TBI IN MINNESOTA CORRECTIONAL FACILITIES: SYSTEMS CHANGE FOR SUCCESSFUL RETURN TO COMMUNITY

JUNE 2015
DISCLAIMER

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*Contributing Authors
**INTRODUCTION**

In 2010, Minnesota applied for and was awarded a federal TBI State Implementation Partnership Grant. This grant, entitled “TBI in Minnesota Correctional Facilities: Systems Change for Successful Return to Community,” was a four-year state partnership grant between the Minnesota Department of Human Services (MN-DHS) and the Minnesota Department of Corrections (MN-DOC). This grant allowed the MN-DOC and MN-DHS to build on work started through an earlier TBI State Implementation Partnership Grant awarded in 2006. In addition, the grant has supported MN-DOC efforts to find innovative ways to identify TBI, to provide TBI training and education to staff across multiple disciplines, and to facilitate continuity of care not only during an offender’s time in prison but also upon release to the community at large. Similarly, Minnesota has made a concerted effort to identify and work with underserved populations that are at increased risk of TBI. Capacity building with American Indian communities has been a stated part of this goal.

**BACKGROUND**

Each year, in the United States, some 1.7 million Americans seek medical care for TBI (Faul, Wald, & Coronado, 2011). Nationally, TBI is a contributing factor in approximately a third of all injury-related deaths and a substantial number of cases of permanent disability (Centers for Disease Control and Prevention, 2014). While promising advances in medical technology and regional trauma services have led to an increase in the number of survivors of TBI, the stark reality is that these advancements have also led to social and medical challenges associated with a growing pool of people with TBI-related disabilities. The outcomes of TBI can result in a variety of cognitive, emotional, and/or behavioral consequences that not only affect the individual but can also have lasting effects on families and communities.

In 2012, there were approximately 1.35 million individuals incarcerated in state prisons, 217,800 in federal prisons and 744,500 in local jails (Bureau of Justice Statistics, 2013). Although still limited in scope, emerging literature is supporting the commonly observed phenomenon amongst correctional professionals that there is an elevated prevalence of TBI in correctional populations in comparison to the general public. A meta-analytic review found the prevalence of TBI in the overall offender population to be 60.25% (Shiroma, Ferguson, & Pickelsimer, 2010), while even higher prevalence has been reported in other correctional systems (e.g.,

“Nationally, TBI is a contributing factor in approximately a third of all injury-related deaths and a substantial number of cases of permanent disability.”
80.2% of adult male offenders MN-DOC, 2008). In addition to understanding prevalence rates of TBI within correctional systems, research is beginning to recognize the influence of an offender’s lifetime history of TBI on the delivery of correctional health services and offender management. Recent findings have suggested an association between TBI and increased use of state correctional psychological/medical services, higher rates of prison rule violations and recidivism, and lower chemical dependency treatment completion rates (Piccolino & Solberg, 2014).

Prompted by local and national calls for increased health screenings, evaluations, and targeted treatment of offenders, the MN-DOC in collaboration with MN-DHS began developing an infrastructure with identification, assessment, and services for offenders with TBI are provided. The following looks at this evolving process and discusses the successes and challenges that a state correctional system has experienced to date with support from two federally funded HRSA grants.

**SCREENING FOR TBI**

It is recognized that offenders in various correctional settings have disproportionate rates of TBI in comparison to the general population, with some estimates suggesting seven times greater risk (Harmon, 2012). Given that the number of individuals incarcerated in a year’s time can be exceedingly high, depending on the type of correctional system and their respective location and population demands, it becomes necessary for the often resource-taxed correctional system to identify offenders most at risk for experiencing chronic TBI-related problems.

The MN-DOC has taken the stance that screening for TBI will provide important health information that may affect the management and treatment of offenders during their incarceration as well as an offender's ability to remain law-abiding, productive citizens upon return to their respective communities. As part of the sustained effort to identify TBI within the correctional setting, the MN-DOC has implemented an intake TBI screening process that is time-efficient (the goal was to average under five minutes for administration) and capable of identifying those offenders who are at increased risk for adverse health outcomes as a consequence of their lifetime history of TBI.

To accomplish this, offenders are screened at the state’s male and female intake facilities with a TBI screening instrument developed
“...a system has been implemented within the MN-DOC...having multiple check points in which TBI is screened for, and embedding staff well-versed in TBI programs that often have high TBI prevalence rates...”

within the MN-DOC. The MN-DOC TBI Screening Tool (see Appendix A) elicits not only an offender's history of TBI events but also places emphasis on outcomes (e.g., seizures) or events (e.g., hospitalized for a significant period of time) that may predispose an offender to long term problems. This is in contrast to other TBI screening instruments that are strongly weighted toward obtaining self-reported symptoms (e.g., headaches, concentration problems, fatigue, etc.) that commonly occur following a TBI. This distinction becomes important for the professional who is attempting to identify and triage offenders most in need of receiving further TBI services from those offenders who present other health conditions that share similar symptoms and may require a different course of treatment.

While it is acknowledged that no screening process is fully reliable when it comes to identifying the issue of interest, in this case TBI with associated impairment, a system has been implemented within the MN-DOC by which the screening and data gathering process continues throughout an offender's incarceration. Offenders initially overlooked by the intake screening process are likely to be captured at a later date. This has been accomplished by: training and educating multidisciplinary staff about TBI; having multiple checkpoints for which TBI is screened; and embedding staff well-versed in TBI into programs that often have high TBI prevalence rates (e.g., substance abuse treatment programs).

Limitations

The TBI screening process has met with mostly positive results, but challenges remain. For instance, it was anticipated that when offenders at the male and female intake facilities were identified as being at high risk for chronic consequences associated with their history of TBI, those individuals would be entered into a TBI-specific database. The purpose of the TBI database would be to construct an accessible system where not only professionals at the intake facility could access the information but also relevant professionals (i.e., neuropsychologist, TBI Release Planner) throughout the system. Unfortunately, this proved difficult for various reasons, but ultimately came down to the time demands it took to upload the information into the database system, which in some months could involve upwards of 500 new admissions. For now, the information obtained from the TBI screening process is filed in the offender's mental health chart where it is accessible to the offender's current treatment provider(s).
Once an offender is identified through the TBI screening process as having a history of TBI with suspected chronic impairment, a potential next step is to determine whether a formal assessment of an offender’s cognitive and emotional functioning is warranted. An assessment becomes relevant for understanding how TBI may affect an offender’s ability to navigate the correctional system, to regulate his/her behavior, to participate effectively in various programming opportunities, and to successfully adapt to public life upon their return to the community at large. In addition, an assessment can be useful in clarifying diagnostic differentials and determining additional services that may be needed.

Examination of cognitive functioning can range from brief screening measures, to intermediate evaluation, to full neuropsychological batteries that may take several hours to complete. Each type of assessment process has potential strengths and limitations. Additionally, these assessment processes generally require staff to be proficient in the administration and interpretation of the assessment tools used in the various processes.

In an effort to maximize assessment services, the MN-DOC placed two neuropsychologists into two of its co-occurring disorders programs which serve either male or female offenders. This was done with an understanding that a significant risk factor for TBI is substance use, and the co-occurrence of TBI and substance disorders would be a targeted area to place these assessment professionals.

A team of neuropsychologists (i.e., psychologists who are specially trained in the assessment of patients with brain injury or disease) is very limited in a state correctional system and assessment demand is great in a system with high prevalence rates of TBI. To address these factors, the MN-DOC assembled a team of doctoral level psychologists and positioned them at key locations throughout the system. They provide screening and intermediate cognitive assessments under the direction of a board-certified neuropsychologist. Each month, these individuals meet with the MN-DOC’s chief neuropsychologist to review cases and to receive training in the administration and interpretation of cognitive tests. The neuropsychologist is also available for ongoing consultation, as warranted. This process has helped to better meet the assessment demands that could not be adequately managed by two neuropsychologists in a correctional population which exceeds 9,000 offenders. The idea of training multiple staff to conduct
intermediate neurocognitive assessments also became relevant when the grant-funded neuropsychologist at the men’s co-occurring program left the program. After the position was vacated, one of the other trained doctoral level psychologists was able to work with the program to conduct evaluations.

At the completion of the assessment process, feedback is provided to the offender and treatment staff who utilizes the information to guide the offender’s treatment. If functional TBI-impairments were present and the offender was approaching their release date, a report was sent to the MN-DOC TBI Release Planner (RP). In turn, the TBI RP used the information obtained from the cognitive assessment to help obtain TBI-specific community services.

Limitations

Challenges that are present when conducting cognitive assessments within a correctional setting include: differentiating an offender’s baseline cognitive abilities, which in this population tend to be low, from the lingering consequences of TBI; not having adequate records and readily available collateral sources; and high rates of co-occurring conditions. These challenges can complicate the diagnostic process. To further complicate matters, many offenders report having experienced TBIs years – sometimes decades – ago, making it very difficult to obtain accurate information relevant for the assessment process.

Having an understanding of the etiology (i.e., cause) of an individual’s presenting issues is always a primary goal. This goal, however, can be difficult given the aforementioned factors that can complicate diagnostic specificity. While in some cases having knowledge of the specific etiology is less relevant, having an appreciation for etiology becomes pertinent when, for example, attempting to determine what treatment would suit an individual best or when seeking community resources such as financial funding upon an offender’s release from prison. For example, in Minnesota, individuals who have an acquired or traumatic brain injury and meet certain additional eligibility criteria are qualified to receive funding for home and community-based services.

“Having an understanding of the etiology (i.e., cause) of an individual’s presenting issues is always a primary goal.”
“...the MN-DOC made a concerted effort to direct TBI services and resources to specific mental and chemical health programs throughout the system.”

Research has indicated that substance abusers, especially those who abuse alcohol, are at increased risk of TBI and offenders with a history of TBI report higher levels of alcohol and drug use preceding their current incarceration than their counterparts (McCrea, 2008; Walker, Hiller, Staton, & Leukefeld, 2003). Likewise, it is established that neuropsychiatric disturbances frequently occur in relation to the cognitive and emotional deficits that follow TBI. With this knowledge in mind, the MN-DOC made a concerted effort to direct TBI services and resources to specific mental and chemical health programs throughout the system. As noted, this involved placing a neuropsychologist at the largest male chemical health program and the state’s female chemical health program within the MN-DOC prison system.

Upon admission offenders entering these respective programs are screened for TBI by multiple health professionals. Based on those assessments, an offender will be recommended for additional TBI-related services (e.g., a neurocognitive evaluation) as warranted. Treatment staff, in conjunction with a doctoral level psychologist, worked together to formulate treatment planning recommendations tailored to the specific needs of the offender. The department’s TBI RP has also been in close proximity to these programs and worked with staff and soon-to-be-released offenders to help facilitate their successful transition to community living. This may include, but is not limited to, initiating Rule 25 assessments (public funding for chemical dependency treatment), home and community based services (HCBS) disability waiver (i.e., Minnesota’s Brain Injury Waiver funding for qualifying children and adults who have an acquired or traumatic brain injury), or other TBI-related services (e.g., setting up social security disability appointments, psychiatry appointments, and/or referral to the state’s brain injury association).

The Minnesota Brain Injury Alliance, through the Ambassador’s Council, (a collaborative group of stakeholders including MN-DOC, MN-DHS and community representatives), reviewed, edited and updated online training materials for MN-DOC staff on the prevalence of brain injury among the MN-DOC prison population, the definition of brain injury, identification of changes that may accompany brain injury, the awareness of co-occurring brain injury and mental or chemical health disorders, and information about the correlation of brain injury and violent behavior.
The MN-DOC also has an established 46-bed inpatient mental health unit (MHU) that provides mental health services to acutely mentally ill offenders and offenders who present chronic mental health problems necessitating a longer term supportive living environment. This unit is also capable of providing assessment services, such as neurocognitive evaluations. Offenders with known histories of TBI and suspected persisting TBI-related symptoms may be transferred to this facility, especially if the offender resides at a facility that does not provide specialized neurocognitive-psychiatric assessment services.

**UNDERSERVED POPULATIONS**

According to the Minnesota Department of Health (2012), American Indians sustain non-fatal TBI injuries at an annualized rate of 164.6 per 100,000 – twice the rate of other racial or ethnic groups. Similarly, TBI-related death rates are highest among American Indian males and females with annual averages of 41.3 and 14.4 per 100,000, respectively (Center for Disease Control and Prevention, 2011). In addition, American Indians are twice as likely to experience a TBI-related disability compared to the general population (Proctor, 2012).

Overall, American Indians make up roughly 10.4% of the inmate population within the MN-DOC system despite being slightly over 1% of the state’s population (MN-DOC, 2014). When disaggregated, American Indian males are 9.6% of the male offender population with American Indian females accounting for 18.8% of the female offender population (MN-DOC, 2014). Limited research has been conducted on the release outcomes for offenders of color with a TBI; however, when the above statistics are taken together, it highlights the numerous challenges facing American Indian offenders with a TBI. Similarly, the data demonstrate the need for improved strategies to better prepare American Indian offenders for transitioning into their communities.

In 2011, the MN-DOC contracted with an American Indian consultant, on behalf of the TBI State Implementation Partnership Grant, to provide technical assistance to strengthen release outcomes for American Indian offenders by promoting awareness by MN-DOC staff and American Indian offenders and within Minnesota’s American Indian communities of both the effects of TBI and cultural considerations required for effective community reintegration into home communities. The consultant developed and facilitated two-hour and 3-day cultural competency training at all MN-DOC facilities. The training sessions were designed to assist
MN-DOC staff in understanding how spiritual and cultural practices, such as use of sacred items and healing ceremonies, can be used alongside conventional methods to improve the overall health of American Indian offenders (Koithan & Farrell, 2010).

In addition, the consultant provided direct services to American Indian offenders, both male and female, at the Shakopee, Oak Park Heights, Faribault and Stillwater facilities. For example, the consultant assisted offenders in developing spiritual connections to sacred prayer objects (e.g., medicine bag and a feather) and referred transitioning offenders to tribal elders for additional spiritual and cultural support post-release.

To strengthen community supports for American Indian offenders in transition, the consultant developed a 67-page statewide transition resource directory highlighting reservation, county and community-based services ranging from basic needs assistance to job training. The resource directory was printed and distributed to service providers (e.g., release planners, case managers, etc.) and advocacy organizations. An updated and expanded version of the resource directory, which includes culturally-appropriate TBI, mental health and health care services, is available on the MN-DOC and MN-DHS websites.

The MN-DOC, in partnership with the MN-DHS and representatives from American Indian communities across the state, held a Listening Session on March 26-27, 2013, at the Bois Forte Indian Reservation. The Listening Session’s objectives were to: increase understanding and awareness of TBI among tribal representatives; identify best practices as well as gaps in terms of relationships and support; build capacity through continued dialogue; and identify action steps and stakeholders for future collaboration (Improve Group, 2013).

The consultant strengthened awareness of TBI within tribal communities by promoting TBI awareness and education within American Indian communities and organizations. For example, the American Indian consultant and the Superintendent of the Minnesota Correctional Facility-Togo collaboratively presented information about TBI to the Executive Council of the Minnesota Chippewa Tribe. As a result, several members of the Executive Council expressed interest in creating an American Indian advisory board with key personnel from the MN-DOC and MN-DHS, to address critical issues impacting American Indians. TBI was identified as one of these critical issues.
“The TBI Release Planner (RP) worked with identified offenders approximately 120 days prior to release, providing a voluntary and client-centered approach to the release planning process.”

**Limitations**

MN-DOC resource allocation issues limited the reach of the grant. The most noticeable challenge was the absence of a full-time MN-DOC tribal liaison. A key recommendation from the Listening Session was the agency’s continued dialogue with tribal leaders to coordinate TBI education, reentry and reintegration efforts. However, limited MN-DOC resources made hiring a suitable candidate particularly challenging – impacting the agency’s ability to develop and sustain communications with tribal leaders about American Indian offenders with TBI.

Balancing the need to deliver cultural competency trainings to MN-DOC facility staff – especially staff in offender supervision roles – with the priority of maintaining adequate staffing levels presents another resource challenge. Effectively managing safe and secure correctional facilities requires adequate staffing. Implementing half-day or full-day cultural competency trainings may create gaps in offender supervision, posing safety and security risks to other staff and offenders.

**TBI RELEASE PLANNING**

Early in the life of this grant, a dedicated TBI RP was hired. To be eligible for specialized release planning due to a TBI, an offender needed to display a functional impairment that significantly impacts their ability to independently navigate their environment. This could be observed in deficits related to memory, decision-making, problem solving, judgment, reasoning, and/or self-preservation.

Obtaining evaluative information on both functionality and cognitive impairment is critical in the release planning process. It is necessary to obtain any previous hospital records and/or information from individuals knowledgeable of the offender’s brain injury and functional history. The neuropsychologist conducted appropriate testing if no current records exist to corroborate functional impairment that significantly impacts an offender’s ability to perform daily living skills.

The TBI RP and neuropsychologist collaborated on potential referrals and to determine an offender’s level of need. The TBI RP worked with identified offenders approximately 120 days prior to release, providing a voluntary and client-centered approach to the release planning process. Each offender actively participated in their own release planning decisions. Release plans include options for medical/mental health, residential, vocational, educational, support
“Resource facilitation is a free, statewide telephone service providing persons affected by brain injury with support in transitioning back to their family life, work, school and the community following release from an institution, such as a hospital or correctional facility.”

Referrals for resource facilitation services at the Minnesota Brain Injury Alliance have been and continue to be completed for each identified client. Resource facilitation is a free, statewide telephone service providing persons affected by brain injury with support in transitioning back to their family life, work, school and the community following release from an institution, such as a hospital or correctional facility. The Minnesota Brain Injury Alliance and the MN-DOC have effectively coordinated referrals allowing offenders to work with a resource facilitator (RF) prior to release. There are approximately eight RFs responsible for specific regions in the state of Minnesota. RFs from the Minnesota Brain Injury Alliance call clients within a few weeks of release, and subsequently every six months, or as needed, for up to two years. The goal is to assist clients affected by brain injury as they problem-solve issues...
and to identify support resources to ensure services offered to clients and their families were meeting their needs.

In addition to obtaining a RF for each client, grant funding for family liaison services provided additional release support and service coordination for several clients. The family liaison provided release planning supports by meeting with individual offenders and their families to explain how a brain injury impacted the offenders’ abilities, and to provide information about community resources. The family liaison also provided valuable feedback and recommendations on offenders’ release plans and assisted the TBI RP in negotiating approvals for brain injury waivers.

For American Indian offenders with a TBI, the American Indian consultant met with those offenders who wanted to discuss cultural issues, concerns and available resources. The consultant also provided cultural support to offenders post-release.

Resource utilization for continuum of care needs was substantially concentrated on substance use treatment facilities located throughout the State of Minnesota. Release planning frequently required generating referrals and collaboration with substance use treatment facilities, particularly Vinland National Center located in Loretto, MN. Vinland National Center is the primary chemical health center in the State of Minnesota serving individuals living with a brain injury, providing both outpatient and residential chemical health services.

Additionally, several efforts have been made in working with community stakeholders to raise awareness about TBI and the need to assess, plan, identify, and coordinate efforts for offenders with a TBI prior to their release. To illustrate, the TBI RP partnered with vocational rehabilitation counselors at the Minnesota Department of Employment and Economic Development and Goodwill Industries to discuss and implement a simplified intake process for offenders with a TBI.

Throughout the life of the grant, the expectation was that TBI will become more widely recognized and accepted as a disabling condition that requires specific and well-coordinated continuum of care. Without ongoing services to address functional and cognitive impairments, numerous vulnerable offenders will not receive vital connections to services that could greatly improve their quality of life. Furthermore, addressing individuals with a TBI in a
address public safety and the needs of the community.

**Limitations**

Various challenges have surfaced specific to reentry efforts. For example, evaluating an offender’s need for services can be a lengthy, resource-heavy process. Neuropsychological testing, in particular, is time-consuming and requires a high level of expertise. Moreover, it is not always known and readily apparent that TBI is present, and may be overlooked based on an offender’s self-report. An offender’s impairment is not commonly apparent via routine interaction, nor is the condition static. It is possible to require multiple interactions with an offender to detect the need for an intervention and determine the proper diagnosis. There was also difficulty obtaining records from community providers in a timely manner, or they were nonexistent due to an offender not seeking appropriate medical care, further complicating the ability to substantiate a brain injury. All of these challenges made the referral process for release planning difficult.

Once proper identification has been established, reentry efforts were further complicated by limited TBI-appropriate resources. An offender may be best served in a 24-hour care environment, yet they may be unable to obtain necessary funding for such a placement. Possible explanations for this exist, including the qualification process based on subjective ratings completed by multiple screeners and/or competing demands for limited funding. If funding was secured, criminal records involving arson, sexual offenses and/or violence can significantly impact an offender’s eligibility for admittance into vulnerable adult settings.

**MOVING FORWARD**

The MN-DOC is proud to be among the first correctional system in the nation to identify high prevalence of TBI in its facilities. The MN-DOC was able to show a high rate of TBI among its offender populations since 2006 and to work towards greater understanding by professionals helping offenders transition successfully back into the community with appropriate supports made possible by this grant. Moving forward, it is recognized that a system comprised of professionals trained to identify TBI and understand the importance of specific brain injury resources will be key. Ongoing opportunities exist to identify TBI, educate professionals as well as create positions to support offenders with cognitive disabilities like TBI. Through this grant, strategic partnerships between large state agencies, such as the MN-DOC, and brain injury professionals have
“Through this grant strategic partnerships between large state agencies, such as the MN-DOC, and brain injury professionals have been cultivated to identify the best places within the care continuum to provide support and intervention to offenders with a TBI. This will very likely continue to demonstrate reduced recidivism and higher quality of life for offenders living with a TBI.”
References


Minnesota Department of Health. (2012). Minnesota TBI/SCI Registry: Injury and Violence Prevention Unit. Accessible by permission only: mark.kinde@state.mn.us.


The Improve Group. (Eds.). (2013). Proceedings from *Listening Session on TBI in Minnesota Correctional Facilities*. Bois Forte Indian Reservation, MN.


**APPENDIX A – TBI Screening Tool**

**MN DOC Intake TBI Screening Tool**
(Trial Version 5 rev. 01.16.14)

<table>
<thead>
<tr>
<th>Name: (last, first)</th>
<th>OID:</th>
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</table>

<table>
<thead>
<tr>
<th>Date of Interview:</th>
<th>Release Date:</th>
</tr>
</thead>
</table>

1. Have you ever had a hit to your head that caused you to be knocked out or dazed (e.g., seeing stars) and confused, for a period of time?

- **No**  If the client says NO, still ask about incidents where the risk of having a head injury is increased (e.g., assaults, fights, car accidents) to see if this jogs their memory. Ask about cause(s) of any visible scars to the face, head or neck.

- **Yes:**
  a. How many times has this happened in your lifetime? _____ # of times. AND...
    - **Cause(s) of head injury (limit to worse 3 events)...** If multiple head injuries (>3) are due to one cause (e.g., boxing or domestic violence) count the multiple TBI incidents as one event and put a (+) sign next to the cause to indicate multiple events:
      1. _____
      2. _____
      3. _____
  b. During any of those times, were you “knocked out”?  **No: Go to Section #2**  **Yes: If yes, how many times? _____**

  AND...
  c. How long were you knocked out? (If more than one head injury reported, ask about the one head injury that stands out the most.)  **<30 minutes**  **>30 minutes**
2. Have you ever...
   
a. Stayed in the hospital for two or more days due to a head injury? □ Yes □ No
b. Had a fractured skull? □ Yes □ No
c. Had a gunshot wound to the head? □ Yes □ No
d. Had a neuropsychological exam (i.e., given tests to see how well your brain works)? □ Yes □ No
e. Had seizures? □ Yes □ No…If yes, are the seizures related to a head injury □ Yes □ No
f. Served in the military and experienced a service-related injury to your head? □ Yes □ No
g. Been choked to the point you have passed out? □ Yes □ No…If yes, how many times?_____
h. Had a head injury that led to significant problems with any of the following: walking, using your hands, vision, hearing, and/or talking? □ Yes □ No
i. Received special services or assistance (e.g., social security disability) because of a head injury? □ Yes □ No

END OF INTERVIEW!

Assessor Name
APPENDIX B – Definitions

**Adult Rehabilitative Mental Health Services (ARMHS):** Five services are billable as ARMHS: Basic Living and Social Skills, Certified Peer Specialist Services, Community Intervention, Medication Education, Transition to Community Living Services.

**Consolidated Chemical Dependency Treatment Fund:** Federal, state and county governments put money into a Consolidated Chemical Dependency Treatment Fund so that Minnesotans with low incomes can get needed treatment for substance abuse. Individuals can qualify for help if they meet clinical requirements and annual income limits for their household size, or if they meet eligibility guidelines for Medical Assistance, Minnesota Supplemental Aid or Supplemental Security Income and have no other insurance or third party that will pay 100% of the cost of treatment, based on assessment.

**Group Residential Housing (GRH):** State-funded income supplement program. GRH pays room and board costs for low-income adults who have been placed in a licensed or registered setting with which a county human service agency has negotiated a monthly rate.

**Long-term Care Consultation (LTCC):** Services include a face-to-face visit to help individuals with a disability become aware of supports and services in the community so they and their family may make an informed choice about where they want to live. During the visit with a social worker or nurse, individuals with a disability can discuss their wants and needs. Individuals receive information about local long-term care services and support options, and about options that might help them pay for services. After their visit, they receive a copy of a support or service plan they helped develop during the visit, with recommendations about service options that could meet their current needs.

If an individual with a disability wants to apply for help paying for long-term care in their home or another setting in the community, a LTCC visit is required even if they have health care coverage.

**Medical Assistance (MA):** MA is Minnesota’s Medicaid program, the largest of Minnesota’s publicly-funded health care programs. It provides health care coverage to over 700,000 low-income Minnesotans each month. Three-fourths of those are children and families, pregnant women and adults without children. The others are people 65 or older and people who have disabilities.

Most enrollees get their health care through health plans. The rest get care on a fee-for-service with providers billing the state directly for services provided.

MA is funded with state and federal funds. The MN-DHS oversees the program statewide; eligibility is administered by county offices. The federal Center for Medicare and Medicaid Services oversees Medicaid nationally.
Social Security Administration’s Adult Disability Benefits: Federal cash assistance program targeting adults with a disability who have previously earned the required minimum work credits and paid Social Security taxes.
## APPENDIX C – TBI Release Planning Data

### Table 1.1: TBI Releasing Planning Statistics

<table>
<thead>
<tr>
<th>TBI Releasing Planning Statistics March 1, 2010 – October 31, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBI Release Planning Cases (Total)</td>
</tr>
<tr>
<td>Rule 25 Assessments</td>
</tr>
<tr>
<td>Long-Term Care† Consultations</td>
</tr>
<tr>
<td>Social Security Applications§</td>
</tr>
<tr>
<td>Psychiatric Appointments</td>
</tr>
<tr>
<td>Mental Health Therapy</td>
</tr>
<tr>
<td>ARMHS Applications</td>
</tr>
<tr>
<td>Medical Assistance Applications</td>
</tr>
<tr>
<td>BIA Referral*</td>
</tr>
</tbody>
</table>

† Long-Term Care Consultations may include Brain Injury, Community Alternatives for Disabled Individual, Community Alternatives Care and Elderly Waivers.

§ Indicates number of new applications for Social Security benefits. Offenders with Social Security benefits in suspense during incarceration were excluded from new applications.

* Referrals initiated for new clients only. Returning clients were excluded. Referrals were made by MN-DOC TBI Release Planner.
Chart 1.1: TBI Release Planning Statistics

TBI Release Planning Statistics
March 1, 2010 - December 31, 2014

† Long-Term Care Consultations may include Brain Injury, Community Alternatives for Disabled Individuals, Community Alternatives Care and Elderly Waivers.

§ Indicates number of new applications for Social Security benefits. Offenders with Social Security benefits in suspense during incarceration were excluded from new applications.

* Referrals initiated for new clients only. Returning clients were excluded.
In 2009, the MN-DOC offered three separate online training modules to its employees, interns, contractors and county workers in an effort to increase awareness about TBI, its symptoms and co-occurring disorders. The trainings were voluntary.

**Table 2.1: DOC TBI Module Users from 2009 – 2014**

<table>
<thead>
<tr>
<th></th>
<th>DOC Employees</th>
<th>DOC Contractors</th>
<th>County Workers</th>
<th>DOC Interns</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBI Module 1</td>
<td>3,169</td>
<td>69</td>
<td>358</td>
<td>8</td>
<td>3,604</td>
</tr>
<tr>
<td>TBI Module 2</td>
<td>1,942</td>
<td>42</td>
<td>187</td>
<td>6</td>
<td>2,177</td>
</tr>
<tr>
<td>TBI Module 3</td>
<td>2,286</td>
<td>51</td>
<td>219</td>
<td>7</td>
<td>2,563</td>
</tr>
<tr>
<td>Totals</td>
<td>7,397</td>
<td>162</td>
<td>764</td>
<td>21</td>
<td>8,344</td>
</tr>
</tbody>
</table>

**Chart 2.1: DOC TBI Module Users from 2009 – 2014 (%)**

**DOC TBI Module Users**

- DOC Employees: 88%
- DOC Contractors: 2%
- County Workers: 10%
- DOC Interns: 0%
The table and chart below indicate referrals made by the MN-DOC to the Minnesota Brain Injury Alliance for brain injury services.

**Table 3.1: DOC TBI Referrals by Year**

<table>
<thead>
<tr>
<th>DOC TBI Referrals</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2006</td>
</tr>
<tr>
<td>31</td>
<td>2007</td>
</tr>
<tr>
<td>13</td>
<td>2008</td>
</tr>
<tr>
<td>9</td>
<td>2009</td>
</tr>
<tr>
<td>22</td>
<td>2010</td>
</tr>
<tr>
<td>19</td>
<td>2011</td>
</tr>
<tr>
<td>17</td>
<td>2012</td>
</tr>
<tr>
<td>20</td>
<td>2013</td>
</tr>
<tr>
<td>27</td>
<td>2014</td>
</tr>
</tbody>
</table>

**Chart 3.1: DOC TBI Referrals by Year**

DOC TBI Referrals as of December 31, 2014
Appendix D – TBI Grants History

Overview of Minnesota’s Traumatic Brain Injury (TBI) Implementation Grants

1996: The federal TBI Act (P.L. 104-168) was passed, authorizing State TBI Grant funding through the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA).

Federal TBI Program Vision: To support state and local agencies develop resources so that all individuals with TBI and their families will have access to acceptable and appropriate services and supports.

Four core components are required for states and territories to be eligible for a State Implementation Grant. They must:

- Have a designated Lead Agency;
- Have a TBI Advisory Council composed of a broad representation of people, including people living with the effects of a TBI and their family members;
- Complete a Statewide Needs and Resource Assessment; and
- Develop a State TBI Action Plan

1997: Minnesota was one of the seven states to receive a competitive State TBI Implementation Grant.

- Governor Arne Carlson designated the MN-DHS as Minnesota’s lead agency;
- The DHS TBI Advisory Committee was recognized as Minnesota’s TBI Advisory Council

Minnesota’s State TBI Grants

1997 – 2001 3-year Implementation grant for $100,000 per year awarded. The MN-DHS and the Minnesota Department of Health (MDH) developed a “hospital discharge model” for individuals with TBI discharged from acute care. This grant developed Minnesota’s Resource Facilitation services. Funding was secured for a no-cost extension for the fourth year.

2002 – 2003 1-year Post-Demonstration grant for $100,000 was awarded to enhance TBI resource facilitation.

2003 – 2004 Second 1-year State Post-Demonstration grant for $100,000 was awarded to further enhance and expand resource facilitation. Legislation was passed in 2004 to fund resource facilitation through expansion of TBI

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1 The lead agency for Minnesota is the Minnesota Department of Human Services.
2 Minnesota’s State Action Plan was last updated by the BI Interagency Leadership Committee (ILC) in 2012.
3 DHS TBI Advisory Committee was formed in October 1990 and established in statute in 1991.
dedicated funds managed by MDH. Resource facilitation contract was developed between MDH and the Minnesota Brain Injury Association.

2006 – 2010

3-year Implementation grant for $100,000 per year awarded. The MN-DHS and MN-DOC partnered in “TBI in Minnesota Correctional Facilities: Strategies for Successful Return to Community” grant. Goals of this grant were to: screen MN-DOC offenders for TBI; build capacity within the MN-DOC Behavioral Health Services to better address the needs of offenders with a TBI; develop dedicated TBI release planner position. Funding was secured for a no-cost extension in the fourth year.

2010 – Present

4-year Implementation grant for $250,000 per year awarded. The MN-DHS and MN-DOC partnered again to execute “TBI in Minnesota Correctional Facilities: Systems Change for Successful Return to Community” grant. Goal of this grant are to: develop tools and protocols to identify offenders who have sustained a TBI and develop model release planning for offenders with functional impairments tied to their TBI; build capacity to identify and address the needs of offenders with TBI, with attention given the unique needs of American Indian offenders living with impairments tied to a TBI; enhance MN-DOC and statewide community capacity to improve ex-offender outcomes upon release from a MN-DOC facility. The grant is now in its fifth no-cost extension year. The fifth year will be completed on March 31, 2015.
Certificate of Recognition

We hereby present

Minnesota Department of Human Services

Awarded on this 14 day of March, 2013

Eating Champs, Inc.

for your achievement and contribution.

Minnesota Department of Corrections

Appendix E - Grant Recognition
March 14, 2013

Dear Mary,

In 2006, FIRSA’s Federal TBI Program began awarding State grantees for outstanding accomplishments in the areas of collaboration and coalition building, impacting systems change and product development. Accomplishments for exceptional advocacy on behalf of individuals with TBI, as well as outreach and training, are awarded to the Protection and Advocacy Systems. Additionally, individuals or family members who have represented the TBI Program in an exemplary manner are also recognized with a specific award highlighting their efforts on behalf of the Program. In 2010, the Big Strides award was initiated for unfunded States that have sustained TBI efforts.

It is our pleasure to award the Minnesota Department of Human Services the 2013 Federal TBI Program Award for Impacting Systems Change.

This award recognizes a State that has developed a product or process that has been incorporated into the State's systems of services and supports for individuals with TBI and their families. Criteria for this award may include: number and types of training/educational protocols formalized within various service delivery systems, legislative and/or policy changes, TBI representation on other systems' boards and councils or the implementation of the State TBI. Action Plan in building and maintaining interagency support, planning and problem solving.

You will be receiving the award certificate in the mail along with a copy of the narrative citing Minnesota's accomplishments supporting this award designation.

Congratulations for implementing innovative programs with Minnesota’s Department of Corrections.

Sincerely,

LCDR Donelle McKenna, MI-ISA
Director, Federal Traumatic Brain Injury Program

Rebecca Desrocher, MS
Assistant Director, Federal Traumatic Brain Injury Program

Enclosure: Award Narrative
2013 Federal TBI Program Impacting Systems Change Award Minnesota

State Department of Human Services

Minnesota has impacted systems change through the Minnesota Department of Corrections (DOC) by:

- Implementing a TBI Release Planner position as an important link to support the successful return to the community of individuals known to have functional limitations due to TBI;
- Planning by the Department of Corrections release affords opportunities to foster community linkages within probation, parole and other services by developing specialized plans as well as opportunities to develop and standardize new release strategies and protocols;
- Implementing the MN DOC TBI Screening Tool at two facilities for 45 working days with 796 complete screens; screening information has been entered into the DOC I-Share system for review/analyses with information being utilized to refine the decision tree/process, design and improve DOC systems and develop TBI-specific release planning models;
- Developing a Native American Cultural Awareness training, "Opening the Dialogue: Sharing a Native American's Journey" in all adult DOC facilities with a Native American Resource Guide nearing completion.

Congratulations to the State of Minnesota for implementing innovative programs with Minnesota's Department of Corrections.