

# How to Approach, Engage, and Direct Individuals Living with TBI- Intensive Workshop (2) for Parole and Probation Professionals

Anastasia Edmonston MS CRC & Judy Dettmer

National Association of State Head Injury Administrators  
(NASHIA)

June 16, 2022



Mountain Plains (HHS Region 8)

**MHTTC**

Mental Health Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration

# Disclaimer and Funding Statement

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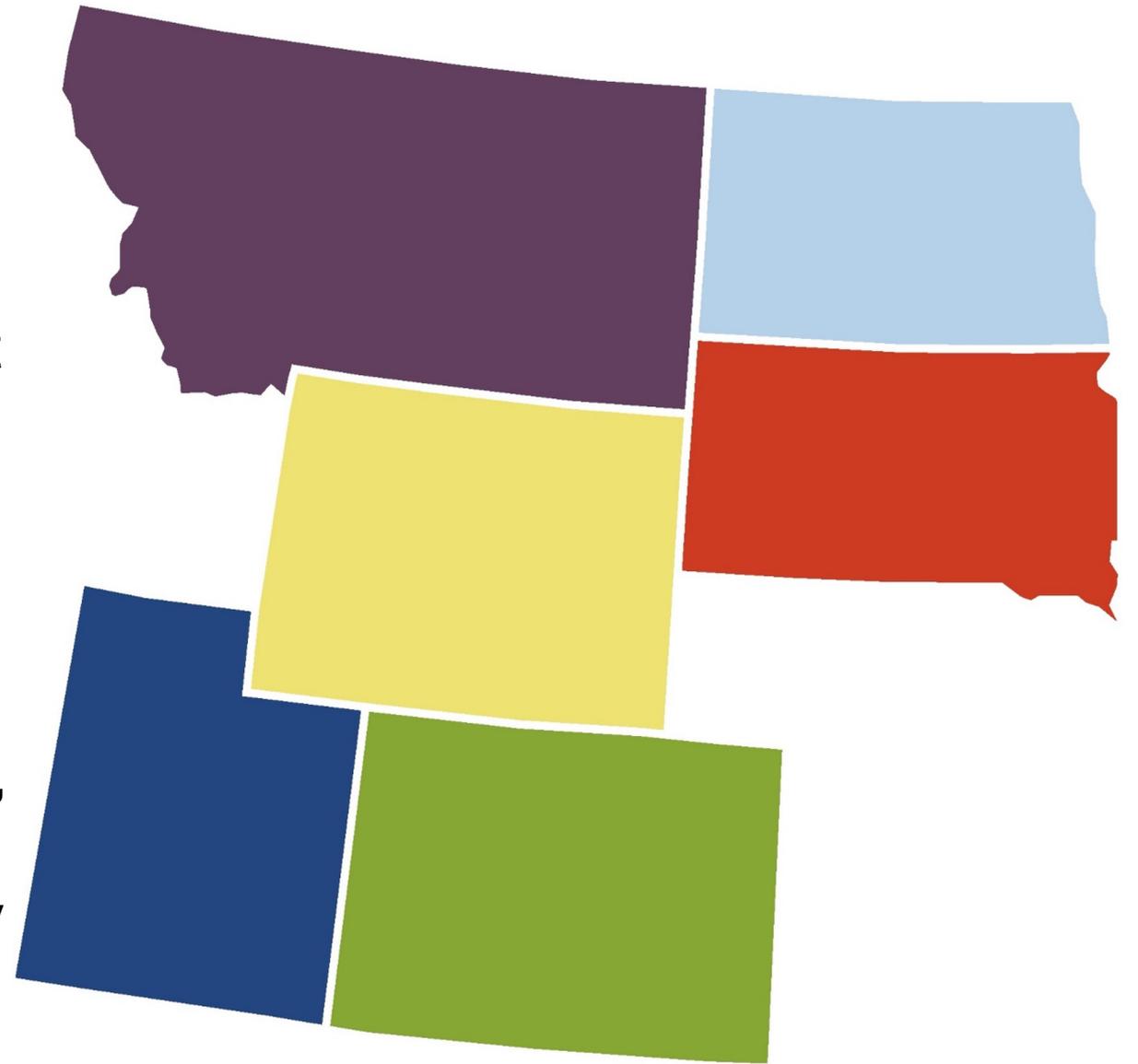
At the time of this presentation, Miriam E. Delphin-Rittmon, Ph.D. served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of Anastasia Edmonston and Judy Dettmer, and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. No official support or endorsement of DHHS, SAMHSA, for the opinions described in this presentation is intended or should be inferred.

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# The Mountain Plains Mental Health Technology Transfer Center

The Mountain Plains Mental Health Technology Transfer Center (Mountain Plains MHTTC) provides training and technical assistance to individuals who serve persons with mental health concerns throughout Region 8 (Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming).

We belong to the Technology Transfer Center (TTC) Network, a national network of training and technical assistance centers serving the needs of mental health, substance use and prevention providers. The work of the TTC Network is under a cooperative agreement by the Substance Abuse and Mental Health Service Administration (SAMHSA).



# Land Acknowledgement Statement

Today, the University of North Dakota rests on the ancestral lands of the Pembina and Red Lake Bands of Ojibwe and the Dakota Oyate - presently existing as composite parts of the Red Lake, Turtle Mountain, White Earth Bands, and the Dakota Tribes of Minnesota and North Dakota. We acknowledge the people who resided here for generations and recognize that the spirit of the Ojibwe and Oyate people permeates this land. As a university community, we will continue to build upon our relations with the First Nations of the State of North Dakota - the Mandan, Hidatsa, and Arikara Nation, Sisseton-Wahpeton Oyate Nation, Spirit Lake Nation, Standing Rock Sioux Tribe, and Turtle Mountain Band of Chippewa Indians.



The MHTTC Network uses affirming, respectful and recovery-oriented language in all activities. That language is:

STRENGTHS-BASED  
AND HOPEFUL

INCLUSIVE AND  
ACCEPTING OF  
DIVERSE CULTURES,  
GENDERS,  
PERSPECTIVES,  
AND EXPERIENCES

HEALING-CENTERED AND  
TRAUMA-RESPONSIVE

INVITING TO INDIVIDUALS  
PARTICIPATING IN THEIR  
OWN JOURNEYS

PERSON-FIRST AND  
FREE OF LABELS

NON-JUDGMENTAL AND  
AVOIDING ASSUMPTIONS

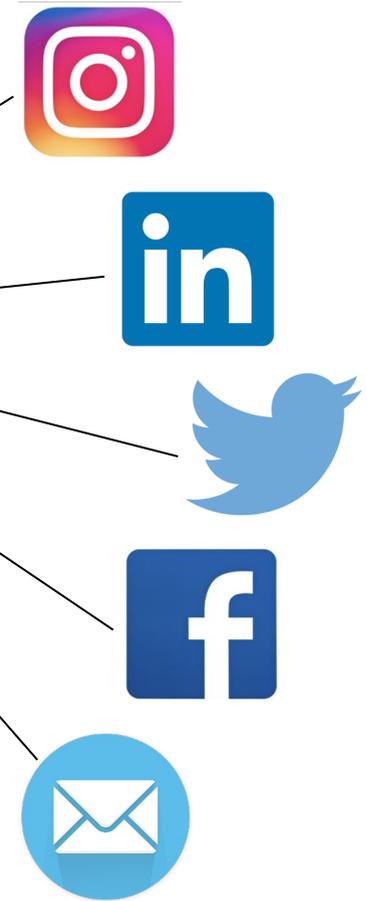
RESPECTFUL, CLEAR  
AND UNDERSTANDABLE

CONSISTENT WITH  
OUR ACTIONS,  
POLICIES, AND PRODUCTS

# Stay Connected

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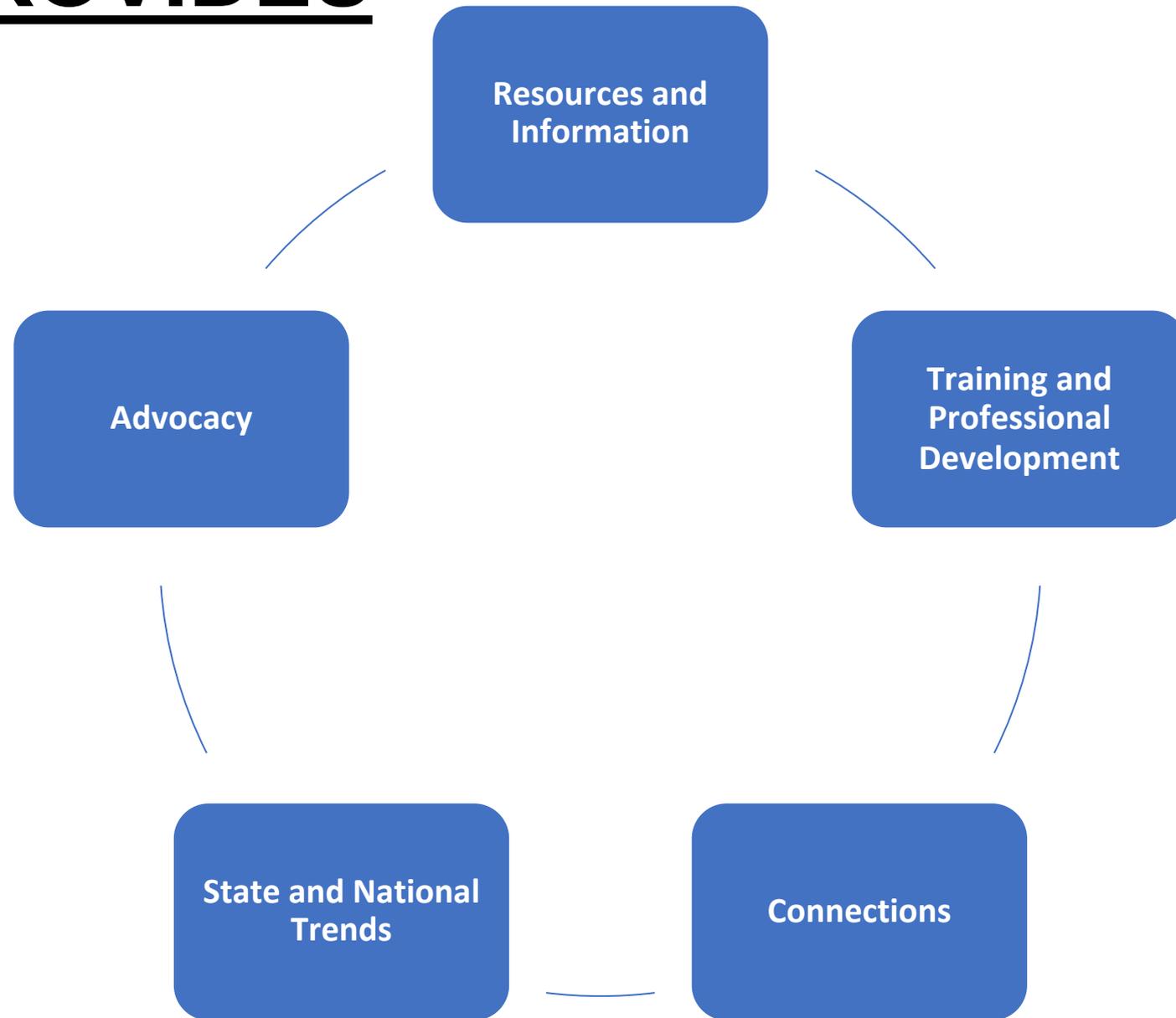
MHTTC

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## **NASHIA'S MISSION**

**NASHIA is a nonprofit organization created to assist State government in promoting partnerships and building systems to meet the needs of individuals with brain injury and their families.**

# NASHIA PROVIDES



# NASHIA TEAM

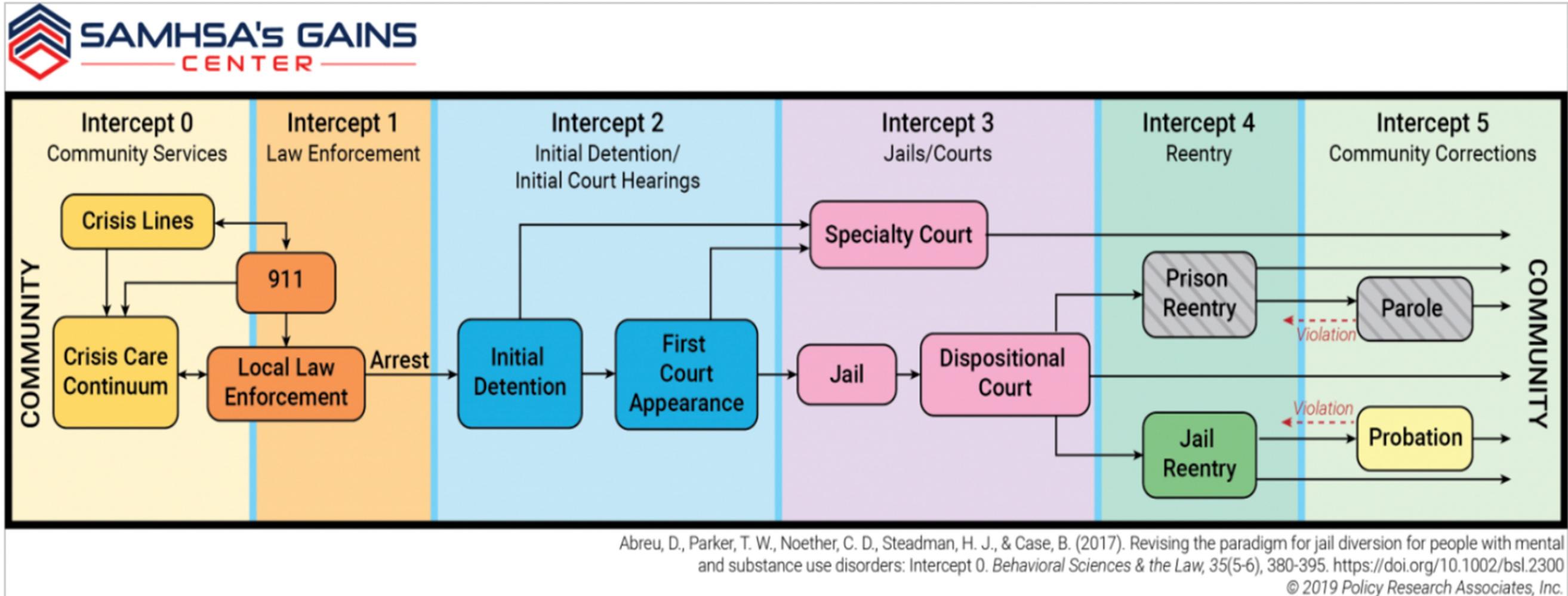


# Sequential Intercept Model (SIM)

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- A conceptual framework for communities for considering interface between the criminal justice and behavioral health system
- An organizing tool
- Currently developing a SIM for individuals with Intellectual and Developmental Disabilities (IDD/DD), autism, and brain injury

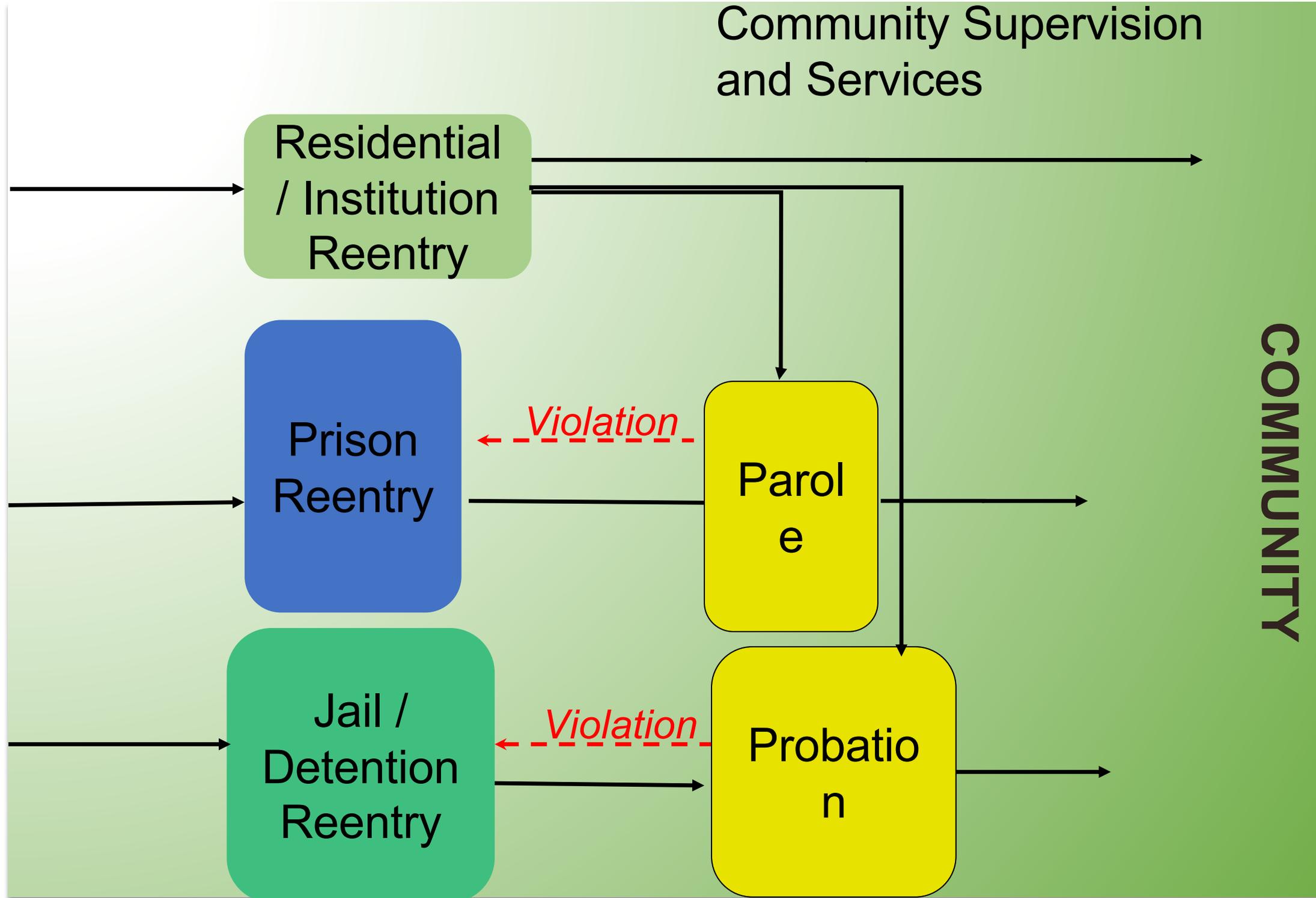
# Sequential Intercept Model



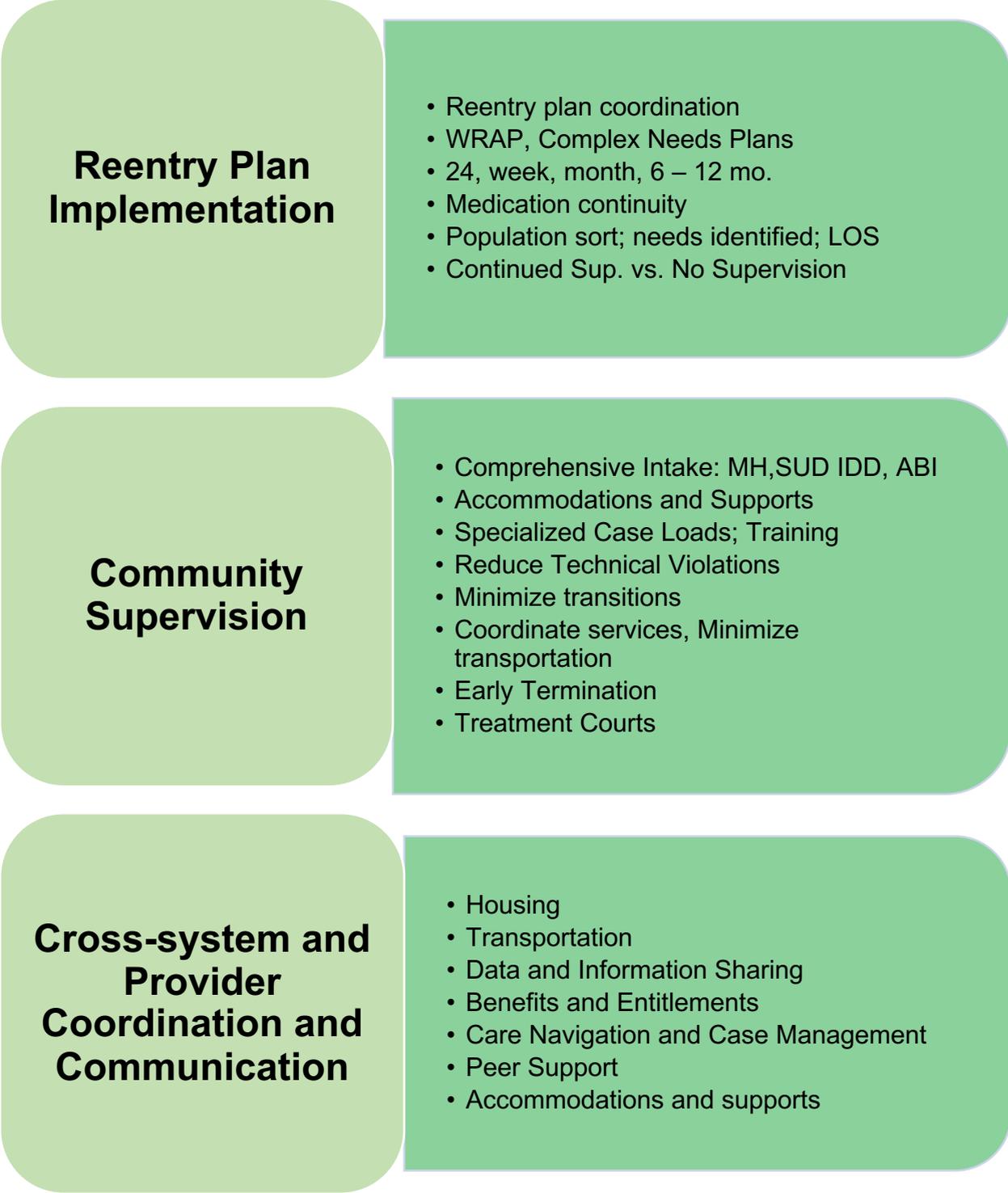
# Intercept 4 Reentry

# Intercept 5

Community Supervision and Services



# Intercept 4 – 5 Focus and Stakeholders



- Individual**
- Criminal Legal**
- Law Enforcement
  - **Courts: Prosecutor, Defense, Judicial Officers and Personnel**
    - **Treatment Courts**
  - **Sheriff and Detention Facilities**
    - Jail Programming
    - **Reentry services;**
    - **Community Provider Jail In-Reach**
  - **Probation and Parole Officers**
- Interventions, Services and Supports**
- Community Response Services (Alt. Health, Co-Response, Mobile)
  - Hospitals, ED, Urgent Care, Crisis Centers; **CCBHC, FQHC, VA**
  - **Supports: Peers –Person/ site-based; family, guardians/ advocates**
  - **Flexible Funds**
  - **Providers: Jail Medical and Mental Health; Community Mental Health and SUD; Community ABI, IDD, VJO**
    - full spectrum of settings & levels of intervention
- Targeted Services**
- **Housing, Homeless Supports; Residential, Home-based care**
  - Sobering and Detox
  - **Transportation**
  - **Education and Employment Services and Supports**
- Systems**
- **Human/ Social Services; SOAR, SSA, Medicaid & Waivers**
  - Government: Local and State; Licensing and Credentialing
  - Foundations and other funding sources
  - Higher Education Connections

## Welcome Back to Part II of our Series!

Before we dive into today's content, are there any questions about what we discussed last week? Please put them in the Chat.

# What *is* a Brain Injury?

An Acquired Brain Injury (ABI) occurs *After* Birth

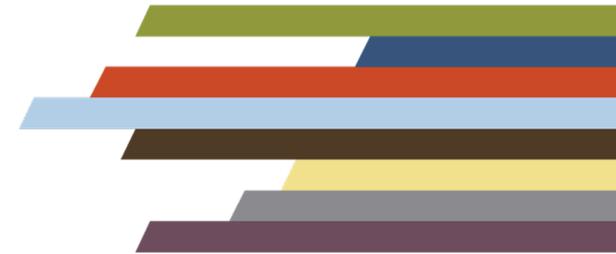
# Types of Brain Injury

## Traumatic Brain Injury (TBI)

TBI is an insult to the brain caused by an external physical force, such as a: fall, motor vehicle accident, assault, sports related incident, or improvised explosive device (IED) exposure

## Acquired Brain Injury (ABI)

ABI is an insult to the brain that has occurred after birth, such as: TBI, stroke, infections in the brain, strangulation and other events that result in a loss of oxygen to the brain; e.g., cardiac event, near drowning, overdose(s)



Having a history of brain injury can increase vulnerability to conditions and behaviors that commonly bring individuals into the criminal justice system, and in contact with Parole and Probation Professionals

Today we are going to focus on how parole and probation professionals can support individuals living with TBI

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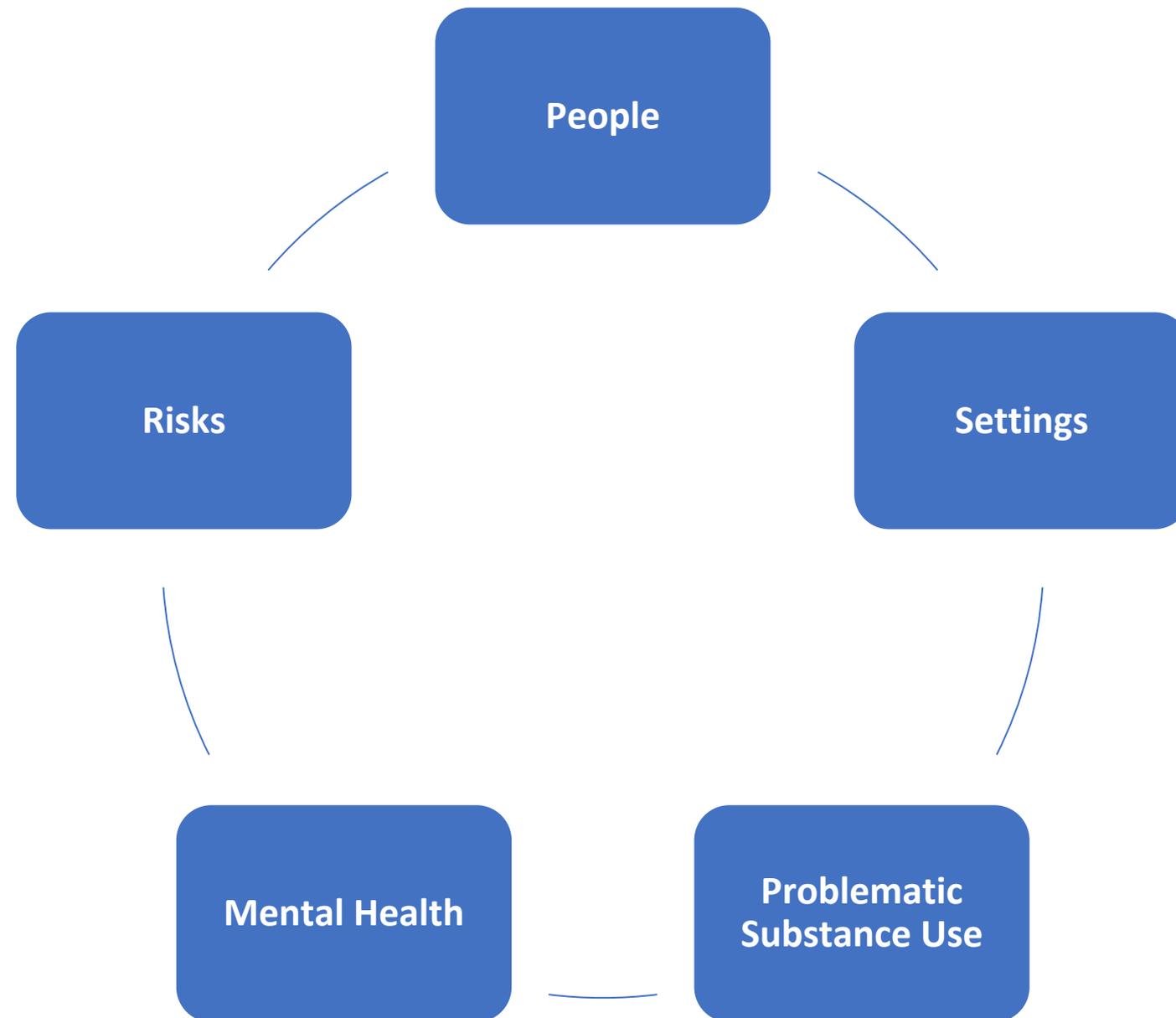
Share examples of applying engagement and support strategies through a brain injury-informed lens

# True or False

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1. People with a history of traumatic brain injury, even if the injury or injuries were mild have a higher risk of completed suicide than those without a history of brain injury
2. Among incarcerated adults, a history of TBI is 20%
3. Surviving an opioid overdose can result in an acquired brain injury
4. If someone has experienced a severe traumatic brain injury, chances are they will spend the rest of their lives in a nursing home
5. If someone is in post traumatic amnesia (PTA) after a blow to their head, they will be in a coma

# Quick review



# The Fingerprint of Traumatic & Acquired Brain Injury

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.Our frontal lobe and the temporal lobes are key to managing behavior and emotions.

**.Our frontal lobe and the temporal lobes are key to managing behavior and emotions. Survived overdose or overdose(s) also puts the frontal and temporal lobes at risk if they are deprived of oxygen**

.Thus, damage to these regions can contribute to mental health and/or addiction problems. Damage to these lobes is considered the **“Fingerprint of Traumatic Brain Injury.”**



# Possible Physical Changes

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<b>Injury-related problem</b>	<b>How it may affect a person functionally</b>
Coordination is impacted	Unsteady gait, poor eye-hand coordination, slow or slurred speech, tremors, paralysis
Trouble with vision	Staring or poor eye contact, blurred or double vision, inability to follow an object with their eyes, difficulty navigating the environment due to a brain injury related field cut, especially in unfamiliar environments
Additional Physical Challenges may include	Seizures, deaf or hard of hearing, fatigue

# Possible Cognitive (Thinking) Changes

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<b>Injury-related problem</b>	<b>How it may affect a person functionally</b>
Memory	Trouble following directions, providing requested information, making appointments
Processing (receptive)	Understanding what is being said and reading
Processing (expressive)	Trouble putting thoughts into words—tip of the tongue syndrome
Problem solving (related to frontal lobe and temporal tip injury)	Impulsive, easily frustrated, sexually disinhibited, interpersonally inflexible, poorly organized, verbally/physically combative

# Possible Behavioral Changes

<b>Injury related problem</b>	<b>How it may affect a person functionally</b>
Depression	Flat affect, lack of initiation, sadness, irritability
Unawareness	Unable to take social cues from others
Confabulation	“Making up stories”
Perservation	Gets “stuck” on a topic of conversation or physical action
Post Traumatic Stress Disorder	Intrusive thoughts, sleep disturbance, hypervigilant (when co-occurring with TBI, symptoms of both can be exacerbated)
Anxiety	Can exacerbate other cognitive/behavioral problems

“Consequences are particularly related to impulsivity and self-regulation”

John Corrigan Ph.D.

Remarks at the September 2018 National Association of State Head Injury Administrators conference, Des Moines Iowa, regarding the consequences of childhood brain injury.

“TBI can create challenges to managing offenders and to their successful community re-entry upon release”

*Shiroma, Feguson, Pickelsimer 2012*



**Looking for Clues**-Careful examination of medical, educational, employment, and prior involvement with the criminal justice system

# Looking for Clues (1 of 2)

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- Has this individual been exposed to a possible TBI or ABI
- Motor vehicle/motorcycle/all terrain vehicle accidents/related emergency department or hospitalization
- Did the individual play organized sports or engage in potentially risky recreational activities
- Is there evidence of childhood abuse or neglect
- Medical records that indicate history of traumatic brain injury or an acquired brain injury from lead poisoning, a stroke, brain tumor, epilepsy, meningitis or encephalitis
- History of overdose or overdoses from opioids and other substances

# Looking for Clues (2 of 2)

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- If a suspected insult to the brain happened in childhood, are there any reports from parents, caregivers, teachers, pediatricians around developmental impacts around not achieving expected benchmarks
- If the suspected insult to the brain happened in adolescence/young adulthood, are there any reports around initiation into drug or alcohol use, did the individual's academic performance diminish, were they experiencing depression, anxiety, were they diagnosed with conduct disorder, attention deficit hyperactivity disorder? Juvenile justice involvement?
- If the suspected insult to the brain happen in adolescence, young adulthood or beyond, did they stumble in anyway at the point they were expected to assume adult roles? Did drug or alcohol use markedly increase? Was there conflicts on the job with co-workers and supervisors, a pattern of leaving employment voluntarily or involuntarily? Was there a diagnosis of depression, anxiety, bipolar disorder or schizoaffective disorder?

To view on-line  
go to:

<https://heller.brandeis.edu/ibh/pdfs/accommodating-tbi-booklet-1-14.pdf>

# Accommodating the Symptoms of TBI

Ohio Valley Center for Brain  
Injury Prevention and  
Rehabilitation

With contributions from Minnesota Department of  
Human Services State Operated Services

# Accommodating Symptoms

Page 10 —

Reflective

Recommendations

***“What helps you  
with... ?”***

- Learning new material
- Remembering assignments
- Staying on track
- Figuring out how to do new things
- Making choices that keep you healthy and safe

# Incorporating Structure

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- With the individual establish a regular appointment time and day
- Address any possible barriers and formulate plans to address them e.g. transportation, internet connection and a private place to talk remotely/by phone
- With the individual, determine the preferred way to track topics and issues discussed, e.g. via journal, phone app etc.
- Incorporate strategies and accommodations recommended for individuals living with brain injury as best benefits the individual, e.g. individual fatigues easily, build in 1-2 minute stretch breaks into sessions, summarize main points at intervals throughout meetings and jot them down or have the individual record them on their phone, at the end record and/or review session “takeaways” and “next steps” (these can serve as homework between session as well as notes of topics to discuss in the next session)

# Accommodating Brain Injury related barriers

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- Encourage the use of a journal and/or calendar in whatever format or formats work for them
- Encourage the creation of a daily schedule with built in reminders
- Use a digital recorder
- Encourage use of rest and low activity periods-strategic naps
- Use of a highlighter when reading text when appropriate
- Use of templates for routine tasks at home and work
- Encourage liberal use of labels (kitchen drawers, files etc.)

# Communication Strategies (1 of 2)

Source: Joelle Ridgeway, MS

- Make and maintain eye contact during interactions
- Speak in short, simple sentences
- Speak in a neutral tone
- Ask the person to paraphrase what you have said frequently
- Give the person time to process what is being said
- When possible, give the person a “heads up” regarding what to expect during your interaction

# Communication Strategies (2 of 2) Source: Joelle Ridgeway, MS

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- Behavior-specific praising: Reinforce the positive behaviors you see—  
*“I like how you are sitting here talking to me”*
- Redirection
- Choose your battles. . . only focus on what matters
- Non-verbal cues (including tone of voice) **will be interpreted first**

# Cuing for Communication



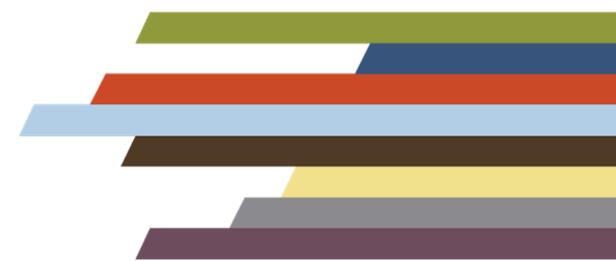
# De-Escalation through a brain injury informed lens

A/Sergeant Jennifer Spieth, Anne Arundel County

Maryland, CIT Team, adapted from remarks made at the  
CIT International Conference, 2020

1. Avoid crowding or “cornering” the individual
2. Avoid asking a lot of questions in the beginning
3. Avoid intervening too quickly or trying too hard to control the interaction by interrupting or talking over the individual
4. If the individual seems “stuck” on a word and you think you know what it is, don’t fill in the blanks for them without first asking if you can help

## Brain Injury Informed Rational for these Techniques

1. Risk of escalation due to misunderstanding of threat to personal safety
  2. Information conveyed verbally may be hard to attend, comprehend, and respond to due to “receptive aphasia”, aka processing challenges
  3. The individual may be living with short-term memory along with “expressive aphasia” aka word finding challenges, as a result the individual may lose their train of thought, become confused and behaviors are at risk of escalating
  4. Asking for permission engages the individual, reduces the risk of embarrassing or insulting them
- 

# Environmental Strategies: supportive to individuals with histories of Brain Injury and/or Trauma

(adapted from SAMHSA.gov)

- Staff person welcomes verbally/ there are welcome signs
- Clear directions with graphics posted
- Scratch paper and pencils at hand for notes
- Necessary forms to be filled out at first appointments are available on line or by mail
- Provide a template of a completed forms as a reference
- Area for children, toys, books, puzzles, child sized tables & chairs
- Waterfalls/fountains
- Plants
- Soothing music and smells
- Artwork by inspirational messages/created by program participants
- Calming paint colors (blue/green, pink, white, violet, grey, yellow)
- Non institutional lighting
- Seating allows for personal space
- Reading & resource materials available in the waiting room
- Non caffeinated beverages/water available

# Final Tips (1 of 2)

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- Repetition of information and practice of strategies is key to eventual internalization of that information and those strategies
- Don't take at face value someone "gets it", they may sincerely believe they are good with say, a change in appointment time, but follow that up with supportive strategies such as a follow up email/text
- Don't automatically assume social or interpersonal faux pas are volitional or intentional, they can be, but they also can be the result of behavioral dysregulation, inability to pick up on or accurately interpret social cues and nonverbal communication and gestures

# Final Tips (2 of 2)

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- Hold people accountable to expectations, rules and requirements, enhancing success of meeting expectations through brain injury informed and person-centered strategies
- Don't assume a "hard stare" is rooted in disrespect or hostility, it can just as easily be related to difficulties in comprehension of what is being discussed

# *What Might it Feel Like to Be Living with a Brain Injury?*

*Writing and processing exercise*



# Up Next in this Series

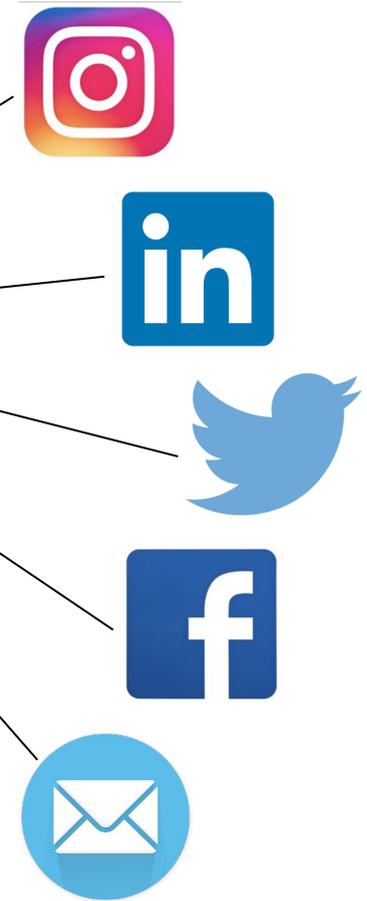
July 14, 2022-11:00 AM Mountain Time: How to Approach, Engage and Direct Individuals living with TBI-Wrap-Up Panel

Questions?

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# Thank You!

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Injury Administrators,

<https://www.nashia.org/> National  
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