Minnesota Community Corrections Association

HAPPENINGS

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2012 MCCA Award Ceremony:

The 2012 MCCA Award Ceremony was held on September 14th at Rasmussen College in Blaine.

Each year, MCCA presents its **Board of Directors Award** to a person who has shown outstanding service and continuing support to the organization. This year's recipient is Kelley Heifort.

Kelley has provided 10 years of excellent service on the board in various capacities. She has always brought energy and her perpetually good sense of humor. Kelley is an ambassador for reentry services, has great passion and works hard. Kelley has been impacting the corrections related field in Minnesota since 1992. At MCF-Shakopee, Kelley started out as a corrections officer and was promoted to program coordinator and eventually returned as a case management services supervisor. She also worked with RS Eden and then worked for the Department of Corrections as Facilities Reentry Program Coordinator. Currently, Kelley became the Facilities Reentry Manager at the DOC's Central office where she has already made a noticeable impact on case management services in the prisons.

In addition to the Board of Directors Award, MCCA presented Sharen Southard with the **Robert H. Robinson Award**, an annual award given to a line staff worker who has demonstrated excellence, creativity, and commitment to community corrections. Sharen has worked in the field of corrections for 29 years as a juvenile probation officer, adult probation officer and as an adult supervised release parole officer. She has exemplified total professionalism and dedication to the field and to the clients she has served. She delivers the highest quality of service to clients, colleagues and community members.

Congratulations, Kelley and Sharen, and thank you!

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The MCCA *Happenings* newsletter is prepared by Amanda Nowack.

The statements contained in *Happenings* are the views of the authors and do not constitute MCCA policy or endorsement by the Association or its Board of Directors, unless so indicated.

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MCCA Mission Statement: The mission of MCCA is to promote the value and recognition of community corrections as an equal partner in the societal response to public safety and offender reintegration. We accomplish this mission through training, advocacy, fellowship, and collaboration.

Organizational Spotlight: National Alliance on Mental Illness of Minnesota (NAMI Minnesota)

The National Alliance on Mental Illness of Minnesota (NAMI Minnesota) is a statewide grassroots 501(c)(3) organization dedicated to improving the lives of children and adults living with mental illnesses and their families. Founded in 1977 to combat the closing of state hospitals without the concurrent development of community services, NAMI has grown from a small kitchen table coalition to a robust statewide organization carrying out its mission by providing education, support and advocacy. NAMI is an organization guided by those it serves with nearly all of the staff, board and volunteers of NAMI either experiencing a mental illness or having a family member with a mental illness. NAMI Minnesota is an affiliate of the national NAMI organization and supports the work of over 25 affiliates covering 42 counties in the state.

NAMI Minnesota's mission is to champion justice, dignity and respect for all Minnesotans affected by mental illnesses. Through education, support and advocacy, NAMI members strive to eliminate the pervasive stigma of mental illness, effect positive changes in the mental health system and increase public and professional understanding of mental illness.

NAMI provides several mental health education programs for different audiences, from families to professionals. NAMI also provides 35 support groups for people with mental illness and their family members throughout the state and has published a number of resource booklets to help families advocate for themselves in various areas, including the juvenile and adult justice systems, civil commitment, psychiatric hospitalization and more. Visit NAMI's website (http://www.namihelps.org/publications/html) for a full list of publications.

NAMI is also the leading mental health advocacy organization in Minnesota, working tirelessly at the Capitol and with policymakers all over the state to improve the mental health system.

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Organizational Spotlight: National Alliance on Mental Illness of Minnesota (NAMI Minnesota) (cont'd)

NAMI's criminal justice project is a primary initiative through which the organization carries out its mission. The project aims to reduce juvenile and criminal justice contact for people living with mental illnesses by:

- Providing mental health and crisis de-escalation training for attorneys, probation and corrections officers, halfway house staff, supportive housing staff, reentry program staff, landlords, property managers and others. NAMI focuses on training staff whose understanding of mental illnesses, crisis response and mental health resources can influence whether a mental health crisis results in juvenile or criminal justice contact.
- Advocating for proven practices and policies like school-linked mental health services; evidence-based alternatives to zero-tolerance polices in schools; 40-hour crisis intervention team (CIT) training for law enforcement and corrections officers; mental health courts; jail and prison release planning; collaboration between mental health providers and probation agencies; and more.

At each step of the way, NAMI's criminal justice project is shaped by input not only from professionals in the field, but also from people living with mental illnesses who have had criminal justice involvement and their families.

For more information, to schedule a training for your organization, or get involved in NAMI's criminal justice work, contact Anna McLafferty at amclafferty@namimn.org.

We Want YOU! MCCA Board Seeks Your Input on Public Policy Issues

by Emily Baxter, Public Policy Co-Chair and Anna McLafferty, Secretary and Past President

The MCCA board of directors has been talking about increasing our organization's presence in the public policy scene. Your experiences in the reentry field give you important insights into how policy makers in Minnesota should approach reentry. So let us know what's important to you! Below we listed several public policy topics we think may interest you.

Please rank the top 3-5 topics you'd like MCCA to focus on in order of importance to you.

Juvenile Justice

__ Reduce collateral sanctions and consequences for kids who have been involved in the juvenile justice system.

__ Support expansion and effectiveness of expungements.

__ Require mental health and crisis de-escalation training for school resource officers.

__ Support making juvenile records (of 16 and 17 year olds charged with felony-level offenses) private and not available to the general public.

__ Eliminate permanent Department of Human Services (DHS) licensing barriers based on juvenile records.

__ Require juvenile courts to operate using mental health court principles (i.e., addressing underlying needs rather than focusing on the offense).

__ Extend the period of time for juvenile stays of adjudication.

__ Oppose further lowering of the age of extending jurisdiction juvenile (EJJ) and adult certification cases.

__ Register juveniles with sex offense records on a case-by-case basis (instead of registering them automatically).

__ Other_____

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We Want YOU! MCCA Board Seeks Your Input on Public Policy Issues (cont'd)

Criminal Justice

__ Reduce collateral sanctions and consequences for adults who have been involved in the criminal justice system.

__ Support expansion and effectiveness of expungements.

__ Fund mental health training for law enforcement officers.

__ Increase funding for diversion initiatives, such as specialty courts.

__ Increase the number of public defenders.

__ Fund additional jail release planning programs and prison release planners.

__ Address problems with access to medications in jails and prisons, as well as in reentry.

__ Increase supportive housing options that will serve people with felony reocrds.

__ Fund the development of forensic assertive community treatment (FACT) teams. FACT teams are designed to help people with serious mental illnesses live successfully in the community.

__ Hold a stakeholder dialogue to look at ways to change sentencing and supervision practices for people with sex offense records to be sustainable, constitutional and safe.

__ Prevent the death penalty's return to Minnesota.

__ Other_____

What did we miss? What changes would you like to see?

_____

_____

What gaps or problems do you see with existing services for the people you work with?

_____

_____

EDUCATION and TRAINING EVENTS

Postpartum Depression and Postpartum Psychosis: Understanding Risk Factors and Warning Signs

January 11, 2013, 9:00 AM—12:00 PM
Goodwill Easter Seals: 553 Fairview Ave N, St Paul, MN 55104

Description:

This training is designed for re-entry staff, mental health practitioners, law enforcement, educators, and attorneys that want to gain a greater understanding of postpartum depression, postpartum psychosis, and homicide as it relates to the criminal justice system. Mental health and legal aspects of each will be discussed. Participants will hear about the difference between postpartum depression and psychosis, as well as what leads some mothers to kill. Risk factors, warning signs, and case studies will be examined. Participants will review best screening practices, prevention, and intervention, as well as the impact these cases have on the family.

Presented by:

Rachel Tiede, MA is employed at Pathways Counseling Center as a Mental Health Practitioner. She is a member of the forensic team and trains other practitioners. Rachel has a Master's degree in Education and is pursuing her second Master's degree in Counseling from Adler Graduate School. Rachel has worked with numerous clients with mental health and substance use problems as well as cognitive impairments. She has also worked with clients with mental illness through pregnancy and with individuals suffering with postpartum depression.

Ellen Longfellow is an attorney with over 25 years of legal experience. She has assisted low income people in need of legal services through a variety of ways. She worked at free legal clinics in Ramsey and Hennepin counties for the nonprofit organization Civil Society, Ramsey County Law Library, and Minnesota Legal Corps. Recently, she has also worked as an advocate for crime victims and elders at the Council on Crime and Justice and the ElderCare Rights Alliance.

Information on past, present, and future trainings can be found online at www.mnmcca.com.

Understanding Forensic Mental Health

Authors: Jerrod Brown[1], Erv Weinkauf[2], Janina Wresh[3], Caitlin Opperman[4], Jay P. Singh[5], Anthony Wartnik[6], Eric Hickey[7], and Ian Mitchell[8]

Introduction to Forensic Mental Health

Forensic mental health comprises a field of professionals focused on the assessment and rehabilitation of people who live with mental illnesses and are engaged in the legal system. The responsibilities of professionals working within this field vary from first responder interventions by police officers, firefighters, paramedics, and mental health professionals (who are called MHPs and serve as the gatekeepers to involuntary psychiatric hospitalization admissions) to assessment and treatment by psychiatrists, psychologists, nurses, and other healthcare and correctional workers. These professionals may work with both perpetrators and victims of crime in military, state hospital, civil commitment, prison, jail, clergy, or community settings.

Some forensic mental health professionals may examine criminal defendants to determine whether they are fit to stand trial and the level of criminal responsibility in those with mental illness. Where people are incompetent to stand trial, these professionals may also work with families to appoint a guardian who may make decisions on behalf of the people. Further, forensic mental health professionals may offer their professional opinions as expert witnesses, though such testimony is frequently the subject of cautious scrutiny given the often different findings of adversarial assessments. In addition to offering assessments and expert testimony, forensic mental health professionals may work in secure units, developing risk management strategies to reduce recidivism risk, at times with specialized populations (e.g., people who commit serial sex offenses or use substances). Finally, forensic mental health professionals are routinely called upon to assess the risk of their clients engaging in self-harm and interpersonal violence. These assessments are used to inform medico-legal decisions related to individual liberty and public protection, as well as to identify potential treatment targets to lower recidivism risk (Singh, 2012). In all of these contexts, it is the duty of the forensic mental health professional to apprise patients of their rights.

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Understanding Forensic Mental Health (continued)

In summary, the specific tasks carried out by forensic mental health professionals may vary, but their dedication to serving the needs of people with mental illness, victims and their families remains constant. This article will focus primarily on special considerations for the assessment and treatment of people with mental illness in criminal justice settings with the goal of reducing recidivism.

Are the mentally ill disproportionately represented as criminals?

Individuals with mental illnesses are overrepresented in the criminal justice system (Fazel & Seewald, 2012). Steadman and colleagues (2009) administered structured clinical interviews to inmates at five jails and estimated the rate of current serious mental illness to be 14.5% in male inmates and 31% in female inmates. According to the Bureau of Justice, as of 2009, there are 7.3 million people in the U.S. under correctional supervision, 1 million (13.7%) of whom have been diagnosed with a mental illness (Skeem, Manchak, & Peterson, 2010). This pattern continues internationally, with psychosis and depression affecting approximately 4% and 10% of prisoners respectively (Fazel, 2012). There are several explanations for these disproportionate rates. Low availability of mental health screening and lack of education concerning access to community mental health resources often result in the treatment of people with mental illness in correctional settings. Further, law enforcement officers receive little training about dealing with people with mental illness other than to transport them to psychiatric hospitals for involuntary treatment evaluation by the MHP (Tucker, et al. 2011). As a result, officers overestimate the dangerousness of people with mental illness, associating a disproportionate amount of violence crimes to them. They do not deserve blame, as even psychiatric associations make the same assumption. The American Psychiatric Organization's Guidelines recommend violence assessments for people with schizophrenia as part of treatment even though a minority of them (8-10%) are actually violent and are unlikely to become repeat offenders (Singh, 2012).

There are several explanations for these disproportionate rates. Lack of available standardized mental health training, lack of education, and lack of access to community mental health resources often force officers to arrest people with mental illness.

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Understanding Forensic Mental Health (continued)

The vast majority of officers receive minimal training on how to deal with people with mental illnesses. Unless they actively seek additional training, they are poorly equipped to detect and develop appropriate strategies to deal with people with mental illnesses. As a result, mental illness has become criminalized, fueling misconceptions that mental illness causes criminal behavior or inherently produces violence (Vitello and Hickey, 2006).

Even without this stigma of violence, the mental health and criminal justice systems will overlap. In its study of medical problems for prisoners, the Bureau of Justice noted that six percent of state and three percent of federal inmates reported mental illnesses, with women reporting twice as often as men (Maruschak, 2008). The correlation between mental illness and prison is greater in youths. Rosenblatt and colleagues (2000) studied 4,924 youths in one county who were part of either a mental health program or the juvenile justice system over 38 months. In that time, 20% of youths who were served by the mental health system were arrested. Similarly, 30% of youths in the juvenile justice system were diagnosed with mental health issues. Streissguth, et al (1996) estimated that close to 60% of people with a Fetal Alcohol Spectrum Disorder (FASD) end up in trouble with the law and that 90% of persons with a FASD live with mental health problems, suggesting that mental illness is highest amongst this part of the population of youngsters in the juvenile justice system. This co-morbidity of criminal behavior and mental illness points to why criminal justice and mental health professionals collaborate and improve their knowledge of the fields' differences.

Improved collaborative models such as crisis intervention teams and mental health courts may lower recidivism rates by encouraging clients to become productive members in their communities (Morrissey, 2009).

Mental Health in the Criminal Context

Mental health services are provided in a different manner in civil versus secure settings. For example, the tools used to conduct clinical assessments in forensic settings were often designed for offender populations. Such tools include the Historical-Clinical-Risk Management-20 (HCR-20), the Brief Jail Mental Health Screen (BJMHS), and the Level of Service/Case Management Inventory (LS/CMI).

Understanding Forensic Mental Health (continued)

These measures assess the violence risk, mental health status, and service needs of offenders (respectively). Lengthy minimum sentences on criminal offenses involving drug or alcohol abuse, and a motivation for a punitive, instead of therapeutic, role for such sentences had disproportionately affected people with mental illnesses (Morrissey, 2009). The majority of the mentally ill reported they were under the influence of alcohol or drugs at the time of their arrest (Ditton, 1999).

The nature of these assessments distinguishes them from their counterparts in non-forensic settings. Melton and colleagues (2007) discuss seven considerations for conducting forensic assessments: 1) scope, 2) importance of client perspective, 3) sympathy and objectivity, 4) voluntary nature of treatment, 5) autonomy, 6) therapeutic alliance and boundaries, and 7) pace. Scope is focused on events or interactions instead of treatment. Boundaries may encourage bond of trust between professional and patient but are also promoting an appropriate emotional distance. Finally, the pace may involve high pressures for accuracy over a shorter period of time.

Separate Professional and Ethical Duties

Issues of consent and confidentiality are frequently confronted in forensic mental health. Because people may seek mental health assessments or treatment when the alternative is a jail sentence, people in this situation are often more resistant than voluntary clients. Some of this resistance may come from the client's attorney who is concerned that the treatment evaluator/provider may be required to report crimes that are disclosed by the client to him or her under a mandatory reporting requirement. There are also limits to confidentiality in forensic settings. For example, the "Duty to Warn", as established in Tarasoff v. Regents of the University of California, 557 P.2d 106 (Cal. 1976), can be a more pressing concern when working with people in the criminal justice system. In Tarasoff, the patient confided to his treating psychotherapist that he intended to kill Ms. Tarasoff and did so two months later. The court found a sufficient relationship between the psychotherapist and the patient that required him to warn her family that she was in grave danger. Practitioners may suspect on occasion that a client is exaggerating his or her symptoms or that a misdiagnosis has been made (Yates, 1994).

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Understanding Forensic Mental Health (continued)

Practitioners must document this uncertainty for the court. Because of this duty to warn and document uncertainties of symptoms, regulations about the release of information may be less protective of client confidentiality in courts than community mental health organizations. The separate duties of mental health workers to their professional code of ethics and the law may come into conflict. Balancing personal privacy with the safety of both the public and people with mental illnesses helps communities and individual interests (Clark, 2006). Admittedly, such a balancing act can be challenging, especially when attempting to gain a client's trust. Upfront notice of disclosures and issues of conflict would only be the first step in achieving such a balance.

Forensic mental health professionals must also reconsider the boundaries associated with their professional roles, even if the duality of the caring, therapeutic role and the controlling, surveillance role may be considered "irreconcilable" (Greenberg, 1997). This tension between the punitive nature of the justice system and the therapeutic goals of the mental health profession may increase when therapists testify as expert witnesses (Bonner & Vandecreek, 2006).

Intervention Programs

Thanks to increasing interaction between mental health and criminal justice professionals, many intervention programs exist specifically for people in the criminal justice system who live with mental illnesses, all with the goal of reducing recidivism. People with mental illnesses oftentimes have difficulties reintegrating into communities, being twice as likely as others under supervision to have their community sentences revoked (Prins, 2009). Alternative programs that link community mental health resources with the criminal justice system are have been shown in empirical studies to reduce risk of recidivism. A retrospective study of people with mental illnesses who entered a mental health court instead of an urban county jail after their arrest found longer periods before new charges for the former (McNeil, 2007). In programs such as specialty mental health probation or parole case loads, officers work directly with mental health professionals. While in jail aftercare or re-entry programs, participants are given direct access to community treatment resources (Skeem, Manchak & Peterson, 2010).

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Understanding Forensic Mental Health (continued)

It is important to note that access to treatment should be paired with efforts to address other risk factors for recidivism such as homelessness, unemployment, and substance use (Singh, Serper, Reinharth, & Fazel, 2011).

Budget Shortcomings

Alternative programs for people with mental illnesses are not always feasible. The criminal justice system has inherited a problem of enormous scope and complexity with minimal support. The Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA), signed in 2004, is a step in the right direction, and received bipartisan support when it was extended. However, plans for its consolidation (potentially reducing its efficacy and specialization) are in recent Presidential budgets and receiving money from it has been exceptionally competitive, with only 10-11% of grants being fulfilled every year (NAMI, 2011). They are commonly faced with larger caseloads as the enforcement of crimes occurs at a greater rate than the process through the criminal justice system (Motivans, 2009). There have been attempts to serve people with mental illnesses more efficiently, but with limited options and resources, especially in rural areas, criminal justice practitioners can be frustrated by their limitations. Over the past few years there is an upward trend in mental health education training programs offered to a variety of criminal justice forensic disciplines. By making forensic mental health education a priority, professionals will acquire new and advanced assessment skills that balance their dual obligations when interacting with the criminal justice system.

Ultimately, while criminal justice and mental health systems appear to serve different societal needs, they overlap in two significant ways: both seek to maintain safety, and both work with many of the same individuals. A criminal justice system more open to the mental health community will result in mutual benefits to people with mental illnesses and the community.

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About the Authors:

1. **Jerrod Brown's** interest in Forensic Mental Health and a love of learning have been the impetus for is ongoing pursuit of knowledge and education. Jerrod has earned Master's degrees in Criminal Justice, Forensics, Clinical Counseling, and Cognitive Disorders. He has completed a post graduate certificate in Autism Spectrum Disorders (ASD) and is currently pursuing his PhD in Psychology. Jerrod is an adjunct instructor for a college in the Twin Cities area, where he teaches courses related to criminal justice. He has worked full-time for 10 years at Pathways Counseling Center, Inc. in St. Paul, MN, and currently is the Treatment Director. Jerrod has testified in court, written Pre-Sentence Investigations, and worked with violent and mentally ill offenders. He has held positions in corrections, probation, security, and mental health treatment. Jerrod is the founder and president of the American Institute for the Advancement of Forensic Studies (AIAFS), an organization specializing in forensic-based trainings for law enforcement, the human service, behavioral science, medical communities, and legal professionals. Additionally, Jerrod is a certified trainer in Fetal Alcohol Spectrum Disorder (FASD) and a problem gambling therapist, certified with the State of Minnesota.

2. **Erv Weinkauf** spent nearly 30 years of his 40-year law enforcement career teaching veteran officers how to improve their skills and be better public servants. Prior to his retirement from law enforcement, Erv was the Chief of Police for the New Ulm Police Department. During his time in law enforcement, he participated in many projects, assignments and cases involving youth and the child welfare system. Since retiring in 2009, Erv has taken on a similar role in college academia. In 2010, he became the Department Chair of the Criminal Justice online BA and MA Degree programs at Concordia University in St. Paul, Minnesota. Erv's passion for teaching is serving him well in his new position.

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About the Authors: (continued)

He continues to share "lessons learned" - empowering practitioners currently working in the field, as well as students who aspire to become the next generation of practitioners making their communities safer places to live and grow.

3. **Janina Wresh** is currently a police officer, Wresh with 18 years' experience working in the Criminal Justice field. She is currently a patrol officer at a suburban Police Department, where she performs patrol duties, specializing in the areas of Domestic Abuse, Crime Scene processing and Crisis Intervention. She spent 14 years working at the Hennepin County Sheriff's Crime Laboratory and Court Division; specializing in the various aspects of evidence integrity concerning crime scenes and investigations. She continues to provide training to law enforcement, district court, and civic groups specializing in crime scene management and evidence integrity. She also performs in-depth evidence integrity audits to various local law enforcement agencies, task forces, as well as 4th Judicial District State Courts. Officer Wresh was founder and president of the MN Property and Evidence Specialists from 1999-2003 providing development of policy and procedure standardization and conference training in Minnesota. She was assigned to Hennepin County Sheriff's Court Division where as a Deputy Sheriff performed investigations, making arrests, enforcing the criminal code and state laws; keeping the standards within the 4th Judicial District State Courtrooms. She also worked with Minneapolis Police Department in a combined effort of proactive foot patrol policing entitled "Safezone". Officer Wresh holds a bachelor's degree in Criminal Justice from Concordia University. She currently is a Criminal Justice Adjunct Instructor for two colleges in Minnesota.

4. **Caitlin Opperman** was a former intern of Pathways Counseling Center working under the direction of Jerrod Brown.

5. **Jay P. Singh, Ph.D.,** is Postdoctoral Research Fellow in the Department of Mental Health Law and Policy at the University of South Florida. He completed his graduate studies in psychiatry at the University of Oxford and has served as a clinical associate at Yale University, where he assisted in conducting a controlled trial of Social Problem Solving Training in the Connecticut Youth Justice System. Currently engaged in risk assessment research in 15 countries, Dr. Singh has been the recipient of numerous awards and recognitions from professional organizations including the American Psychology-Law Society, the Royal College of Psychiatrists, the European Congress on Violence in Clinical Psychiatry, the Society for Research in Child Development, and the Society for Research in Adolescence. He has also taught courses for the University of Oxford, Tufts University, the Washington International Studies Council, St. Clare's Liberal Arts College, and Oxbridge Academic Programs. Dr. Singh's latest research has used systematic review and meta-analytic methodology to explore a number of major issues concerning violence risk assessment. In addition, Dr. Singh is actively involved in the development of novel statistical methodologies and risk assessment tool construction.

6. **Anthony P. (Tony) Wartnik** served as a trial judge for 34 years, almost 25 years on the Superior Court in Seattle, retiring in 2005 as the senior judge. He served as Dean Emeritus of the Washington Judicial College, chaired the Judicial College Board of Trustees, and the Washington Supreme Court's Education Committee. Judge Wartnik chaired a task force to establish protocols for determining competency of youth with organic brain damage and the Governor's Advisory Panel on FAS/FAE. In addition, he chaired the Family and Juvenile Court Committees and the Family Law Department of the King County Superior Court, as well as the Sealed Adoption Files Committee. In the latter capacity, Judge Wartnik was responsible for creating the current protocols and policy for the determination of when sealed adoption files can be opened and the appointment of confidential intermediaries ("C.I.s"). Judge Wartnik is the Legal Director for FASD Experts, the first multidisciplinary forensic FASD diagnostic team in the United States, and a consultant to the Fetal Alcohol and Drug Unit (FADU) at the University of Washington, School of Medicine.

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Understanding Forensic Mental Health (continued)

About the Authors: (continued)

He received both his B.A. and J.D. degrees from the University of Washington and its School of Law, has attended National Judicial College courses on managing complex mental health cases and managing death penalty cases, participated in SAMSHA's Training the Trainers Program, and provides annual FASD scientific research updates. Tony is an internationally known speaker and author on the topic of FASD and the courts.

7. **Dr. Eric Hickey** has published several books and scholarly articles on the etiology of violence and serial crime (www.erichickey.com). His book, Serial Murderers and Their Victims, 2012, 6th ed., (Thompson -Wadsworth-Cengage Publishers), is used as a teaching tool in universities and by law enforcement in studying the nature of violence, criminal personalities and victim-offender relationships. His current research focuses upon the development of his theory of relational paraphilic attachment (RPA) and sexual predators. His expertise is regularly sought by the media including appearances on CNN, History Channel, NPR, Larry King Live, 20/20, A&E Biography, Good Morning America, CBC, True TV, Discovery and TLC. He consults with private agencies and testifies as an expert witness in both criminal and civil cases including pedophilia, child molestation, fetishes; stalking; adult rape and sexual assault, robbery, burglary and homicide. A former consultant to the FBI's UNABOM Task Force, Dr. Hickey assists local, state, and federal law enforcement in training and investigations. He is a member of an FBI Threat Assessment Regional Evaluation Team that addresses campus violence and potential threats. He is internationally recognized for his research on multiple homicide offenders and has conducted seminars in countries throughout Europe, Asia and North America.

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Seizures and Epilepsy: What All First Responders and Corrections Officers Should Know

WHAT IS EPILEPSY?

Epilepsy, or recurrent seizures throughout an individual's lifetime, is one of the least understood and least recognized disorders. However, it affects nearly 2% of the general population – more than schizophrenia[1], autism[2], or psychopathy[3]. While twice that number (4%) of the general population will have a seizure at some point in life[4], usually as a symptom of sudden illness, epilepsy is the diagnosis for repeated seizures lacking a treatable cause.

Despite this high prevalence, epilepsy is still a disorder shrouded in stigma and folk wisdom rather than science. As late as the 1970s, epilepsy was considered legal insanity, and was sufficient to have people institutionalized for life[5]. While great strides have been made since then, there is still a great deal left where it is necessary to educate members of the community, beginning with the very basics of what constitutes a seizure. In this article, we will limit the discussion to the two most common types of seizures that produce changes in an individual's behavior: *tonic-clonic* and *complex partial*. The most common type of seizure altogether is an *absence* seizure, which resembles daydreaming, but since it does not cause any involuntary physical actions in the sufferer, we will save them for the next article instead.

Most people, when thinking of seizures, imagine the most severe type – the disabling, full-body convulsions of a tonic-clonic (*grand mal*) seizure. These can occur in individuals with epilepsy as well as in individuals undergoing withdrawal from drugs or alcohol. Tonic-clonic seizures occur suddenly, with the person often crying out, falling, and convulsing, sometimes for several minutes. "Folk wisdom" has instructed bystanders to restrain individuals in the grips of these seizures, and to put objects in the mouth. Both of these processes are useless, dangerous, and have led to serious injuries and fatalities[6].

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In addition to the dramatic tonic-clonic seizures, individuals may experience *complex partial seizures*, where awareness is suddenly and deeply impaired, but with few outward signs. These events are closer to what might be called a "trance" rather than a "seizure". Individuals undergoing complex partial seizures appear transfixed and unresponsive, and may engage in *automatisms* – pointless, repeated behaviors like picking at clothes or wandering around[7]. These seizures can last for 2-5 minutes, and cannot be interrupted by outside forces.

Luckily, complex partial seizures rarely occur in individuals without epilepsy. This means there is a chance for family and friends to intervene and explain when an individual is in the throes of a complex partial seizure. However, since complex partial seizures do not look like tonic-clonic seizures, and can lead to what seems like insubordination, lack of understanding about complex partial seizures has led to tragic consequences.

Excessive Force and Proper Treatment of a Seizure

During both emergency response and incarceration, there are two serious issues of excessive force that can emerge. Both occur when well-meaning individuals respond to epilepsy in popular but dangerously misguided ways. This includes using restraints on those with tonic-clonic convulsions, and assuming intentional disobedience when an individual is on automatism.

Restraining an individual with a tonic-clonic seizure is perhaps one of the most dangerous and unnecessary responses imaginable. Proper first aid for a tonic-clonic seizure consists of removing hazards in the individual's way, but letting the seizure run its course[8]. Restraints are often used in an innocent attempt to stop the convulsions by pinning the individual down. However, this means people having seizures wind up in positions where they cannot breathe, where they may inhale vomit, and where the force necessary to quiet a convulsion can break bones. This has caused tragic and unnecessary deaths in corrections facilities around the nation – including some juveniles[9].

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It is worth noting that individuals with no history of epilepsy are still fully capable of experiencing a tonic-clonic seizure. Offenders being held on substance abuse charges are one of the highest-risk populations for these seizures, as the shock of drug or alcohol withdrawal can often bring about seizures in people who have an alcohol dependency[10]. Regardless of whether the seizure is a first for the individual, the immediate first aid care remains the same (emergency medical services should be contacted, though, if there is no history of epilepsy)[11].

The other concern, which can emerge in the context of both tonic-clonic and complex partial seizures, is that of excessive force against individuals experiencing seizures. At least one case per year has been reported over the past decade of police in Europe or America using excessive force on individuals unable to control their actions. Recent cases have involved police tasering individuals who kicked or scratched them during tonic-clonic seizures[12], tasering an unarmed man who did not comply with an order to freeze (his automatism involved wandering, on par with sleepwalking)[13], force-feeding medications like Benadryl in attempts to stop seizures in progress[14], and putting a man suffering a tonic-clonic seizure in a straitjacket and shackling him face-down on a mattress until he suffocated[15].

Aside from the tragedy of these stories, the majority have also led to successful lawsuits or settlements against cities and counties for the use of excessive force. These can cost hundreds of thousands, if not millions, of dollars in damages for a single event[16]. Thus, it is essential for those involved in the care of individuals in custody to know and understand how to appropriately respond to seizures to avoid risking the life of an individual with epilepsy as well as to prevent unnecessary loss of taxpayer resources.

Proper First Aid for a Seizure in Progress

As a general rule, the best thing you can do for a seizing individual is nothing at all. Let the seizure runs its course, and do not restrain, hold, or touch the individual.

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The person may shriek or gasp; these are not signs of pain, but simply air erratically escaping the lungs[17]. Leave the person alone, even if they are on the floor. Focus instead on securing the scene. Keep calm and try to help others remain calm. If there are dangerous objects near the person, remove these hazards. The exception to the no-touching rule would be if the immediate surroundings pose a threat – like a cement floor where the individual's contractions cause them to repeatedly bang their head. In that case, a pillow or folded blanket should be placed under the head; however, the person must then be watched to ensure they will not suffocate.

Time the seizure. A seizure lasting less than five minutes in someone who is known to have epilepsy generally does not require medical attention. However, if the seizure is longer than five minutes or the person has no history of epilepsy or an unknown history, emergency medical care should be called.

Once the seizure is over, the person will be exhausted, and often confused. They may have also experienced incontinence, and may feel very embarrassed or ashamed. Help them to a safe place where they can rest, and examine the person for any serious injuries. The person may experience hallucinations or amnesia as well as confusion for a few hours after the seizure. This very rarely results in violence or aggression, and generally presents simply as disorientation or nonsensical language. Again, the best treatment is a safe environment and monitoring for symptoms of distress. In the rare case that there is aggression or dangerously out of line conduct, sedatives may be prescribed specifically for this *postictal* (post-seizure) stage.

Basic first aid of a tonic-clonic seizure begins with education. Police and/or corrections staff should communicate when an offender has a history of epilepsy or heavy drug dependency that might predispose them to either kind of seizure. It is crucial to understand that individuals in the throes of a seizure are rarely dangerous and usually have no intent to frighten or harm. They are, for all intents and purposes, unconscious. In a complex partial seizure, individuals cannot perform more than simple, repetitive motions like walking.

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During tonic-clonic seizures, individuals cannot form conscious intent to struggle or fight. Any kicking or scratching is the result of muscle contractions, not an effort to harm.

Conclusion

Epilepsy is a very common, but rarely discussed disorder that consists of repeated seizures. Individuals in both short and long-term custody alike have a greater risk of seizures, which makes proper education on first aid care critical for both first responders and corrections officers. Knowledge of appropriate first aid prevents unnecessary harm and prevents liability lawsuits for injuries arising from the use of excessive force.

Authors:

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