

**Office of the Secretary of
Public Safety**

**2008 Report on
the Incidence of
Traumatic Brain Injury
in Offender Populations**

*In response to:
Chapter 879, 2008 Virginia
Appropriations Act,
Item 381 (C)*





COMMONWEALTH of VIRGINIA

Office of the Governor

John W. Marshall
Secretary of Public Safety

November 1, 2008

The Honorable Charles J. Colgan
Chairman, Senate Finance Committee
General Assembly Building, Room 625
Capitol Square
Richmond, Virginia 23219

The Honorable Lacey E. Putney
Chairman, House Appropriations Committee
General Assembly Building, Room 947
Capitol Square
Richmond, Virginia 23219

Gentlemen:

Pursuant to Item 381 (C), Chapter 879 (2008 Acts of Assembly), I am submitting to your respective committees the *2008 Report on the Incidence of Traumatic Brain Injury in Offender Populations*.

Please do not hesitate to contact me if I can provide any additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "John W. Marshall".

John W. Marshall

Preface

Authority for the Study

Chapter 879, 2008 Appropriations Act - Item 381 (C) of the Virginia General Assembly provides that:

The Secretary shall analyze the incidence of traumatic brain injury in the adult and juvenile state-responsible and local-responsible offender populations. Copies of the analysis shall be provided to the Chairmen of the House Appropriations and Senate Finance Committees by November 1, 2008.

Acknowledgements

A workgroup chaired by Barry Green, Director of the Department of Juvenile Justice prepared this analysis and report. Workgroup members from the Department of Corrections included: Terri Crisley, R.N., Robin Hulburt, Ph.D., Michael Leininger, Harvard Stevens, M.D. Members from the Department of Juvenile Justice included: Tim Joost, R.N. and Steven Peed, Ph.D. Members from the Department of Rehabilitative Services included: Mary Margaret Cash and James Rothrock. In addition, Jeffrey Kreutzer, Ph.D. and Aaron Juni, Ph.D. from the VCU/MCV Health Center and Anne McDonnell from the Brain Injury Association of Virginia served as representatives to the workgroup. The workgroup thanks the Department of Juvenile Justice Research and Evaluation Unit headed by Lynette Greenfield for their assistance in the preparation of this report.

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EXECUTIVE SUMMARY

Item 381c of the 2008 Virginia Acts of Assembly directed the Secretary of Public Safety to “...analyze the incidence of traumatic brain injury in the adult and juvenile state responsible and local responsible offender populations.” The incidence, management, and treatment of traumatic brain injury (TBI) in offender populations is of concern as reports have surfaced that suggest the possibility of significant rates of TBI in this population. If this is the case, targeted interventions to identify and treat the sequelae of TBI may result in better management of incarcerated individuals and reduced recidivism.

As a result of interest in this area, representatives of the Department of Juvenile Justice (DJJ), the Department of Corrections (DOC), and the Department of Rehabilitative Services (DRS) met with delegates and other interested parties beginning in early 2006. Subsequently, representatives from the Virginia Commonwealth University Health Center TBI Model System (VCU) collaborated with DJJ and developed a grant proposal to study the incidence of TBI in Virginia’s juvenile justice system and to develop a model for best practices in this area. Unfortunately, this grant was not funded during the 2008 year funding cycle.

In response to the Acts of Assembly directive, the Director of Department of Juvenile Justice, Barry Green, convened a workgroup that met over the summer of 2008. Members of this workgroup included representatives from DOC, DJJ, DRS, VCU, and the TBI advocate community. This workgroup reviewed relevant professional literature in the area, collected and analyzed data from DOC and DJJ, and surveyed other states regarding their experience in this area.

The results of this effort suggest that: (1) the available data are limited and do not allow us to establish with certainty the prevalence of TBI in Virginia’s offender populations; however, the available data do suggest that a significant portion of the incarcerated population may have a history that suggests the possibility of TBI. (2) while a few other states have begun to investigate the extent of this problem in their offender populations, there does not appear to be reliable data regarding incidence rates or a best practices model. (3) DOC, DJJ, and DRS do not have the necessary internal resources or expertise to conduct the research to accurately describe the scope of the problem or to develop a best practices model for these populations.

Given these findings, the workgroup’s recommendation is that funding be secured for research to establish the scope of the problem and to develop a best practices model for these populations. Furthermore, the best place to begin this effort appears to be with the population of juveniles committed to Virginia’s juvenile correctional centers. To advance this goal, the Director of the Department of Juvenile Justice and the Commissioner of the Department of Rehabilitative Services met with the Commonwealth Neurotrauma Initiative Board to ask that they prioritize research in this area during the 2009 funding cycle.

INTRODUCTION

Traumatic brain injury is implicated as a causative factor in behaviors such as aggression, impulsivity, and substance abuse that may lead to arrest and incarceration. Thus, the incidence, management, and treatment of TBI in offender populations are of concern.

In recent years, progress has been made in the classification of TBI as well as in its diagnosis and treatment in acute medical settings. In addition, the identification and treatment of individuals suffering the effects of TBI over the longer term has been recognized as an important priority. The U.S. Department of Defense and The Veterans Administration have been particularly active in this area in order to address the increased number of individuals returning to civilian life after suffering combat related TBI. Nevertheless, no universally accepted instrument is utilized to screen for TBI and the diagnosis of TBI can be complicated depending upon severity (mild, moderate, severe), length of time since injury, and population (adult, pediatric, forensic). Commonly utilized procedures to establish a TBI diagnosis include neurological evaluation, brain scan, and neuropsychological evaluation. It is obviously easier to diagnose a TBI immediately following the causative incident than it is years later.

Studies in acute care medical settings have examined such issues as the recognition of TBI and reliability of diagnosis. Available studies tend to focus on the identification and treatment of TBI near the time of injury; fewer studies have addressed identification and treatment of TBI years or decades after the injury. Following medical stabilization, psychosocial interventions to treat persons suffering from TBI tend to be customized to the needs of the individual and focus upon the behavioral and emotional sequelae of the injury including such symptoms as memory problems, anger, depression, substance abuse, etc.

Information concerning the incidence and management/treatment of TBI in offender populations is limited. Existing reports have provided a wide range of prevalence estimates. Most of these reports appear to suffer from serious methodological flaws that limit their applicability. Studies of TBI in offender populations are complicated for a variety of reasons including: the injury may be years or decades old; reliable records are often unavailable; and the usual self report reliability issues are exacerbated because of the potential for secondary gain.

AVAILABLE DATA

Data on the number of individuals incarcerated in DOC and DJJ who have a history that includes a diagnosis of TBI were not accessible. However, DJJ maintains a database on committed youth that has data relevant to the issue of head injury. DOC gathered head injury history data from a sample of inmates received during the month of August, 2008. These data are the available existing data that can be used to attempt to address the question of incidence of TBI in the state responsible offender populations. However, it is important to emphasize that these head injury data do not directly address the issue of the incidence or severity of TBI, which is a separate diagnosis related to head injury.

JUVENILE JUSTICE DATA

All youth committed to DJJ Juvenile Correctional Centers undergo medical, psychological, educational, and social evaluations at DJJ's Reception and Diagnostic Center in Bon Air, Va. Treatment needs are identified for each youth. As part of the medical and psychological evaluation process, examiners are asked to address 5 questions regarding history of head injury and episodes of unconsciousness relevant to the issue of TBI. These data are maintained within a comprehensive database managed by DJJ's Research and Evaluation Unit.

Appendix 1 presents a summary of these data for all juveniles evaluated during FY 2007 (7/1/2006-6/30/2007). The medical information suggests that 17.2% of the population had experienced a head injury and the psychological information suggests that 21.7% of the population had received medical attention due to head trauma. Furthermore, both the medical (18.2%) and psychological (17.1%) information suggest that approximately 18% of the population has experienced a loss of consciousness. While these data do not establish the prevalence or severity of TBI in this population, they do suggest that close to one in five juveniles committed to DJJ has a history that raises the possibility of TBI.

DEPARTMENT OF CORRECTIONS DATA

While DOC conducts medical and mental health evaluations for inmates received at their facilities, they do not maintain a readily accessible database relevant to the issue of TBI. Thus, examiners at seven DOC facilities gathered information regarding history of head injury and episodes of unconsciousness for all prisoners received at those facilities during August, 2008. Appendix 2 presents information on this sample of 786 prisoners.

These data suggest that 17.8% of this sample had experienced a head injury. Furthermore, 61.9% of those who had experienced a head injury had a loss of consciousness. Data were also collected regarding the cause of injury (motor vehicle accident most frequent followed by assault) and age at first injury (mean= 20.9 years). Also, data are presented by gender.

Like the DJJ data, the data from DOC do not establish the prevalence or severity of TBI in this population. Like the DJJ data, the DOC data suggest that close to one in five inmates has a history that raises the possibility of TBI.

ADULT AND JUVENILE LOCAL RESPONSIBLE OFFENDER POPULATIONS

Data regarding TBI from locally operated jails and juvenile detention centers are not available in a centralized database. While some of these facilities may collect relevant data, obtaining meaningful data from these facilities will require resources to do research beyond the capability of this workgroup. Thus, this report does not address the issue of the incidence of TBI in these populations.

SURVEY OF OTHER STATES

JUVENILE JUSTICE

A survey was sent to the Council of Juvenile Correctional Administrators that asked: whether they were aware of any efforts in their state or elsewhere to assess/treat TBI in the juvenile justice population; if their state collected data regarding juvenile offenders with TBI; if their state collected data regarding treatment for TBI; and if their state planned to collect such data in the future. Appendix 3 provides a summary of responses to these questions as well as to follow-up questions.

23 responses were received to this survey. Only 1 response indicated an awareness of any efforts to assess/treat TBI in the juvenile justice population and 1 response indicated that their state planned to collect relevant data in the future. No one responded that their state currently collects data regarding the prevalence and/or treatment of TBI in their juvenile justice populations.

ADULT OFFENDERS

Appendix 4 presents the summary of results from a survey that was sent to the Association of State Correctional Administrators regarding the identification of adult offenders with TBI. Responses were received from 29 states. Twelve of these states indicated that they identified offenders with TBI. Seven of the states provided some estimate of the percentage of the confined population with TBI. These estimates ranged from less than 1% (New Jersey, Wisconsin) to a potential 80% (Florida).

DISCUSSION

Current data are indirect and limited; they do not allow one to establish the prevalence of TBI in Virginia's offender populations. The available data suggest that perhaps 20% of Virginia's state responsible juvenile and adult incarcerated populations may have a history of head injury. However, the percentage of the population that has functionally significant TBI as a result of head injury is unclear. Nevertheless, these data raise the possibility that a significant portion of the juvenile and adult incarcerated populations could be subject to the effects of TBI.

Responses to the surveys of other states do not suggest that correctional systems outside of Virginia have a better understanding of the prevalence or significance of TBI among their offender populations. While there are indications that some states are beginning to investigate these issues (e.g. Wyoming, Florida), there does not appear to be a sufficient body of knowledge available to guide policy makers. Thus, research appears warranted to establish the incidence of TBI in these populations and to develop state of the art protocols for the management and treatment of offenders who have functionally significant symptoms of TBI.

RECOMMENDATIONS

Given the lack of information in this area, the workgroup recommends that research be undertaken to investigate the prevalence of TBI in Virginia's offender populations and to establish effective and efficient protocols for the identification and management/treatment of TBI in these populations. Initially, it is recommended that research focuses on youth incarcerated in DJJ. Such a project has several apparent advantages, including:

- all juveniles incarcerated in Virginia are evaluated at a single reception and diagnostic center
- DJJ has a comprehensive database in place that facilitates data collection
- DJJ routinely conducts comprehensive medical, psychological, educational, and social evaluations on all youth committed to state care

Because of the lack of standardized assessment and treatment protocols and the complexity of research with this population, this project requires expertise and resources beyond the current capabilities of DJJ, DOC, and DRS. Thus, it is recommended that funding be secured to engage experts with the resources to accomplish such research. In an attempt to secure funding, Mister Green and Commissioner Rothrock have made a presentation to the Commonwealth Neurotrauma Initiative Board and asked that the board prioritize research in this area during the 2009 funding cycle.

APPENDICES

Appendix 1

FY 2007 DJJ Head Injury Incidence Data

The data presented below originates during the juvenile's assessment process at the Reception and Diagnostic Center (RDC). Every juvenile committed to the Department undergoes a thorough medical, social, psychological, and educational assessment to best determine the needs of the individual juvenile. This information is captured through the Juvenile Profile Packet (JPP). Information pertaining to head injury is documented within the JPP. The JPP for juveniles received to RDC during FY 2007 was used to generate the following data.

Medical Information

The following information was obtained from the Medical Form of the JPP completed at RDC.

1. Has the juvenile experienced a **head injury**?

Response	# of Juveniles	% of Juveniles
Yes	139	17.2%
No	668	82.8%
<i>Total*</i>	<i>807</i>	<i>100.0%</i>

* This does not include two responses of "Not Known" and one missing response.

- 17.2% of juveniles received at RDC in FY 2007 reported an instance of head injury.

2. Has the juvenile experienced a **loss of consciousness**?

Response	# of Juveniles	% of Juveniles
Yes	146	18.2%
No	658	81.8%
<i>Total*</i>	<i>804</i>	<i>100.0%</i>

* This does not include six responses of "Not Known".

- 18.2% of juveniles received at RDC in FY 2007 reported a loss of consciousness in their medical history.

3. Has the juvenile experienced **seizures**?

Response	# of Juveniles	% of Juveniles
Yes	28	3.5%
No	782	96.5%
<i>Total</i>	810	100.0%

- 3.5% of juveniles received at RDC in FY 2007 reported seizure(s) in their medical history.

Psychological Information

The following information was obtained from the Psychological Form of the JPP completed at RDC.

1. How many times has the juvenile **lost consciousness due to head trauma**?

Response	# of Juveniles	% of Juveniles
0	622	82.5%
1	105	13.9%
2	23	3.1%
3	2	0.3%
4	0	0.0%
5	2	0.3%
<i>Total*</i>	754	100.0%

* This does not include 71 missing responses.

- 17.5% of juveniles received at RDC in FY 2007 had lost consciousness due to head trauma at least one time.

2. Has the juvenile **received medical attention due to head trauma**?

Response	# of Juveniles	% of Juveniles
Yes	164	21.7%
No	592	78.3%
<i>Total*</i>	756	100.0%

* This does not include 69 missing responses.

- 21.7% of juveniles reported they had received medical attention due to some type of head trauma.

Appendix 2

Head Injury Histories among Newly Received Offenders (August 2008)

Institution	Frequency	Receptions	% Injury
Fluvanna Correctional Center for Women	12	76	15.8%
Southampton Womens Work Center	0	43	0.0%
Bland Correctional Center	17	30	56.7%
Powhatan Reception Center	50	189	26.5%
Coffewood Correctional Center	6	16	37.5%
Mecklenburg Correctional Center	44	402	10.9%
Haynesville Correctional Center	11	30	36.7%
Total	140	786	17.8%

Race	Frequency	Percent
Black	62	44.3%
White	75	53.6%
Other	3	2.1%
Total	140	

Cause of Injury	Frequency	Percent	% Loss Consciousness
Motor Vehicle Accident	52	37.1%	41.0%
Assault	42	30.0%	26.5%
Fall	21	15.0%	18.1%
Accident	15	10.7%	7.2%
Other	8	5.7%	6.0%
Medical	2	1.4%	1.2%
Total	140		83

Loss of Consciousness	Frequency	Percent
No	51	38.1%
Yes	83	61.9%
Total	134	100.0%
<i>Unknown</i>	6	4.3%
Overall Total	140	

Number of injuries	Frequency	Percent
1	107	76.4%
2	22	15.7%
3	9	6.4%
4	1	0.7%
6	1	0.7%
Total	140	

Age Data	N	Minimum	Maximum	Mean
Current Age	140	8	70	36.5
Age at First Injury	135	1	51	20.9

Head Injury Histories among Selected Receptions to DOC by Gender

Gender	Cause of Injury	Frequency	Percent
Male	Motor Vehicle Accident	46	35.9%
	Assault	41	32.0%
	Fall	19	14.8%
	Accident	13	10.2%
	Other	8	6.3%
	Medical	1	0.8%
	Total	128	

Female	Motor Vehicle Accident	6	50.0%
	Assault	1	8.3%
	Fall	2	16.7%
	Accident	2	16.7%
	Medical	1	8.3%
		Total	12

Gender	Loss of consciousness?	Frequency	Percent
Male	No	46	37.7%
	Yes	76	62.3%
	Total	122	
	<i>Unknown</i>	6	4.7%
Female	No	5	41.7%
	Yes	7	58.3%
	Total	12	

Gender	Number of injuries	Frequency	Percent
Male	1	100	78.1%
	2	19	14.8%
	3	7	5.5%
	4	1	0.8%
	6	1	0.8%
		Total	128
Female	1	7	58.3%
	2	3	25.0%
	3	2	16.7%
		Total	12

Gender	Age Data	N	Minimum	Maximum	Mean
Male	Current Age	128	8	66	36.19
	Age at injury	123	1	51	20.66

Appendix 3

Survey of Other States – Juvenile Justice

Virginia DJJ developed a web-based survey to determine the scope of assessment and/or treatment of traumatic brain injuries in the juvenile justice system. Using the Council for Juvenile Correctional Administrators distribution list, juvenile justice administrators from each state were requested to complete the survey. A total of 23 state juvenile justice administrators accessed the survey, however most did not complete the short survey.

Survey Results

1. Are you aware of any efforts in your State or elsewhere to assess and/or treat TBI in the juvenile justice population?

Responses	# of State Responses	% of State Responses
Yes	1	4.3%
No	10	43.5%
No Response	12	52.2%
<i>Total Respondents</i>	23	100.0%

- Only one State responded that they were aware of efforts to assess and/or treat traumatic brain injury.

- 1a. Please provide a brief description of any efforts to assess and/or treat TBI.

Responses	# of State Responses	% of State Responses
Responded	2	8.7%
Did not repond	21	91.3%
<i>Total Respondents</i>	23	100.0%

- Two states provided brief descriptions of their efforts regarding TBI.
- “When DJJ youth are institutionalized to long term treatment, the mental health clinician asks the youth if they have any TBI. This is noted on their mental health assessment and if any follow up is needed, they are referred to the medical department.”
- “The assessment process is an informal assessment for youth who enter our Reception and Diagnostic Unit within the Juvenile Correctional Facilities. The assessment is made by the medical department and the psychologist with the unit. We do not use a formal assessment just a review of the youth’s file from the community and self report. We are not collecting data in a formal manner.”

1b. Please provide a person to contact regarding these efforts.

Responses	# of State Responses	% of State Responses
Responded	0	0.0%
Did not repond	23	100.0%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

- None of the juvenile justice administrators provided contact information pertaining to TBI.

2. Does your State currently collect data regarding juvenile offenders with TBI?

Responses	# of State Responses	% of State Responses
Yes	0	0.0%
No	11	47.8%
No Response	12	52.2%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

- Nearly half of the responses indicated that they were not currently collecting data regarding TBI in juvenile offenders.

2a. How does your State define TBI?

Responses	# of State Responses	% of State Responses
Responded	1	4.3%
Did not repond	22	95.7%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

- One state defines TBI based on a “Medical diagnosis by a M.D.”

2b. How is the data collected?

Responses	# of State Responses	% of State Responses
Self-Report	0	0.0%
Medical Records	0	0.0%
Testing	0	0.0%
Other	0	0.0%
Did not repond	23	100.0%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

2c. Please define other methods used to collect data.

Responses	# of State Responses	% of State Responses
Responded	0	0.0%
Did not repond	23	100.0%
<i>Total Respondents</i>	23	100.0%

2d. What specific variables/questions are used to identify TBI?

Responses	# of State Responses	% of State Responses
Responded	1	4.3%
Did not repond	22	95.7%
<i>Total Respondents</i>	23	100.0%

- One state uses a medical examination to identify a juvenile with TBI.

2e. If a juvenile offender had a TBI prior to his/her involvement with the juvenile justice system, would this individual's TBI information be captured in your database?

Responses	# of State Responses	% of State Responses
Yes	1	4.3%
No	0	0.0%
No Response	22	95.7%
<i>Total Respondents</i>	23	100.0%

- One respondent indicated that information concerning a juvenile's history of TBI may be located in their medical record in written form.

2f. If a juvenile offender had a TBI while involved with the juvenile justice system, would this individual's TBI information be captured in your database?

Responses	# of State Responses	% of State Responses
Yes	1	4.3%
No	0	0.0%
No Response	22	95.7%
<i>Total Respondents</i>	23	100.0%

- In response, one state indicated that the occurrence of a TBI while involved in the juvenile justice system may be recorded in the juvenile's medical record.

2g. What percentage of your committed population had a TBI? (Please specify the year)

Responses	# of State Responses	% of State Responses
Responded	0	0.0%
Did not repond	23	100.0%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

2h. Has your State had any juveniles experience a TBI while in a juvenile correctional facility?

Responses	# of State Responses	% of State Responses
Yes	0	0.0%
No	0	0.0%
No Response	23	100.0%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

3. Does your state collect data regarding treatment provided for a TBI?

Responses	# of State Responses	% of State Responses
Yes	0	0.0%
No	2	8.7%
No Response	21	91.3%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

- Of those responding to this questions, both indicated that their state does not currently collect data related to TBI.

3a. What specific variables/questions are used regarding treatment of TBI?

Responses	# of State Responses	% of State Responses
Responded	0	0.0%
Did not repond	23	100.0%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

4. Does your State plan to collect this data in the future?

Responses	# of State Responses	% of State Responses
Yes	1	4.3%
No	1	4.3%
Don't Know	8	34.8%
No Response	13	56.5%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

- The majority of respondents indicated that they are not aware of efforts to begin collecting TBI data, while one state indicated that they may capture this information at some point in the future.

5. Please provide, if possible, a contact person for additional information regarding data.

Responses	# of State Responses	% of State Responses
Name	5	21.7%
Title	5	21.7%
Address	5	21.7%
City	5	21.7%
State	5	21.7%
Zip Code	5	21.7%
Phone Number	5	21.7%
Email Address	5	21.7%
No Response	18	78.3%
<i>Total Respondents</i>	<i>23</i>	<i>100.0%</i>

Appendix 4

ASCA Responses: Traumatic Brain Injury Survey - September 2008

Jurisdiction:	Name:	Email Address:	Phone Number:	Title:	Has your state identified offenders with Traumatic Brain Injury (TBI)?	a. How was TBI defined?	b. How were the offenders identified?	c. What number and % of the confined population had a TBI?	What strategies, if any, are being considered or implemented to address this population?
Alabama	Marcus Tavel	marcus.tavel@doc.alabama.gov	334-553-6538	Administrative Analyst	No				None at this time that I am aware of, however, I believe that this issue will be addressed in our new mental health contract.
Arkansas	Mr. John Byus	John.Byus@arkansas.gov	870-267-6952	Administrator Medical Services	Yes	Very broadly. Documented TBI in community with clear functional deficits.	Self report or through intake screening. All inmates can request ADA accommodation as well.	We have recently added a new subcode to our classification system for TBI. We have identified 82 out of 15900 population has TBI (4%). Obviously that is a considerable underestimate.	New addition to classification system. I am co-chair of C/TBI Advisory Council. We are looking at developing throughput tools for use at intake. The problem is determining throughput relative to functional deficits given that there are likely a considerable number of inmates with minor TBI with minor functional impairment. Also for those that screen positive for TBI a full neuropsych assessment is not possible or practical - cost is prohibitive and resources are not available.
Connecticut	Daniel Bernish-Fry D.	dani.bernish@go.state.ct.us	860-692-7661	Director of Health and Addictions	Yes	WDOC medical and mental health clinicians define traumatic brain injury as damage to the brain caused by some type of blow to the head or other form external traumatic event. Evidence of resulting impairment may be demonstrated by indicators of impaired level of functioning (i.e., cognitive, physical, behavioral, or emotional).	Inmates are routinely screened for medical and mental health problems at prison intake. As part of this routine screening, inmates are screened by our contract medical/mental health staff if they have ever experienced a head injury (i.e., been in a car accident, experienced a concussion, loss of consciousness, memory difficulties, etc). Subsequently physical and/or psychological symptoms are assessed and clinically significant issues are referred to medical staff for further assessment as medically necessary. Further, in April of 2007 the Traumatic Brain Injury Association of Wyoming conducted a survey on a sample of 144 male and 51 female inmates in an effort to study to survey potentially undiagnosed brain injuries among the Wyoming prison population.	Traumatic Brain Injuries that are identified via medical and mental health assessment at intake receive intervention and treatment that is considered medically necessary. In the past, inmates with significant impairment they are being referred for additional services such as cognitive and behavioral Brain Injury Waiver which can include case management, cognitive retraining/feedback, residential habilitation, in-home support, etc). The Brain Injury Associations of Wyoming is providing prison case managers with training to facilitate a better understanding of the types of brain injury, the scope of brain injury in the prison population, the areas of the brain and their basic functions. As a result of the training case managers are able to identify physical, cognitive, behavioral and emotional changes that may accompany brain injury, discuss practice strategies for working with persons with brain injury, including how to adjust their own style to facilitate positive interactions.	
Florida	Frank Johnson, M.D.	frankjohnsonfrank@real.doc.fl.us	850-410-4619	Deputy Assistant Secretary of Health Services, Clinical	Yes	We did not use a formal clinical definition of TBI due to the screening at intake. However, if an offender presented with a formal diagnosis of TBI, we used that.	They were identified at intake through a screening tool and self-reporting. Nursing and mental health staff also asked about head injuries.	80% of the population self-reported significant incidences of head injury, 20% self-reported incidents of head injury resulting in hospitalization, unconsciousness or significant losses or amnesia.	We are in the third year of a grant focusing on the population. The approach is three pronged - identification through screening and assessment, developing specific TBI interventions for programming, and release planning for offenders with TBI.
Georgia	Edward R Bailey DO MEdA	baileed01@doc.state.ga.us	404-657-2217	Acting Statewide Medical Director	Yes	Most commonly it is used as a modifier to a diagnosis, such as, "seizure disorder secondary to trauma", etc.	This is identified by the clinician based upon history, physical exam and the effect of trauma on the brain.	Since it is usually identified with a modifier on a diagnosis, there is no easy way for us to retrieve the number of individuals having this within our system.	N/A
Idaho	Rona Sivgert	rsivgert@doc.idaho.gov	208-696-2047	Health Services Director	Yes	Brain injury due to trauma.	At medical screening - health appraisal - detail neuro evaluation - after Neurologist's consultation.	Do not track at this time.	

1 of 3

Traumatic Brain Injury Survey

Last updated: 9/4/08 at 5:25 PM

ASCA Responses: Traumatic Brain Injury Survey - September 2008

State	Name	Email	Phone	Director of Planning & Research	Yes	Ahead injury, generally, but not always leading to a period of loss of consciousness	Screening questions as part of the intake process: 65	4-650 or +33%	CONSIDERED - More refined assessment tool Categorization by severity/functional impairment Relationship to Disciplinary Reports - Relationship to use of Mental Health Services. Appropriate interventions
Indiana	Amanda Copeland	acopeland@doc.in.gov	317-232-1926	Director of Planning & Research	Yes	Ahead injury, generally, but not always leading to a period of loss of consciousness	Screening questions as part of the intake process: 65	4-650 or +33%	CONSIDERED - More refined assessment tool Categorization by severity/functional impairment Relationship to Disciplinary Reports - Relationship to use of Mental Health Services. Appropriate interventions
	Scott A. Haas, M.D.	Scott.Haas@ky.gov	502-554-2220 ext. 307	Medical Director	Yes	Offenders have been identified incidentally through medical and/or mental health evaluations and histories. There has been no concerted effort to attempt identification of all TBI inmates. On some occasions, the injury occurred during incarceration which made identification simple and immediate.	See above. In addition, some offenders were given structured interviews and clinical assessments from psychological staff.	There is no absolute count that can be made at this time as those records are not easily able to be queried.	Inmates with TBI who also have functional impairments are housed in less acute facilities and in medical or mental health areas that can provide the support of activities of daily living, medication management and safety that the inmates require. Those without functional impairment are treated in accordance with their level of functioning and classification score.
Louisiana	Raman Singh M.D.	rnsingh@connections.state.la.us	225-342-1320	Medical/ Mental Health Director	No				Very small numbers of inmates with TBI. Must end up on ventilator support. They receive rehab as appropriate. Ends of life issues are of a concern.
	Lynda Zeller	Zeller2@michigan.gov	517-373-3246	Health Services Administrator/Communications Director	No				We have not developed a specific strategy to address the issue of prisoners with traumatic brain injury. Issues would be assessed from an individual standpoint with a focus on prisoner's level of functioning. We have placed individuals in the Social Skills Development Unit or in Residential Treatment Programs given an inability to function in general population. As we continue to work on providing more services for the cognitively impaired prisoner, regardless of the cause of the impairment, we will also address prisoners with traumatic brain injury.
Minnesota	Shari Burt	shari_burt@state.mn.us	651-361-7229	Division Director	No				We are in the process of acquiring an electronic medical record that will facilitate tracking of TBI and other clinical conditions
	Awel	marlam.awel@doc.mo.gov	573-634-3363	Division Director	No				In our psychiatric residential treatment units, we have vast number of individuals with head injuries. They typically have another diagnosis of mental illness. When identified through neuropsych testing, they are referred to medical for a neurological followup if there are concerns about acute problems. Otherwise, treatment is dictated by the assessment of the individual. Deficits are documented and the treatment plan reflects specific interventions. There is no program specifically designed for TBI. They are identified on intake and managed on a case by case basis.
Nebraska	Steve King	steve.king@nebraska.gov	402-475-7734	Planning & Research Administrator	No				
	Robert Bammsier, D.O.	rbammsier@doc.nv.gov	775-887-3362	Medical Director	No				

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New Hampshire	Dr. Ben Lewis	blewis@hdcc.state.nh.us	603-271-7263	Director, Bureau of Quality Improvement, Compliance and Research	No				None	On the occasions when we have an inmate experience TBI they are managed via an area hospital and an individualized treatment plan. Please note that we have not had many offenders with TBIs as of this date.
New Jersey	Ralph P. Woodhead	rwoodhead@doj.state.nj.us	609-594-5945	Medical Director	Yes					
New York State	Brian Fischer	CommissionerSecretary@doj.state.ny.us	518-457-8134	Commissioner	No					We have had only one case over the past year which is 1 in 4,000.
Ohio	Dr. Robert Hammond	Robert.Hammond@doj.state.oh.us	614-726-1932	Bureau Chief, Mental Health	No					
Oklahoma	Michael Jackson	mike.jackson@doj.state.ok.us	405-592-6130	Chief Medical Officer	No					The TDOC has a "special needs" facility designed to handle sub-acute and chronic cases such as TBI.
Philadelphia	Bruce Hefner	bruce.hefner@jisons.phila.gov	215-685-7614	Chief of Medical Operations	Yes					Two staff trainings by The Brain Injury Association of RI in 2006.
Rhode Island	A.T. Vigil, III	atvigil@doj.rh.gov	401-482-2811	Director Health Services	No					When necessary, we work with people with TBI individually. Other times, a person may be able to cope in general population with few problems. We examine each case individually and make appropriate decisions about care and subsequent referrals when necessary.
South Carolina	Dept. of Corrections	campbell.russell@doj.state.sc.us	803-665-2707	Director Health Services	No					We are not planning any changes at this time.
South Dakota	Justin L. Fallon	justin.fallon@states.sd.us	605-367-5162	Mental Health	No					We do not identify this population and have no plan to target that population.
Tennessee	Donna White	donna.k.white@state.tn.us	615-741-1000	Director, Mental Health Services	No					They are identified on intake and managed on a case by case basis.
Vermont	Ron Smith	rsmith@doj.state.vt.us	802-241-2269	Chief, Mental Health Services	No					
Washington	Barbara B. Curtis	bbcurtis@doj.wa.gov	360-725-8716	Utilization Review Manager	Yes					This is an area that our Department continues to review. Currently, most of our information being collected through offender self report. Our department has representation on the Missouri Head Injury Advisory Council. This offers us an opportunity to further review our practices.
West Virginia	Jim Rubenstein	jrubsent@mail.wvnet.edu	304-599-2036 ext. 35	Commissioner Health Services	No					Our informants are capable of handling these offenders internally.
Wisconsin	James Greer	James.Greer@wisconsin.gov	608-240-5122	Director	Yes					TBI inmates are provided with the same systemic protections as inmates with SMI. Also, appropriate accommodations are made via ADA policy.
Wyoming	L. Sam Bobbely	lsbobe@wyo.state.wy.us	307-777-6301	Program Manager	Yes					Actively involved in a statewide council on TBI to increase awareness, evaluation and support of individuals with TBI. Evaluating our intake questions to determine best ways to capture information about history of TBI.
Total: 29					Yes - 12 No - 16					

Appendix 5

Workgroup

CHAIR: Barry Green – Director Department of Juvenile Justice
Dawn Smith – Assistant for Administration
Paul Van Lenten, Jr. – Legislative Fiscal Analyst

The workgroup held three meetings over the summer of 2008 with participation from the following individuals:

Department of Juvenile Justice

Tim Joost, R.N. - Health Services Unit Administrator
Steven Peed, Ph.D. – Director, Behavioral Services Unit

Department of Corrections

Terri Crisley, R.N. – Chief Nurse
Robin Hulburt, Ph.D. – Mental Health Program Director
Michael Leininger – Legislative Liaison
Harvard Stevens, M.D. – Chief Physician

Department of Rehabilitative Services

Mary Margaret Cash – Assistant Commissioner, Director of Community Based Services
James Rothrock – Commissioner

VCU/MCV Health Center

Aaron Juni, Ph.D. – Post Doctoral Fellow
Jeffrey Kreutzer, Ph.D. – Director, VCU TBI Model System

Brain Injury Association of Virginia

Anne McDonnell – Executive Director

The workgroup thanks the DJJ Research and Evaluation Unit headed by Lynette Greenfield for their assistance in the preparation of this report.