsy to receive basic information about the condition so that, if necessary, first aid procedures can be activated immediately. Besides that, a deeper knowledge of the condition promotes a better understanding and as a consequence less prejudice.

WOMEN'S ISSUES

There are specific issues that affect women with epilepsy.

pre menstrual epilepsy

Menstruation can sometimes cause an increase in the number of seizures, and for some women this is the only time they experience seizures. The reason for this is unclear, but it is thought that hormonal changes at this time, or the change in body fluids could be responsible. Some women will benefit from

being prescribed a specific extra form of medication to take while they are pre-menstrual or during their period to alleviate this.

Pregnancy

Continuing antiepileptic medication during pregnancy is important but many women are concerned about the potential risk to the unborn child. These issues should be discussed with the prison doctor but it's true to say that the vast majority of women with epilepsy continue taking their medication throughout pregnancy and deliver perfectly normal babies. In taking one type of antiepileptic drug the risk of malformation of the developing baby is increased to 7%. This will increase if more than one type is taken. Taking a folic acid supplement of 5mg a day will reduce these risks.

During pregnancy a minority of women may find their seizures increase. The most common reason for this is because antiepileptic drugs are not taken as prescribed or because they are not being effective due to repeated vomiting. Sleep deprivation, though not usually a problem in a prison setting, can also result in an increased seizure pattern. An increase in weight during pregnancy can increase the amount of medication needed to control epilepsy and so it is important that medication is monitored.

Labour

Seizures during labour are rare but the medical staff in attendance should be informed that the woman has epilepsy. The medication needs to be taken as normal throughout the labour.

Feeding babies

Babies benefit best from breast feeding and the fact that the prisoner is taking antiepileptic drugs should not be a problem. In fact, breast feeding can be an effective way of weaning the baby off the small amount of medication it will have absorbed during the pregnancy.

Menopause

Some women find that the hormonal changes that occur during the menopause can affect their epilepsy. For some it may be the time it starts, for others it may be the time it stops. HRT treatment does not usually affect epilepsy but should seizures increase on the introduction of HRT the possibility of an interaction should be considered.

CONCLUSION

This Guide has achieved its purpose if it has persuaded prison staff that epilepsy is not the fearsome affliction it is sometimes thought to be and that most people in their care who have epilepsy can be safely and effectively supported in prison.