

Amanda Blasko:

Welcome to The NCJA Podcast. Listen to lively discussions with a variety of guests about promising criminal justice practices and programs worth taking a closer look at, your interesting ideas from around the country on a variety of important and timely topics and learn how you can adjust or adapt your Byrne JAG grant program for improved success. Thanks for joining us. We hope you enjoy.

Welcome back to another episode of The NCJA Podcast. Today's episode is an exciting one. Dr. Kimberly Gorgens has joined me today to talk about the impact of traumatic brain injuries or TBIs on criminal justice. We'll discuss how prevalent these injuries are in the criminal justice system, how TBIs affect an individual's success within the system, and how the Colorado Brain Injury Model came to fruition.

Thank you so much for being here, Dr. Gorgens. I'm thrilled you're here today. Would you mind briefly introducing yourself for the listeners?

Dr. Kimberly Gorgens:

Sure. My name is Kim Gorgens. I am a professor at the University of Denver. I've been here for 24 years. In that role, I teach graduate students. My primary area of focus is neuropsychology, clinical neuropsychology, and psychophysiology about the brain. I also teach in our forensic psychology program about the criminogenic risk associated with all different manner of psychobiological conditions.

I supervise student clinicians working in our in-house forensic clinic. I supervise also our postdoctoral fellows doing forensic work across different settings. I have a really small clinical neuropsych forensic practice where I get to choose really interesting cases like death penalty cases and juvenile homicide cases. And I oversee a whole suite of really interesting brain-related research.

So we have a big concussion biomarker study, and we, of course, have all of our work in the traumatic brain injury and acquired brain injury space in other vulnerable settings, so criminal legal settings, services for people exposed to interpersonal violence and shelters for people who are unhoused. We have partnerships with those kinds of places to look at ways that we might serve their folks better. So I think of it as I teach and study and work with people with vulnerable brains.

Amanda Blasko:

I like that phrase, vulnerable brains.

Dr. Kimberly Gorgens:

Which is something we all have, frankly.

Amanda Blasko:

Right, exactly.

Dr. Kimberly Gorgens:

Yeah.

Amanda Blasko:

That's cool. And you also are the first and only person on The NCJA Podcast with the TED Talk that I'm aware of anyway.

Dr. Kimberly Gorgens:

Oh, I love it. Yeah, I have two TED Talks. The first one is about youth sport concussion, but it's actually about neurotic parenting, if I'm being honest. That's 2010 and 2018 is about brain injury and criminal justice.

Amanda Blasko:

Very cool. And shout out to Judge Bowen in Adams County, Colorado, who is also a previous NCJA Podcast guest for connecting us.

Dr. Kimberly Gorgens:

Please shout out to Judge Bowen. The best.

Amanda Blasko:

So before we dive into the core of our conversation today, I thought it might be beneficial just to provide an overview of what a traumatic brain injury is or a TBI. So would you mind defining the term and maybe also discussing how you became interested in the TBI space, particularly as it intersects with the criminal justice system?

Dr. Kimberly Gorgens:

Yeah, I'll speak to that latter piece first maybe. I had the luxury of really two pathways into the field in psychology. One was a pretty traditional forensic trajectory, which included, I went to grad school at Southern Illinois University, and it included a stint at Menard Psychiatric Prison in Chester, Illinois. And some other really great training. I worked as a paramedic and built at that time critical incident programming for my colleagues. I love that space.

My academic training as a neuropsychologist was pretty in the box as far as traditional neuropsych training goes and had a lot of exposure to populations who had people who'd sustained brain injury. One of the I think the premier rehab settings in the country is a space called the Center for Comprehensive Services in Carbondale, Illinois and the chance to learn from some of the best.

I had a really long-standing interest in working with that clinical population, folks who'd sustained a brain injury and their families and caregivers and supporters, and also this interest in forensic settings. And over time, the chance to cross pollinate both of those interests has proven to be really amazing, and it's where most of my career has been spent. And frankly, I think it's where some of the coolest programming that we've been involved in has been centered.

Anyway, it's like two converging streams of interest. And now I'm so excited to see this space be claimed by so many people who find it in the same way. They come to it via other fields. And your question about traumatic brain injury is a super easy one. A traumatic brain injury is the kind of injury to your brain that you sustain by an external blow or some force applied to the head, and that includes also blast injuries.

In that case, you're not really struck by or struck against something, but the damage is done by that hyper-pressurized blast wave and its contact with brain tissue. So traumatic injuries are the application of some force. And worldwide, there's almost 75 million of those injuries a year. The population base rate for any kind of brain injury is probably just under 10% in the US.

Amanda Blasko:

Perfect. Thank you for that. That's really helpful. So what does the landscape of TBI injuries look like? I know you mentioned in the general population worldwide, but how prevalent are these injuries specifically for individuals who are in the criminal justice system and how does having a TBI or even having a vulnerable brain affect outcomes for individuals while they're in the system and beyond?

Dr. Kimberly Gorgens:

This is really where my heart is in our programming is advocating for the needs of people in that space. So what we have found to be true in Colorado and in other settings using this model where they're sharing data with colleagues around the country who are doing this research, some of our data were used in a recent meta analysis published last year by my colleague Casey LaDuke's team in New York. And all of those data together converge on a number that is about between 45 and 55% across Colorado.

Among adults, that number is about 55%. Depending on the specialty court setting or the kind of jail setting, that number can range in juvenile settings from 18% in probation to 97% on the high end in repeat female offenders specialty programs. So there's a lot of variability, but Casey LaDuke's team just reiterated that 45% number across all of criminal justice settings and across all ways of measuring brain injury history. So the population base rate, of course, I mentioned is below 10%.

And statistically speaking, this I really just say even for people who are better statistical thinkers than I'll ever be, there's no way to randomly sample a population base rate of less than 10% and get to more than half. It just isn't possible. And it speaks to the trajectory in the accumulation of other

vulnerabilities that traumatic brain injuries includes for people, particularly folks who were vulnerable already.

Amanda Blasko:

That's super interesting. I don't want to say co-morbidity, but kind of. It's the intersection of various things make your outcomes worse and worse.

Dr. Kimberly Gorgens:

That's exactly right. So we coined the term the superfecta because we got to co-morbidity and then we had the trifecta. And so the superfecta are folks who are involved in the criminal legal system who have a significant brain injury history, so not including all the folks who have sustained just an uncomplicated mild injury or a concussion, also mental illness, also significant history of substance misuse. And that number in our research is about 74%. Clinically speaking, those are the folks at greatest risk for poor outcomes.

What we know is when you study them while they're incarcerated is that they have a harder time in jails and prison settings. They have more disciplinary infractions. In some cases, they pose a risk to staff. They also use more health services. They're more likely to make suicide attempts. They fare poorly while they're in an institution. And then on the community reentry side, they also fare more poorly. So they're more likely to reoffend. They're more likely to violate the terms of community release, and they're less likely to complete those terms successfully.

Each of those three categories, folks with brain injury are overrepresented. They're at the highest risk for poor outcomes. And as we talk more, we'll talk about how I think about brain injury screening models and what you know about someone if you only know they have a brain injury history. But really if you just are talking about risk and allocating resources in a resource limited setting, like a criminal legal setting, then knowing who your highest acuity folks are can be the decision between feeling like you're wasting time or investing it in the right direction.

Amanda Blasko:

Right, yeah, that's a really good point. So before we dive into the specifics of the Colorado Brain Injury Model, would you mind talking a little bit about how you and your team went through the process of doing various pilot projects that were precursors for the model?

Dr. Kimberly Gorgens:

I'll just go all the way back and tell you that the model, we sketched this on the back of a napkin at a happy hour with margaritas, my colleagues and I. There were three of us, me on the academic and neuropsych side, my colleague Jennifer Gafford, who at that time was the chief psychologist at Denver County Jail, and my colleague Judy Dettmer, who at that time headed up the Colorado Brain Injury Agency. It's now called MINDSOURCE.

And the three of us at a happy hour over margaritas were bemoaning the things that each of us didn't. And for Jennifer Gafford, it was quality access to behavioral health services and assessment for the inmates in her care. And for Judy, it was meaningful data about the brain injury needs in a population of folks who were in the criminal legal system.

And for me as the academic, it was like I wanted real life opportunities for students in training to be exposed to populations that I love so much, that they may not otherwise ever have a chance to interact with. So we sketched out this model on the back of a napkin and then pitched that to now Sheriff Elias Diggins at Denver County Jail, and he was thankfully so totally on board.

And we were able to get a pilot of what we have come to call our Colorado Brain Injury Model at the Denver County Jail within two weeks, and did background and credentialing for about 30 students and rotated the students through and invited a really meaningful participation from the inmates there so that the program was informed by the things that they wanted to see and what did they want as a takeaway, for example.

And we had two summers of data from these kinds of pilot programs, and we used together those data and applied for some state and federal funding and have since expanded our footprint in that space, in the grant funded space. And now the Colorado Brain Injury Model is in 27 other states. It's in BC in Canada. It's in other countries. I just did some training on this model in New Zealand.

It is so portable and easy to disassemble and reassemble in whatever way makes sense for different systems. We have a new grant here in Colorado studying this brain injury model in the competency restoration system. So it just is so easily molded to fit settings where people are getting stuck.

Amanda Blasko:

That's super interesting. I love a good happy hour problem solving.

Dr. Kimberly Gorgens:

I know.

Amanda Blasko:

So great.

Dr. Kimberly Gorgens:

You put a bunch of brilliant people together over a margarita and some magic happens.

Amanda Blasko:

You just feel the brains thinking. It's cool. Yeah, I like that a lot. So you mentioned funding and you mentioned that you're now moving more into the grant funded space. Are they Department of

Justice grants? Are they state grants? Are they through philanthropy organizations? Or all of the above? Or how has that shifted from when you started to now?

Dr. Kimberly Gorgens:

Yeah, it's really all of the above. And what I always say about our model is that we have built this with twigs and sticks and chewing gum and scotch tape. We've put all of this together on the super cheap. It's really lean. It's designed to be used in settings that are by definition under-resourced and underserved. So we've done almost everything for free and we make all of our materials available for free to all of our partners.

So all of that said, we first had a Colorado Department of Behavioral Health grant. That was, I think, for about two years. We have had federal funding. We had some ACL, Administration for Community Living, dollars for four years. We have in the interpersonal violence space in this particular study is working with women who have had contact with law enforcement for an incident of IPV and looking at applying the model and then tracking their outcomes, service usage, and then prosecution outcomes.

That study is funded by the National Institute of Justice. And we have a Fines Committee grant right now that is funding the build out of our competency restoration model. We are the scrappiest team of people. If there are funds available, we're all in, especially where those funds will support provider time, will support student time. I mean, we're just all about finding pockets of money.

That said, there aren't a lot of pockets of money. So this is the kind of work that you really do need to get creative with. And ultimately, there's a payoff and then it makes people's jobs easier, but it requires people to momentarily think outside the box.

Amanda Blasko:

Yeah, I love that. You have to basically take all the different funding sources and braid them together.

Dr. Kimberly Gorgens:

It is braiding for sure, like macrame, like some pretty high level macrame for sure.

Amanda Blasko:

Could you describe how does the Colorado Brain Injury Model work and what are the key components of the model?

Dr. Kimberly Gorgens:

Excellent. The model has three component parts, and again, we have disassembled. On the startup side, we've done a million different iterations of the model, and this is where we've landed over time and trial and error. And we've implemented the model in ways that look very different

depending on the setting. We're implementing it with the FBI in Kansas City, for example. So that will look a little bit different.

But the basic Colorado Brain Injury Model is to screen for brain injury and to screen for cognitive function. So screen for brain injury. Second part is screening cognitive function and for other psychosocial vulnerabilities. And the third piece that has always been I think where the magic happens is to do several things. One is to use those results to promote self-advocacy in the person that you did the testing with, so teaching someone about the ways their brain works or the ways that they have a vulnerable brain, and now they're caretakers of a more vulnerable brain.

And the importance of not getting into more fights or being helmeted on motorcycles or whatever the case is. And teaching them something about how to address whatever those cognitive deficits are, using things that they may be good at doing. Also, promoting advocacy within the system, so training the other stakeholders how to manage that. In this case, let's say it's someone in a correctional setting. So we may be teaching the correctional officers how to safely manage an inmate who is super impulsive or inattentive or has slower processing speed, for example.

Or teaching the judge how to manage someone in the courtroom, teaching a behavioral health clinician in those systems how to deliver psychotherapy or anger management curriculum. So that third piece is about advocacy and customizing the delivery of treatment as usual. And where it's possible, that third component part also includes hooking people up with care coordination. And in a lot of states here in the US, there are resource facilitators available that are funded by statewide used to call it trust fund dollars, but sometimes they're funded by traffic surcharges.

But these dollars go to brain injury agencies to deliver free resource facilitation to folks with a history of brain injury. So making that handoff for people, particularly for our folks who are in the system, has proven to be pretty extraordinary. So that third piece is like you have to do something about it. You have to do education with all of your stakeholders. And ultimately, you have to help someone land on their feet. And we've found a lot of luck with that care coordination model.

Amanda Blasko:

That's really cool. Do you assess everyone that goes into jail or prison in Colorado for this model, or am I thinking too small and it's way bigger than that?

Dr. Kimberly Gorgens:

Well, it's bigger than that in some settings. We have some settings that are regularly screening brain injury history and cognitive complaints and making those referrals. We had the great fortune here in Colorado to have two pieces of entirely stakeholder-led pieces of legislation, one for Department of Corrections, the other for police departments statewide, to screen victims of violent crime in the acute phase for brain injury history.

That Department of Corrections partnership is rolling out right now. That pilot is happening in La Vista Correctional Facility, which is a women's prison here in Colorado. So in that setting, all of the women in that setting are being screened for brain injury history, cognitive dysfunction. And as they approach release, they'll be connected with those kinds of community resources. We have a whole series of totally free, self-paced, and group-led, facilitator-led curricula that are designed to promote self-advocacy.

So for example, in Department of Corrections, we call it the Ahead curriculum, but these women in DOC will get screened for brain injury history and cognitive dysfunction, and then they'll participate in these Ahead group modules, which are designed to teach them compensatory skills and teach them how to manage executive dysfunction, for example. And then as they get closer to being released, we'll make a handoff. A warm handoff we found is more successful to put a name to a face with their local care coordinator for brain injury.

Amanda Blasko:

And you touched on this a little bit, but what are the most common recommendations upon assessment and finding out that someone does have a traumatic brain injury?

Dr. Kimberly Gorgens:

It's such an important point, and I should have probably led with this. And Amanda, thank you for circling me back to it. We're not teaching folks to manage someone's brain injury. We are teaching folks how to accommodate an attention deficit or slow processing speed in the context of doing a relapse prevention group in a community correction setting or to do family skill training for reentry. How do you do your job knowing something about the way that your client's brain works?

So our recommendations in the model that I feel so strongly about, that doesn't always work in a lot of settings, but if you can do the cognitive and psychosocial screening with a clinician and get a really thorough picture of where someone's gaps are, where their strengths are, then you can weigh in really specifically to that audience, the behavioral health clinician, the correctional officer, the probation officer, substance abuse treatment tech. You can tell them how to do their job in light of inattention or slow processing speed or poor verbal memory, for example.

And the recommendations are all super basic. This is seat someone facing away from an open door because they're going to be distracted and not pay any attention to anything you say. The person with poor verbal memory, their recommendation might be this person's not going to remember any of the things that you say after your meeting. If you need them to remember something, you have to remind them to write it down.

And then the meeting with that client when we talk about gaps is like, "Gosh, you know what? Your memory is terrible, just like you said, and here's what you're going to do about it. You have got to write things down if you need to remember it. And you're going to carry paper and let's practice writing things down." We hand the lifting to that stakeholder and then the system, we tell them,



"Here's how to do your job and be mindful of all the ways that what you're doing is certain to fail if you don't tweak it just this little bit."

Amanda Blasko:

I really like what you're saying here. It's not necessarily large scale adjustments, it's small adjustments that make a huge difference, but it gets to stakeholder buy-in. So I'm wondering for our listeners, if states are interested in embarking on a process like this, where should they start and what are the stakeholders that they must get on board?

Dr. Kimberly Gorgens:

This is a great question. And stakeholder buy-in, we've always had the benefit of great inmate and probationer buy-in. I use the example from one of our longstanding allies. His name is Markelle Taylor, and he talks about feeling like he was the passenger in a car careening down the highway at 100 miles an hour and having a conversation with a student clinician where they talked about being impulsive and poor executive function, for example, and gave him mindfulness techniques that made him feel more like the driver of that car.

So for our probationer and inmates or victim, for persons who are receiving behavioral health, all of those stakeholders have had instant buy-in because they've got tools and strategies and it helps them make sense of what's been their experience of the world, the things are confusing. And people in the criminal justice system just think they're garbage. This is the messaging they've internalized.

For our correctional and law enforcement colleagues, when we had one pilot year where we invited our colleagues to make referrals for the folks they thought had a brain injury history, that hit rate was 100%. Our officers know exactly who we're talking about, and they're frustrating. And as I mentioned, statistically, this is not common, but people who are easily agitated, for example, and really impulsive could pose a risk to those staffs.

So knowing how to deescalate someone who has slow processing speed, for example, it's the same deescalation technique, but here's how you modify it for this person who processes four seconds behind everybody else. So we've had a lot of really great buy-in from our officer colleagues across the board. And behavioral health clinicians initially balk at this and think, I don't treat brain injury.

And then when they realize, we're not telling you you suddenly have to treat something that's outside your scope of practice, but we're telling you how to deliver cognitive behavioral therapy in a way that is more likely to land for someone who is impulsive or inattentive or has whatever cognitive gap that we're talking about, and it's like a slight tweak, always free to treatment as usual that increases the likelihood that that treatment can be successful.

And at the end of the day, for people who are in under-resourced, overtaxed settings, what they like to know best is that their time is spent wisely. If they thought this might make a difference for someone's outcomes, which our research suggests it does, they'll spend that time and they're okay turning the chair around in the room, for example. These are pretty low drag interventions, and we found they have a pretty huge payoff.

Amanda Blasko:

Yeah, it's interesting that the behavioral health clinicians was the piece that you almost struggled with the most, but I also like the way that you laid it out for everyone. It's like, A, we're actually providing you a value add because we're giving you the toolbox metaphor is really good. We're helping you do your job better too.

Dr. Kimberly Gorgens:

Exactly, exactly. I always tell my student clinicians when I'm training them to do this work that you don't need to tell an audience of another therapist or psychologist what to do. You need to tell them how to deliver care. So repeat important points. Invite the client to write down summaries before you leave for the day. Ensure that they record meetings in their calendar. It's whatever it is. Telling them how to do their job is actually something that's pretty special in our model.

Amanda Blasko:

I want to just say thank you so much.

Dr. Kimberly Gorgens:

The contact people, my colleague, Judy Dettmer, who was there for margaritas, is now with the National Association of State Head Injury Administrators. It's called NASHIA, N-A-S-H-I-A.org. And Judy has made it her mission to bring this model to as many different sites and stakeholders as possible. We have an online totally self-administered or clinician-administered version of brain injury and cognitive screening. So NASHIA manages the subscription for that.

They also make it available on the cheap for systems that have fewer resources. So a great place to start is with NASHIA, and you could tell them that Kim sent you and they'll sure appreciate that. I'm joking, they'll be horrified. But this is the change that we want to see happen in the world is that we can support our colleagues who are working in these settings to meaningfully use their time to the best possible effect and to support the folks who otherwise get ground to a pulp in these systems.

Amanda Blasko:

And then also raise awareness for system partners that this is an ongoing and extremely vulnerable population that needs more attention too.

Dr. Kimberly Gorgens:

Right, right. We know this. We have decades of research to suggest that these are the folks whose trajectories are a wreck right after community release. In fact, most of them don't stay afloat for

even that six month time point, which to all of my colleagues working in those systems makes perfect sense. These are the folks that we work with.

Those are the clients that you worry about as you're crafting these very careful community re-entry plans or safety plans. And if we could tweak the way that we deliver care to accommodate someone's cognitive function, then we might actually stand a chance of making the difference that we imagine we're making as we're spending the time doing it.

Amanda Blasko:

I love that, and I also love the self-advocacy piece of the model. I think that's really important.

Dr. Kimberly Gorgens:

And for anyone interested in how special the self-advocacy piece, my colleague Markelle Taylor has a chapter in a recent book. It's called *Sex with a Brain Injury*, Annie Lioy. They are a brilliant novelist. It's a first-person account of their experience with brain injury, but also a historical through line of unrecognized brain injury in our contemporary history. Harriet Tubman, for example. And it's a new way of thinking about the suffering that brain injuries include. Of course, this is an invisible injury.

And we know now that these folks, the risk for all of these other downstream conditions, substance abuse, mental illness, are extraordinarily high, and especially for people who are injured whose brain is already vulnerable. So they had a disadvantaged childhood, exposure to childhood trauma, for example. So their trajectory is even worse. So this is a really tangible way to intervene and ultimately bend the curve on that trajectory and help people navigate their way through and ultimately out of those systems.

Amanda Blasko:

That's a great place to end, I feel like. Thank you for such a fascinating and insightful discussion today.

Dr. Kimberly Gorgens:

Amanda, thank you for having me. And then a standing offer, if I can be helpful to consult with colleagues as they're listening to this to reach out. I'm here at the University of Denver and super findable. Awesome. Awesome. Thanks, Amanda. Take good care.

Amanda Blasko:

Thank you.