

How to Approach, Engage, and Direct Individuals Living with TBI-A Training Series for First Responders-Introduction

Anastasia Edmonston MS CRC & Judy Dettmer

National Association of State Head Injury Administrators (NASHIA)

June 9, 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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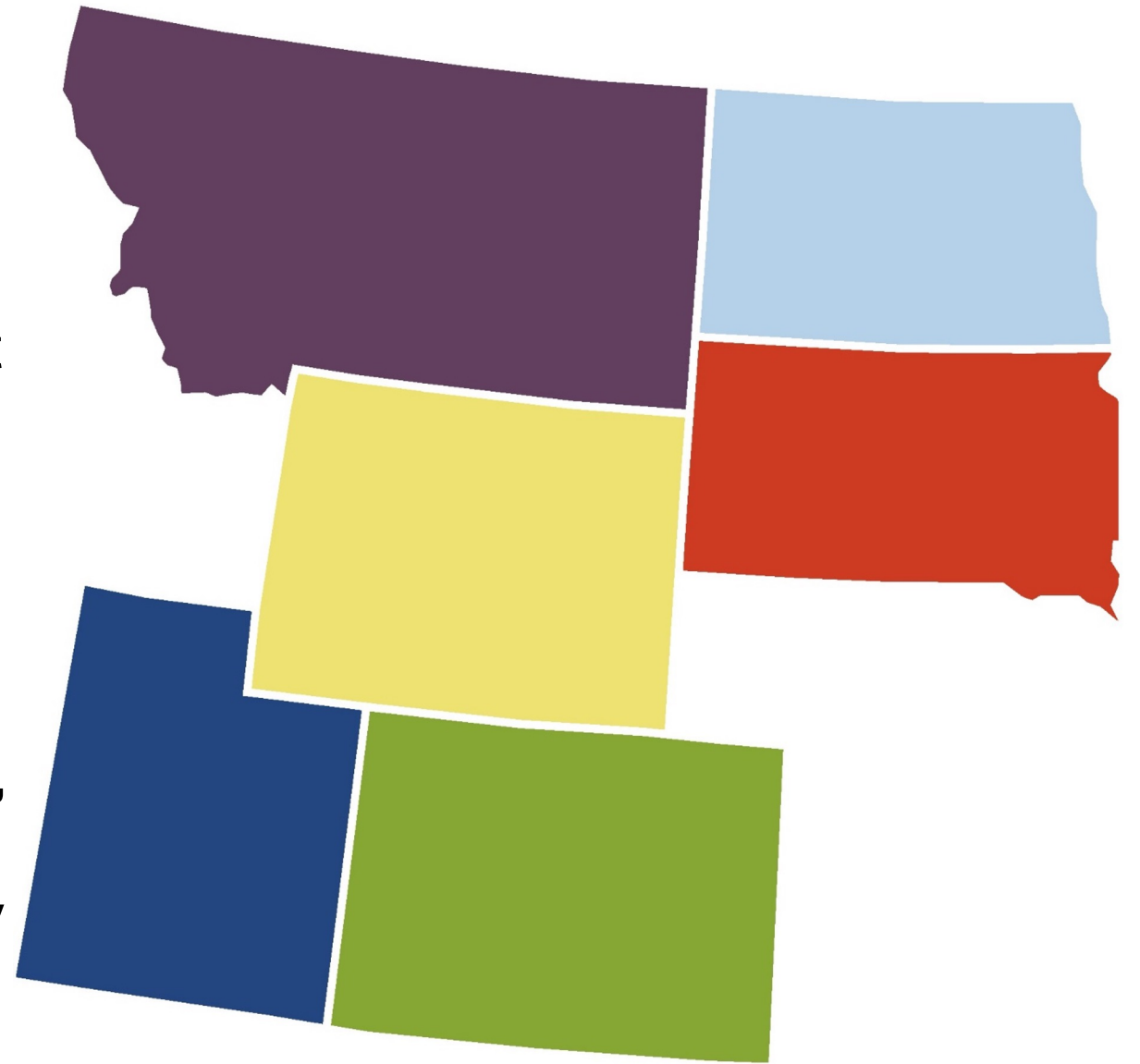
At the time of this presentation, Miriam E. Delphin-Rittmon, Ph.D. served as acting SAMHSA Assistant Secretary. The opinions expressed herein are the views of Anastasia Edmonston and Judy Dettmer, and do not reflect the official position of the Department of Health and Human Services (DHHS), or SAMHSA. 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

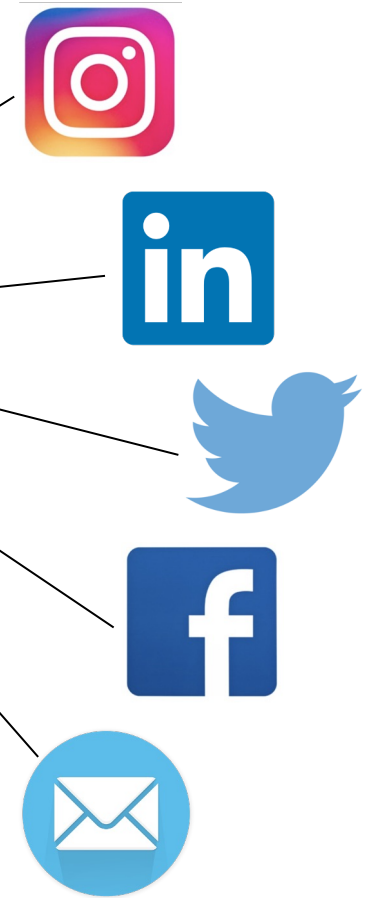
NON-JUDGMENTAL AND
AVOIDING ASSUMPTIONS

RESPECTFUL, CLEAR
AND UNDERSTANDABLE

CONSISTENT WITH
OUR ACTIONS,
POLICIES, AND PRODUCTS

Stay Connected

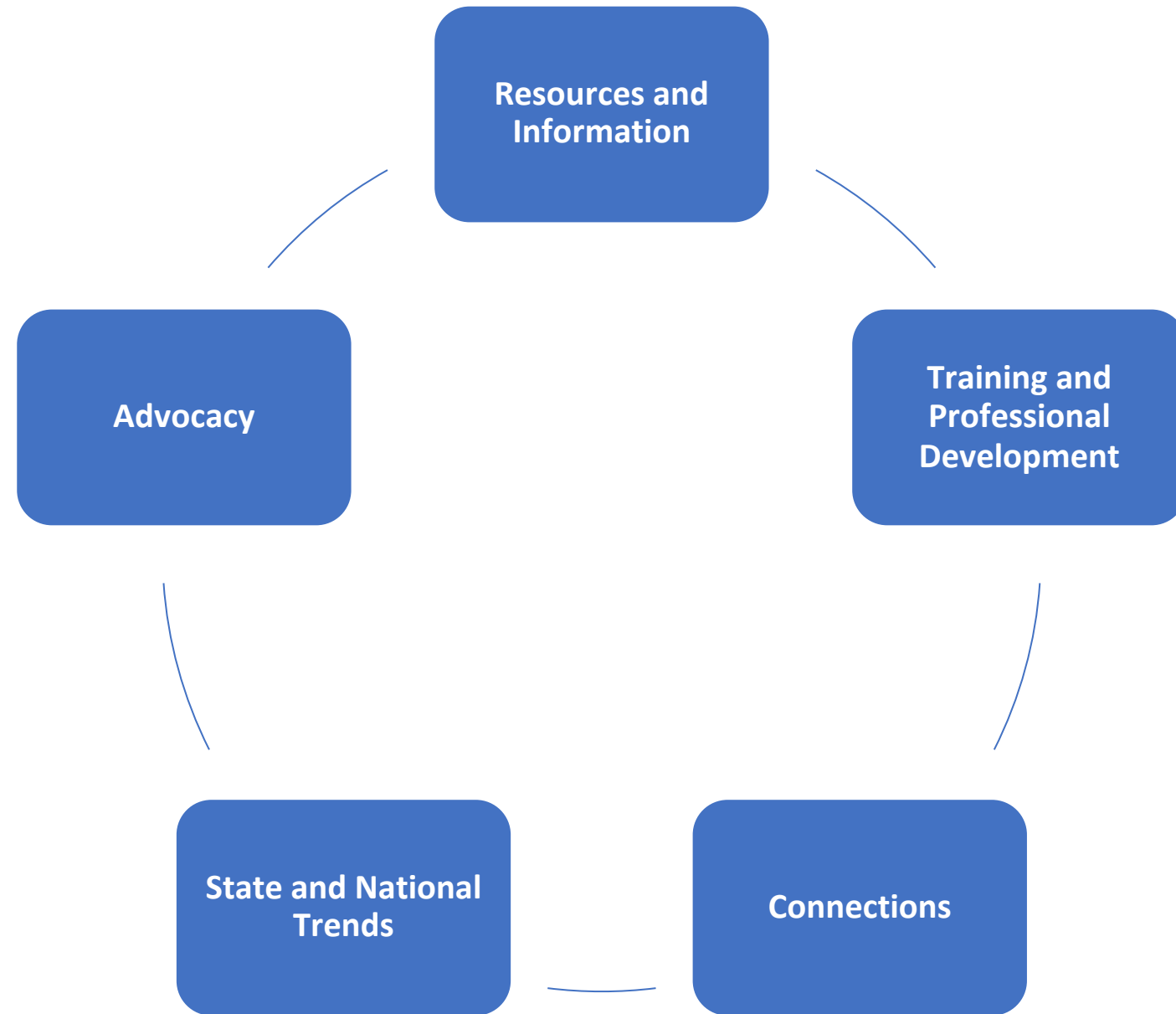
Scan this QR code to follow us on Instagram, LinkedIn, Twitter, and Facebook. You can also join our e-mail newsletter!



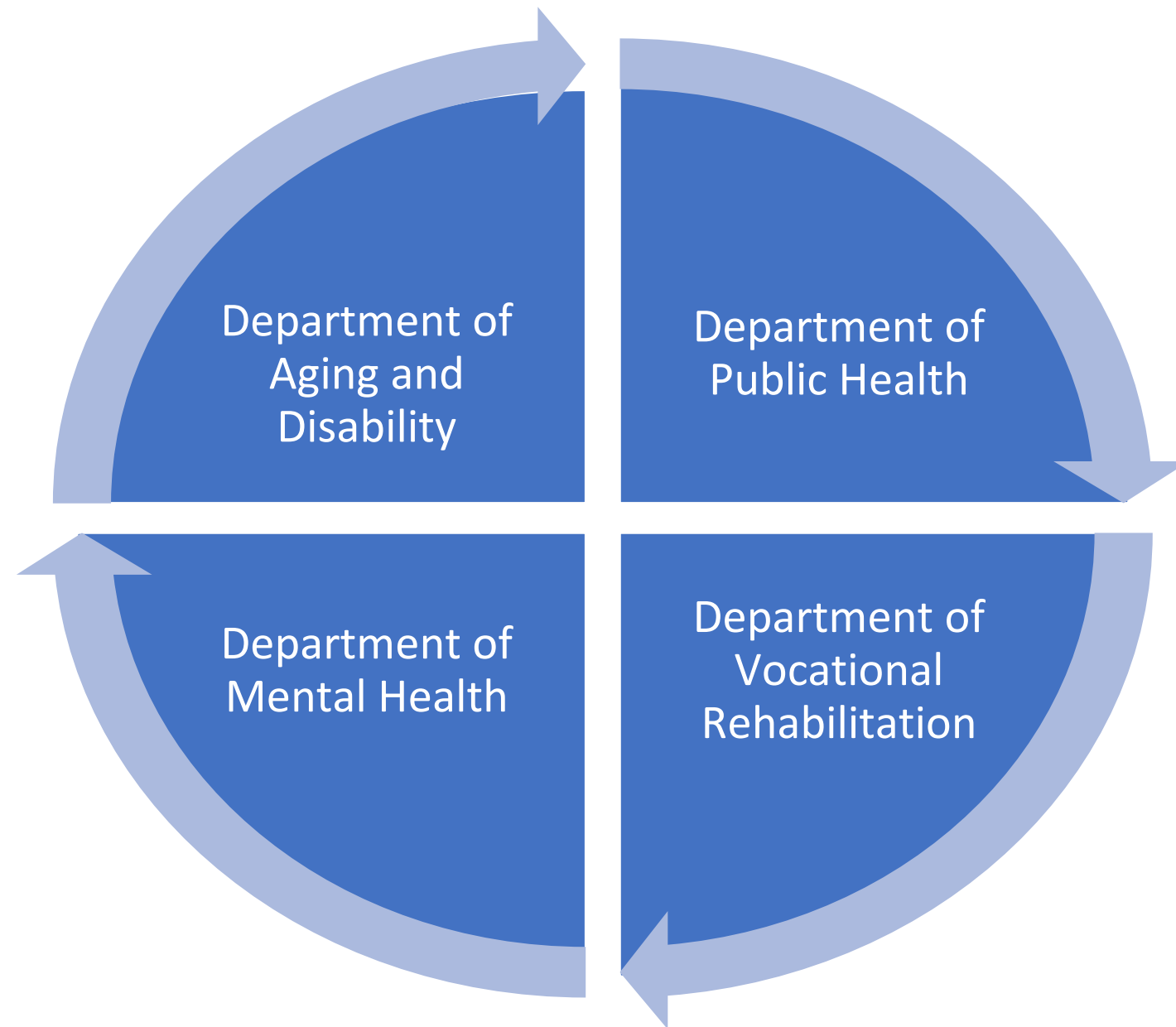
NASHIA'S MISSION

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



STATE BRAIN INJURY PROGRAMS



PARTNERSHIPS ARE ESSENTIAL



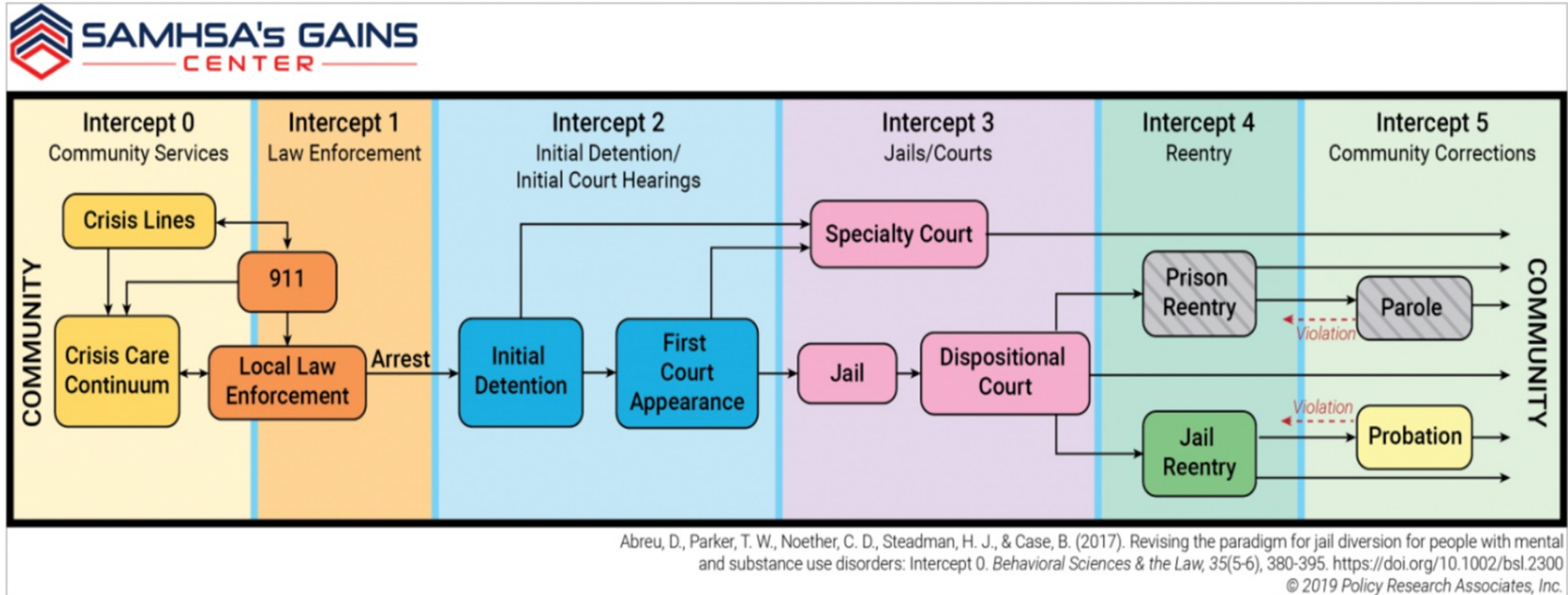
NASHIA TEAM



Sequential Intercept Model (SIM)

- 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



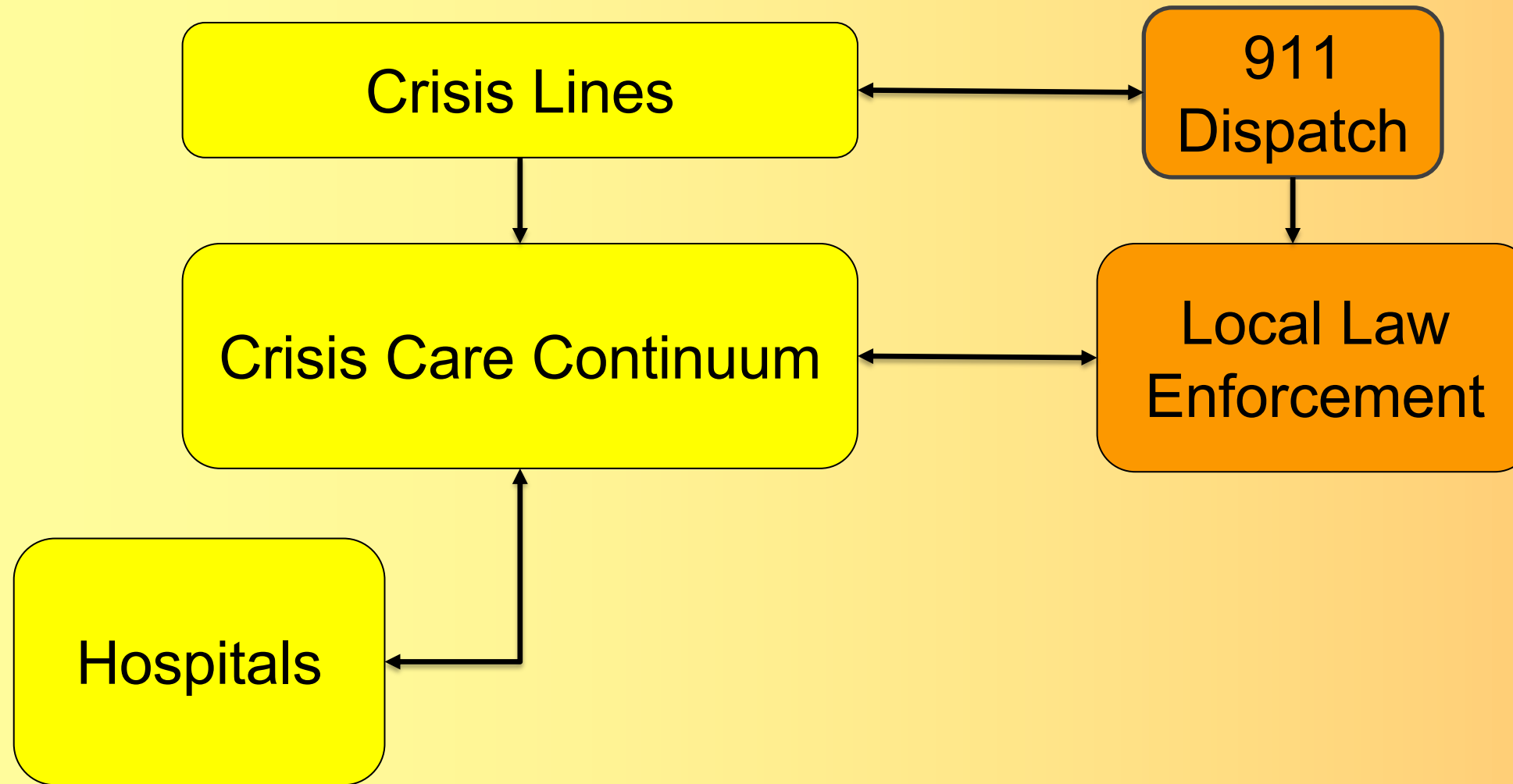
Intercept 0

Community Services

Intercept 1

Law Enforcement

COMMUNITY



Intercept 0 – 1 Focus and Stakeholders

Deflection to Services

- Alternatives to legal system
- Population and needs identification
- No Wrong Door
- Proactive services

Care Continuum

- Pre-Crisis
- Crisis
- Stabilization
- Recovery and On-going Services and Supports

Cross-system and Provider Coordination and Communication

- Housing
- Transportation
- Data and Information Sharing
- Benefits and Entitlements
- Care Navigation and Case Management
- Peer Support

Individual

Criminal Legal

Interventions, Services and Supports

- **Call Centers (911,988, warmlines, NAMI, 211)**
- **First Responders: EMS, Fire, Law Enforcement**
- **Community Response Services (Alt. Health, Co-Response, Mobile)**
- State Institutions
- **Hospitals, ED, Urgent Care, Crisis Centers; CCBHC, FQHCs, 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 and levels of intervention

Targeted Services

- **Housing, Homeless Supports; Residential, Home-based care**
- **Sobering and Detox**
- **Transportation**
- **Education and Employment Services and Supports**

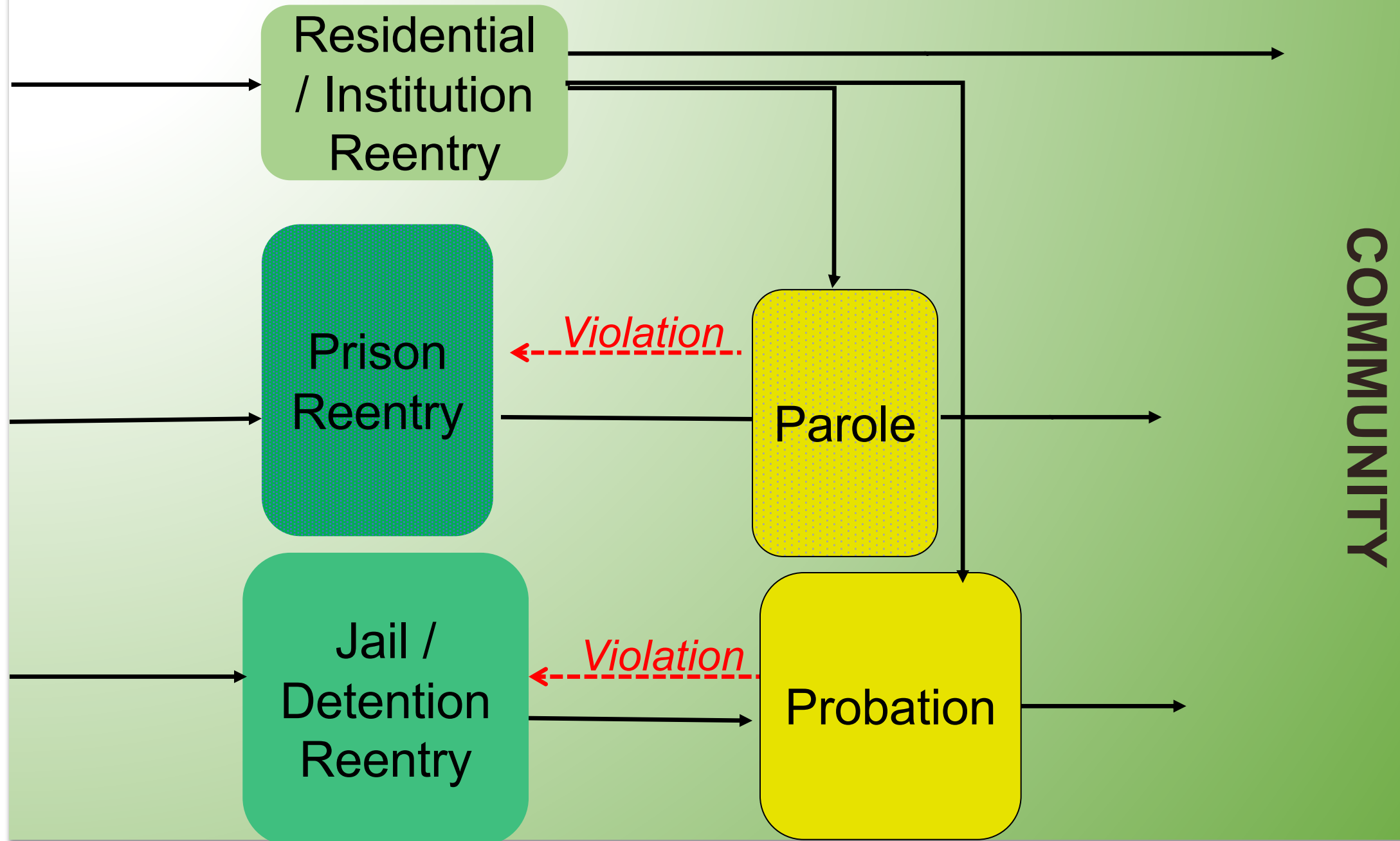
Systems

- **Human/ Social Services; SOAR, SSA; Medicaid/Waivers**
- **Government: Local and State; Licensing and Credentialing**
- Foundations and other funding sources
- **Higher Education Connections**

Intercept 4 Reentry

Intercept 5

Community Supervision and Services



Intercept 4 – 5 Focus and Stakeholders

Reentry Plan Implementation

- Reentry plan coordination
- WRAP, Complex Needs Plans
- 24, week, month, 6 – 12 mo.
- Medication continuity
- Population sort; needs identified; LOS
- Continued Sup. vs. No Supervision

Community Supervision

- Comprehensive Intake: MH,SUD IDD, ABI
- Accommodations and Supports
- Specialized Case Loads; Training
- Reduce Technical Violations
- Minimize transitions
- Coordinate services, Minimize transportation
- Early Termination
- Treatment Courts

Cross-system and Provider Coordination and Communication

- Housing
- Transportation
- Data and Information Sharing
- Benefits and Entitlements
- Care Navigation and Case Management
- Peer Support
- Accommodations and supports

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**
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- **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

Traumatic Brain Injury An Overview for First Responders

Tips and strategies for brain
injury informed engagement



Why is it Important?

Having a history of brain injury can increase vulnerability to conditions and behaviors that may be factors in both crisis situations as well in services and supports during re-entry post incarceration

Why is it important for first responders, law enforcement and probation and parole professionals to have a working understanding of Brain Injury?

Recognizing possible signs and symptoms of brain injury in individuals experiencing crisis in the community and interacting in a brain injury informed way can reduce escalation of crisis situations and improve engagement with community services

What *is* a Brain Injury?

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

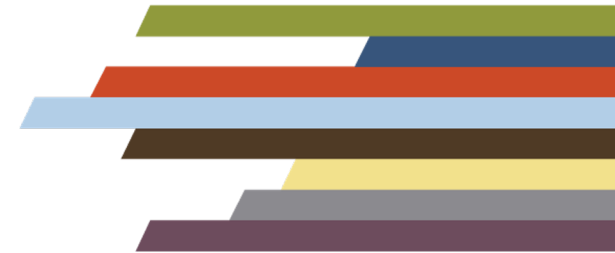
Types of Brain Injury

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)



Traumatic Brain Injury Severity

Distribution of severity:

- **Mild injuries = 80 percent**
(Loss of consciousness (LOC) < 30 minutes, post traumatic amnesia (PTA) < 1 hour)
- Moderate = 10–13 percent
(LOC 30 minutes to 24 hours, PTA 1 to 24 hours)
- Severe = 7–10 percent
(LOC >24 hours, PTA >24 hours)

Brain Injury Through the Life Span

- Childhood TBI
- Mild and multiple mild TBI's incurred during youth/adolescence
- Mild to moderate TBI's incurred in adulthood
- Mild to Severe TBI's incurred later in life, 65+
- Aging with a history of Brain injury

Who is NOT considered to be living with a Traumatic Brain Injury (1 of 2)

An individual living with an Intellectual/Developmental Disability such as Down's Syndrome

Why?

- Before their brain injury people are on an expected developmental path
- Brain Injury can occur at any age or stage of life
- After brain injury, a person may have what is referred to as “splinter” skills. For example, they may get lost driving from their house to the local grocery store, but retain the physical skills and ability needed to drive. For individuals living with Downs Syndrome, their intellectual skills are relatively static.
- For an individual impacted by brain injury, for them, their loved ones, friends and colleagues; there is a definite *before and after*

Who is NOT considered to be living with a Traumatic Brain Injury (2 of 2)

An individual living with Dementia (e.g., Alzheimer's, Lewy Body, Vascular Dementia)

Why?

- Dementia, even early onset dementia occurs in midlife and beyond
- A Brain Injury can occur any time after birth
- People living with Dementia experience progressive loss of cognitive and physical skills, with the period from diagnosis to death spanning on average, 10 years
- People living with a history of severe brain injury may be able to learn new information/skills if it is repeated/lots of opportunity to practice, those living with Dementia cannot learn new information and hang on to it

What might individuals living with Brain Injury, Intellectual Disabilities and Dementia have in common?

- They may co-occur
- There can be challenges to regulating behavior
- Similar strategies for engaging in a positive way and de-escalation techniques can be deployed by first responders and law enforcement professionals

Some Risk Factors for TBI

(Adapted from Corrigan 2014)

- You are very young
- You are an older adult
- You use substances or are around people who do

Brain Fast Facts (1 of 2)

CDC 2017

2.8 million Americans are treated in Emergency Departments (ED), hospitalized, or die as a result of a TBI each year

There were about **61,000** TBI related deaths in the US in 2019-that works out to roughly **166** related deaths a day

Suicide accounted for **35.5%** of TBI related deaths in 2019

Among non-fatal TBI-related injuries in 2013:

Rates of Emergency Department (ED) visits highest for those **75 and older** and **children 0 to 4**

Being **struck by or against** an object was the leading cause of TBI related ED visits for those 15 to 24

Falls were the leading cause of hospitalization among **children 0 to 14** and **adults 45 and older**

Motor vehicle crashes were the leading cause of hospitalizations for adolescents and persons **14 to 44** years of age

Brain Fast Facts (2 of 2)

CDC 2017

The brain reaches its adult weight of 3 pounds at age 12

On average the brain reaches full maturity at age 25

The last part of the brain to develop is the Frontal Lobe

The frontal lobe reaches biological maturity in females at 23, males 24

Post Traumatic Amnesia



Post Traumatic Amnesia may be observed in:

- Individuals who have been in a motor vehicle crash, including a “fender bender”
- Individuals who have been victims of violence-including intimate partner violence
- Individuals who have experienced a fall
- Individuals who had their “bell rung” playing organized or recreational sports

*Don't take at face value that they are fine; they may say they are, and they may appear to be fine. Encourage them to get checked out, **especially if they are an older adult***

Observing: Thinking/Cognitive Clues of a Possible Brain Injury

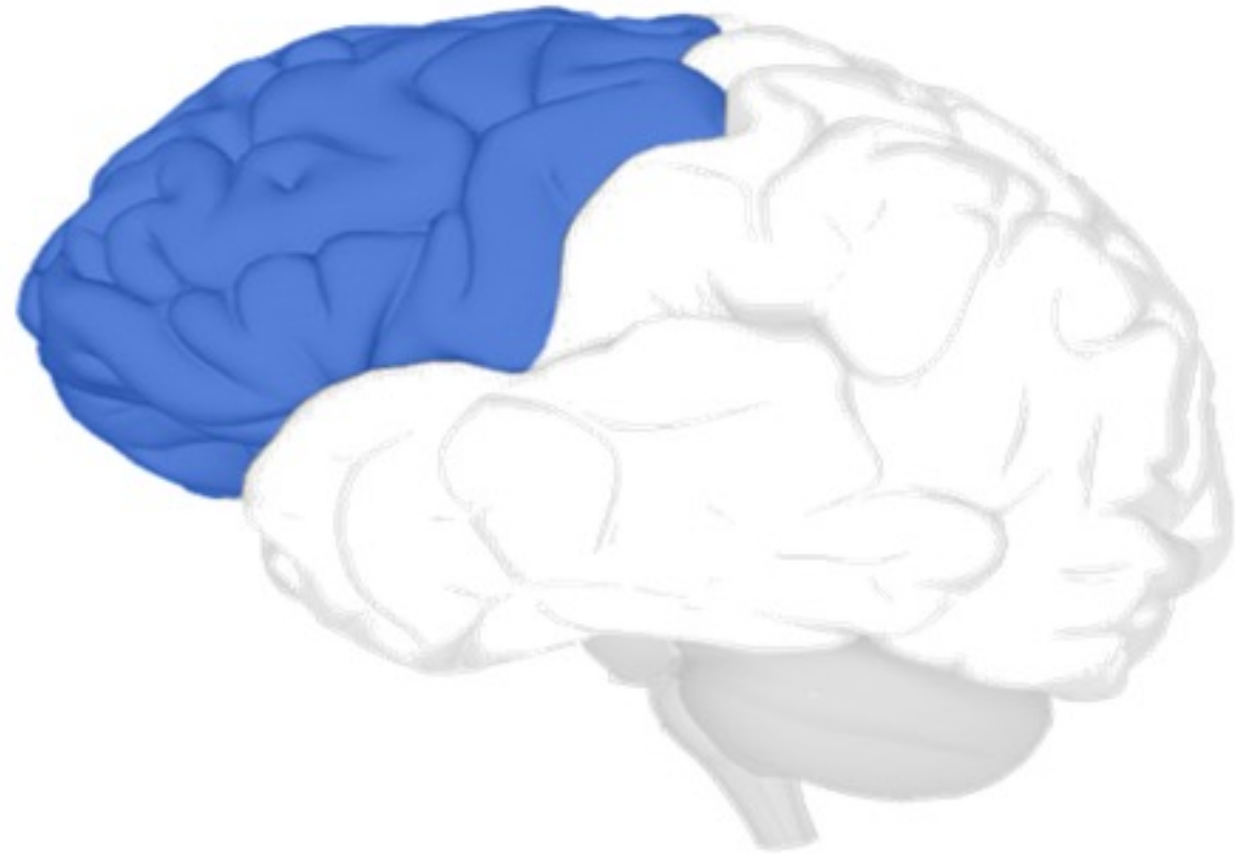
- Blank facial expression in response to a question or request
- Seems unable to relay basic personal information such as where they are coming from, where they are going, what is their current address
- Responses are disorganized
- Responses include information that was not requested (e.g., after stating their name and adding extraneous information such as who they were named after)
- Repeats responses
- Responses are not factual given the situation/known facts

A review of the epidemiologic characteristics of repetitive TBI in the general population, excluding athletes and service members found that post injury, at least 5.5% of individuals experienced another TBI that required medical attention. Each subsequent injury can magnify disability thus increasing TBI burden, especially if the injuries occurred before the brain had recovered from the earlier injury. Risk factors included; male, alcohol intoxication, epilepsy, lower socioeconomic status

Lasry, O., Liu, E. Y., Powell, G. A., Ruel-Laliberté, J., Marcoux, J., & Buckeridge, D. L. (2017). Epidemiology of recurrent traumatic brain injury in the general population: A systematic review. *Neurology*, 89(21), 2198–2209. <https://doi.org/10.1212/WNL.0000000000004671>

The frontal lobe is the area of the brain responsible for our “executive skills,” or higher cognitive functions.

- These include:
- Problem-solving
- Spontaneity
- Memory
- Language
- Motivation
- Judgment
- Impulse control
- Social and sexual behavior



The temporal lobe plays a role in emotions and is also responsible for:

- Smelling
- Tasting
- Perception
- Memory
- Understanding music
- Aggressiveness
- Sexual behavior

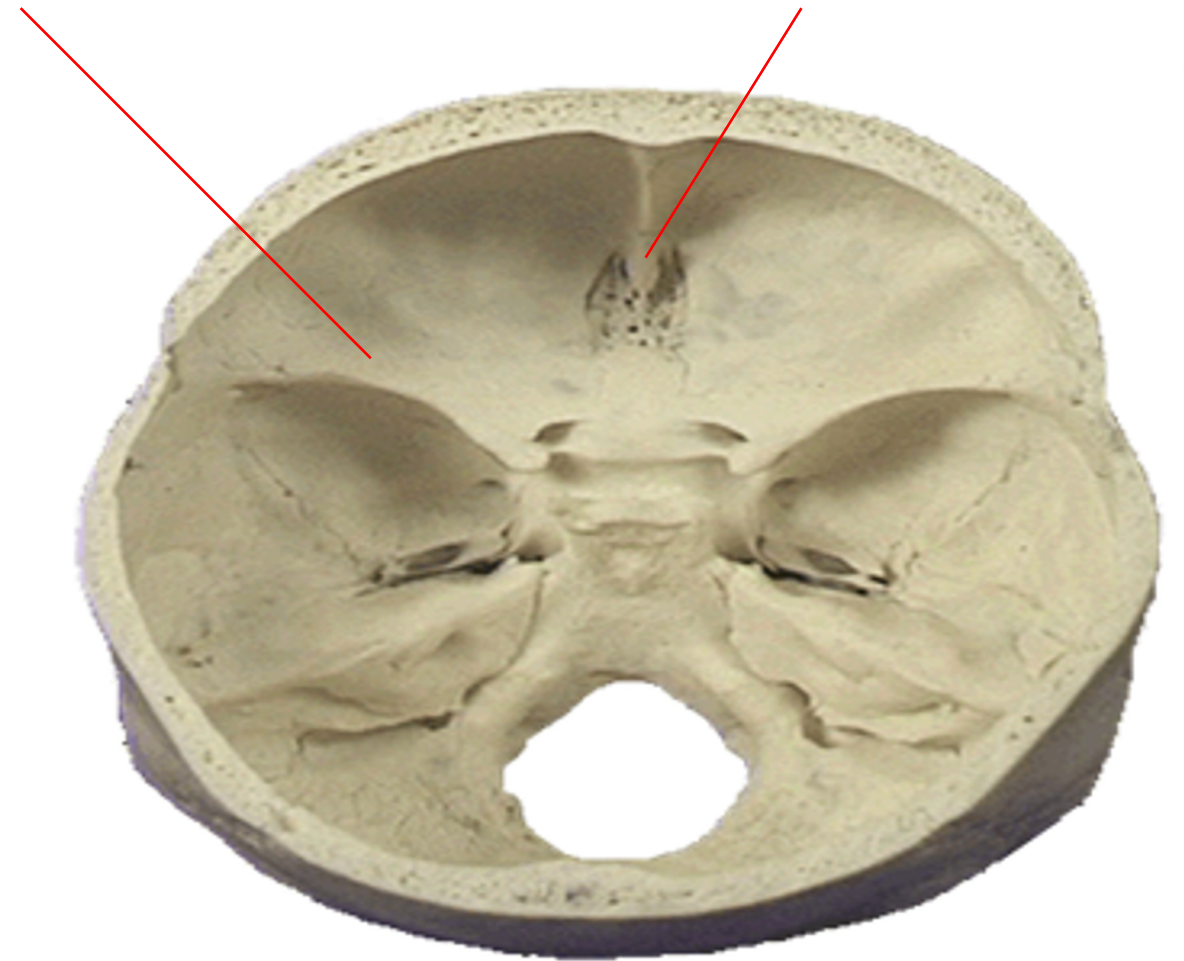
The left temporal lobe aids in understanding language and learning and remembering what we hear

The right temporal lobe aids in learning and remembering non-verbal information-what we see



Why the Frontal & Temporal Lobes are so vulnerable to injury

The brain is the consistency of overcooked cauliflower. When an excessive outside force is applied, the brain can be shaken within the skull, causing it to come up against the hard bony ridges located on the underside of the skull



Common Challenges After Brain Injury-that may be observed by 1st responders

COGNITIVE/THINKING	EMOTIONAL	PHYSICAL
Memory and Attention	Depression and anxiety	Unsteady gait, poor coordination
Comprehension of what is being read or heard	Reduced or lack of awareness of functional impact of injury-imposed challenges	Slow or slurred speech
Communicating thoughts verbally or in writing	Disinhibition and impulsivity	Sensitivity to noise or light
Problem solving difficulties, impulse control and difficulty organizing thoughts, words and actions (aka executive skills)	Reduced frustration tolerance and irritability	Fatigue

There are other clues that may indicate a person may be living with a history of brain injury

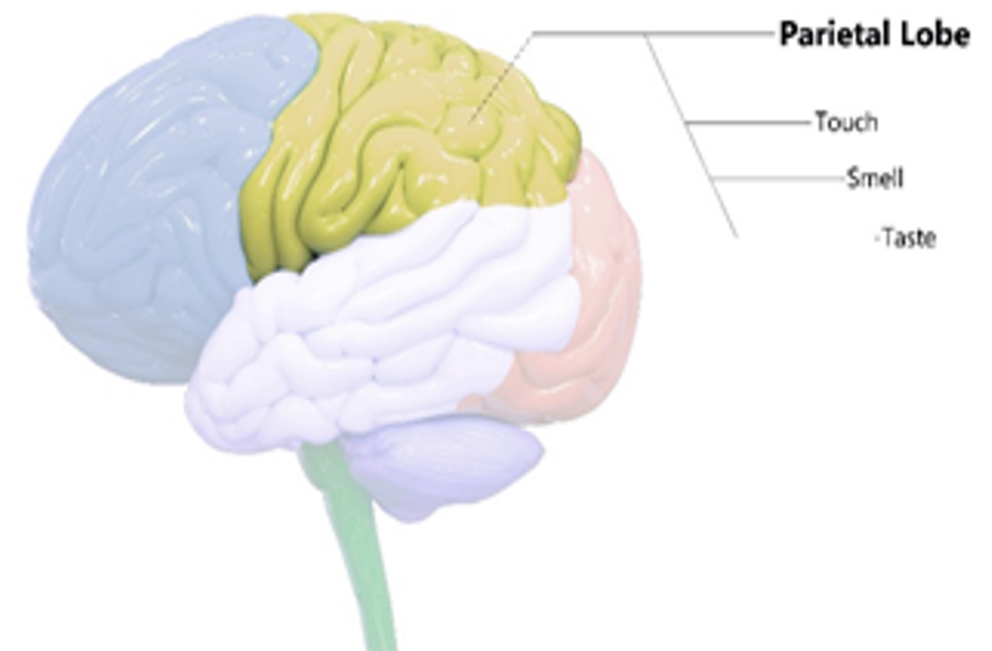
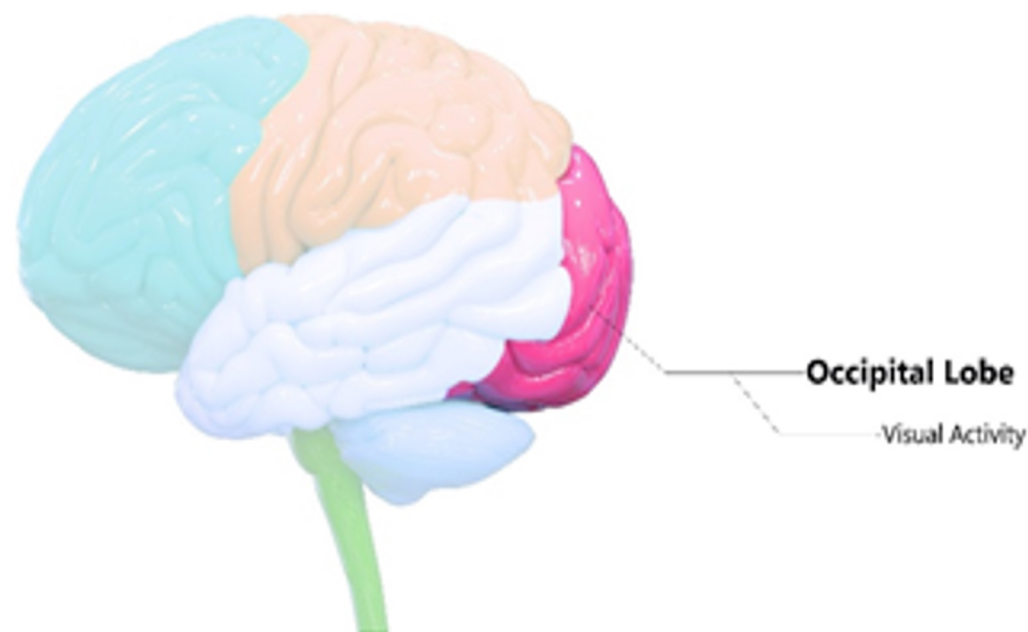
- You may observe scars on an individual's forehead, neck, face
- The individual is unsteady on their feet, limps or drags one foot while walking, may use a cane, walker or wheelchair
- Individual is wearing an eye patch, or they have what looks like a diamond cut lens in one side of their glasses
- The individual denies problems or challenges that are clear to others
- Individual seems to have difficulty making eye contact or looks like they are not paying attention to you

The Fingerprint of Traumatic & Acquired Brain Injury

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.”**



What can Living with a Traumatic Brain Injury Look Like?



In the Chat....

- What are some of the **physical** signs and symptoms of brain injury do you notice that Eddie, Brian and Tracy are living with?
- What are some of the **cognitive/thinking** signs and symptoms of brain injury do you notice that Eddie, Brian and Tracy are living with?
- What are some of the **behavioral/emotional** signs and symptoms of brain injury do you notice that Eddie, Brian and Tracy are living with?
- What are some strategies that you observed they are using for support of their brain injury related challenges?

Recognizing Brain Injury (1 of 2)

People with TBI are over-represented:

- **Among the incarcerated- 41-51%, with some estimates as high as 85%**
- Among the homeless
- And in treatment settings that support individuals living with mental health and substance use disorders

Recognizing Brain Injury (2 of 2)

People with TBI are over-represented:

- **Among those impacted by Intimate Partner Violence, prevalence of victims with TBI is 11-79%** <https://www.gao.gov/assets/gao-20-534.pdf>
- Native Americans and African Americans
- Individuals impacted by racial and economic disparities
- Among those who serve/have served in the Armed Forces
- Athletes—professional and amateur

Recognizing racial and economic factors across minority populations (1 of 2)

- Non-Hispanic black and Hispanic individuals are less likely to receive follow up care and rehabilitation following TBI than non-Hispanic whites
- Racial and ethnic minorities are also more likely to have poor psychosocial, functional, and employment outcomes post TBI than non-Hispanic whites
- People with lower incomes & without health insurance have less access to TBI specialized care
- According to the Centers for Disease Control and Prevention, people in rural areas have a greater risk of dying from a TBI compared to those living in an urban area, due to time needed to travel to emergency care, less access to a Level 1 trauma center and difficulty getting services, such as specialized TBI care

Traumatic Brain Injury and Native Americans & Alaskan Natives (1 of 2)

- Unintentional injury is the third leading cause of death of Native Americans and Alaskan Natives (NA/AN) of all ages
- Studies over the past few decades find that NA & AN have higher rates of TBI than other racial/ethnic groups

Traumatic Brain Injury Native Americans & Alaskan Natives (2 of 2)

- Native American and Alaska Native people have the highest TBI related mortality in the United States
- Native American and Alaska Native children with severe TBI tend to have poorer functional outcomes than their non-Hispanic White peers, while researchers are not certain why this is, hypotheses include the following barriers:
 - Children may have limited family support due to the distance from home to hospital
 - Treatment alliance mismatch related to cultural factors
 - Fewer family-team meetings perhaps as a result

“TBI in Kids: time reveals all wounds”

Marilyn Lash, speech & language pathologist

Later Developmental Emergence of Deficits, AKA

“*Growing into Brain Injury*” *Dr. Gerry Gioia, pediatric neuropsychologist*

Growing into Brain Injury

Without proper supports, brain injury can lead to mental health and addiction issues that bring people living with “hidden” TBI into the criminal justice system.

Appropriately, structure offered by school, parents, and community fall away as children go through adolescence into adulthood. A TBI that incurred at age seven may not be fully “unmasked” functionally or behaviorally until age 11, 12, or 13 with the challenges of middle school/puberty

The frontal lobe and temporal tips injured earlier are unable to adequately respond to the expectations of behavioral regulation and executive skill functioning

Brain Injury among Juvenile Justice Involved Youth

- “A meta-analysis found the prevalence of brain injury in the juvenile justice system to be an average of 44%” *
- In a 2014 article in the *Journal of Adolescent Health*, newly admitted adolescents to the New York City jail system found that **50 percent** of the male juveniles and **49 percent** of the females had a history of TBI

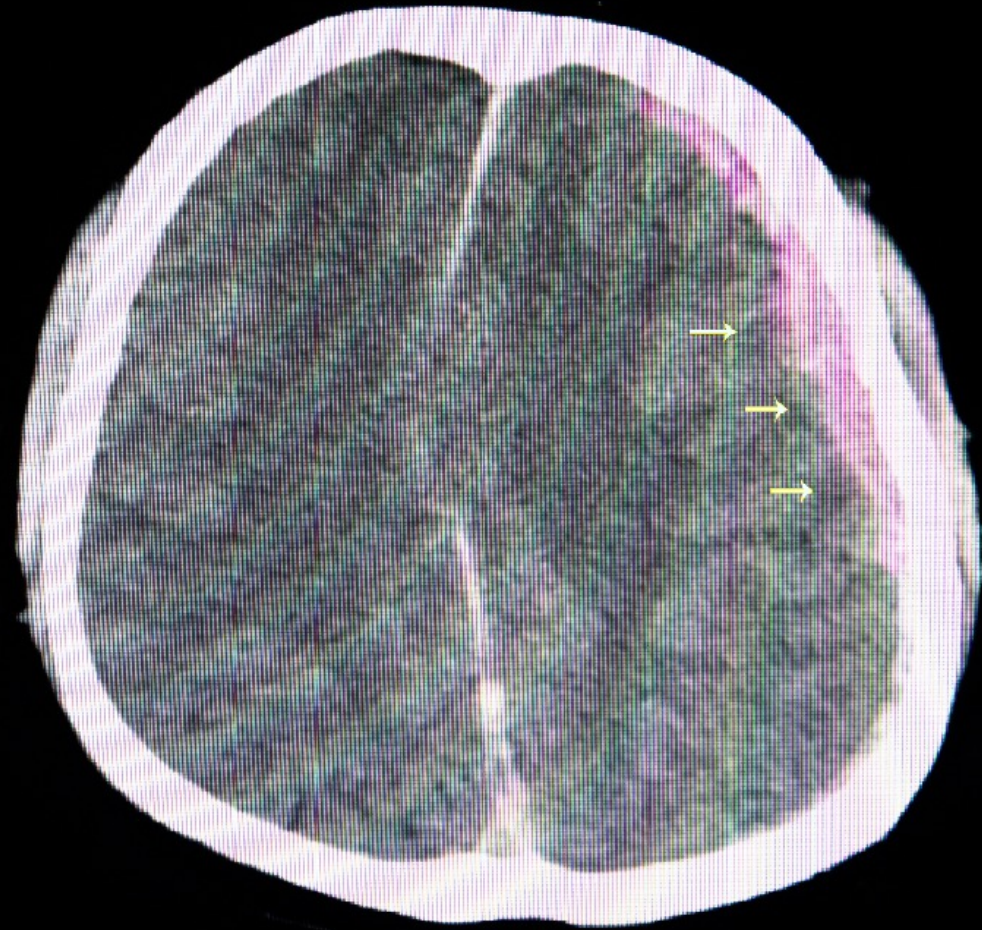
These adverse consequences of childhood traumatic brain injury often overlap with experience of adverse childhood experiences, access to appropriate long-term services, lower socioeconomic circumstances

Sustaining traumatic brain injury during childhood and adolescence increases the risk of any criminality 6-8-fold, conduct disorder 5-7-fold and concomitant criminality and conduct disorder 18.7-fold*

*From the NASHIA Criminal and Juvenile Justice Best Practice Guide

Risks of Brain Injury Specific to Older Adults

- Low force = substantial injury-as is said about kids & concussion, “when in doubt, check it out!”
- Adults aged 65 and older are at a greater risk of being hit by a car as a pedestrian than are children, many older adults cannot navigate crossing the street at a crosswalk at the expected rate of four feet per second
- Older adults are active! This is a good thing, but it does come with sports related risks for those 55-64 years of age those risks include; skiing-related TBI and bicycle-related, commonly occurring while mounting or dismounting a bike



**Older Adults-is it a TBI,
Dementia, Delirium, a
Behavioral Health Disorder?**

Example-you respond to a call because an older adult is confused, seems out of it, maybe they were shopping, and the employees noted something off- it may be due to a slow bleed caused by a bump on the head that, had it happened in youth or middle age, would have been no big deal, it can very well be a big deal if not attended to quickly

Substance Use Disorders-Alcohol

- “Alcohol intoxication is one of the strongest predictors of Traumatic Brain Injury”
- “A substantial proportion of Traumatic Brain Injury occurs in intoxicated individuals”
- Having a history of TBI is a potential risk factor for developing an alcohol use disorder
- Using alcohol after brain injury can negatively impact post brain injury recovery

Source: Weil, Z. M., Corrigan, J. D., & Karelina, K. (2018). Alcohol Use Disorder and Traumatic Brain Injury. *Alcohol research : current reviews*, 39(2), 171–180.

“Are they drunk or living with a Brain Injury?”

- Individuals who are intoxicated exhibit unsteady walking with **no observable pattern** to their gait- individuals living with brain injury exhibit a **pattern** to their gait, for example, always limp on their right side
- Individuals who are intoxicated will smell of alcohol
- Red eyes are common among individuals who have had too much to drink and is not typically associated with TBI

Of course, people with a history of brain injury may drink to excess, and may exhibit the above clues, our point is don't assume someone having trouble walking is automatically drunk

Source: Schackelford et.al, “ Training Law Enforcement Officers to Differentiate Traumatic Brain Injury and Alcohol Intoxication”, *Contemporary Issues in Communication, Science and Disorders Volume 43.154-163* retrieved on 4.27.20
https://pubs.asha.org/doi/pdf/10.1044/cicsd_43_S_154

“TBI and Methamphetamine: a double hit to the brain”

According to a recent article in the Journal of Neurological Sciences:

“Methamphetamine is the most abused synthetic psychostimulant worldwide

These two brain insults crosstalk at structural, biochemical, and cellular levels

If combined, the two entities may synergize to cause significant neuronal damage”

Hypothetical Nonfatal Overdose Review case through a Brain Injury Informed Lens (1 of 4)

Knowing a positive history of brain injury in an individual's life, can lead to strategies to mitigate the risk of fatal overdose among people who use drugs. In many states, including Utah and some jurisdictions in Wyoming, as well as in my home state of Maryland, Local Overdose Fatality Review teams pull cases, typically quarterly to identify trends in order to formulate targeted responses to spikes in overdoses

This approach can also be used following a nonfatal overdose

Hypothetical Nonfatal Overdose Review through a Brain Injury Informed Lens (2 of 4)

A 49-year-old man passed was found unresponsive in his room by a housemate. The housemate-initiated CPR and called 911. First responders arrived and were able to restore breathing. He was transferred to the local hospital and kept under observation, as well as treatment for wounds around injection sites, for 24 hours.

The roommate told the first responders he had been drinking the night before and he believed he had injected heroin as well. Additional information about this individual's history includes a bout of meningitis at the age of 10 that required hospitalization, poor academic performance that began in middle school. When he was a sophomore in high school, he was the passenger in a vehicle driven by a friend. They were both intoxicated, and the driver ran off the road. The driver was killed, and the individual was hospitalized with a severe concussion and broken ribs. He experienced headaches for years and according to his family, he was initially prescribed opioids to treat the pain from his injuries.

Hypothetical Nonfatal Overdose Review case through a Brain Injury Informed Lens (3 of 4)

Additional available information:

- Dropped out of high school
- Worked periodically as a delivery driver for local florists and pharmacies as well as an auto part company
- Maryland case search reveals several short term stays in the county detention center for theft, assault and battery
- On several occasions he entered outpatient treatment for his substance use but left prematurely, on at least one of those occasions it was reported he had conflicts with fellow group members, and he had reported to his counselor, he couldn't sit still during groups

Hypothetical Overdose Fatality Review (ODFR) case through a Brain Injury Informed Lens (4 of 4) Breakout room discussions appoint a notetaker/reporter (make a note of your room #)

Looking through this individual's story through a brain injury informed lens,

Any health or learning related challenges before the age of 10?

Did he experience any chronic pain or have difficulty sleeping following the car accident that was treated with prescription painkillers?

Were there any changes in his academic performance after the car accident?

Is there any report of prior survived overdose(s)?

Anything else jump out at you?

Given what you have learned about this individual, can you:

Suggest brain injury informed interventions that may have altered his trajectory prior to this latest overdose

Suggest post discharge strategies, supports, interventions following the most recent overdose

Questions?

Strategies and Interventions for Support and Engagement-Next week's intensive sessions

- **For Law Enforcement and EMS-**

We will focus on in-the-moment suggestions to deescalate, redirect and communicate effectively with citizens who may have a history of brain injury

- **For Parole and Probation-**

We will focus on in-the-moment suggestions to engage returning citizens who may have a history of brain injury as well as how to support these individuals for long-term success in the community

Up Next in this Series

June 16, 2022-9:00 AM Mountain Time: How to Approach, Engage and Direct Individuals living with TBI-Intensive Workshop for Law Enforcement and EMT Personnel

June 16, 2022-1:00 PM Mountain Time: How to Approach, Engage and Direct Individuals living with TBI-Intensive Workshop for Probation and Parole

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

Thank You!

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National Association of Head
Injury Administrators,

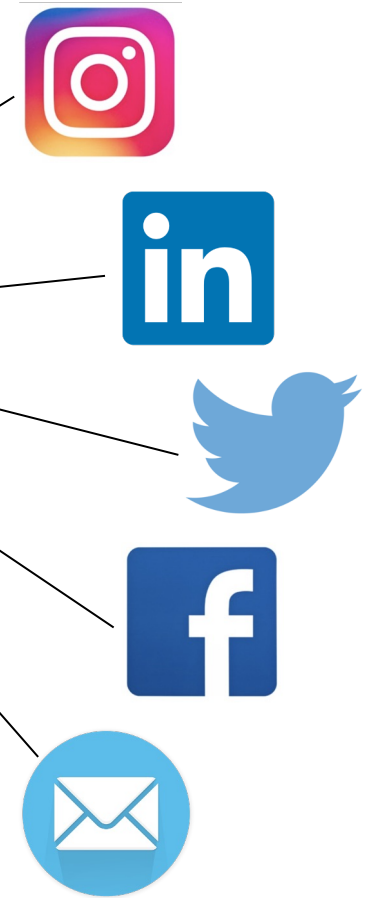
[https://www.nashia.org/ National
Association of Head Injury
Administrators](https://www.nashia.org/National-Association-of-Head-Injury-Administrators)

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How to Approach, Engage, and Direct Individuals Living with TBI-A Training Series for First Responders-Introduction

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